Australasian Health Facility Guidelines

Part B - Health Facility Briefing and Planning

HPU 610 Subacute Care Unit

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Australasian Health Facility Guidelines

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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 as traditional owners and continuing custodians of the land throughout Australia and the Torres Strait Islander people as the traditional owners and continuing custodians of the land throughout the Torres Strait Islands. We acknowledge their connection to land, sea and community and pay respects to Elders past and present.

Acknowledgement of Te Tiriti o Waitangi

We acknowledge Māori as tangata whenua in Aotearoa New Zealand; Te Tiriti o Waitangi obligations have been considered in developing these 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.

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01 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 developed by AHIA following an extensive consultation process completed in 2024.

1.2 INTRODUCTION

This HPU outlines the specific requirements for the planning and design of Subacute Care Units, including:

- Rehabilitation Inpatient Units
- Geriatric Evaluation and Management (GEM) / Older People's Health Inpatient Units
- Palliative Care Inpatient Units.

Patients accommodated on subacute care inpatient units typically have a longer length of stay than patients on acute inpatient units, have significant involvement of family and carers, and require specialised interdisciplinary care with the focus on optimising a patient's level of function and quality of life. For these reasons, there are specific planning and design requirements that are different to acute inpatient units.

The document is structured to provide recommendations relating to subacute care units, as well as service specific requirements for rehabilitation, GEM/older people's health and palliative care. While the information contained in this document can be used to plan a range of rehabilitation inpatient units, additional information will be required for briefing of highly specialised inpatient rehabilitation services such as spinal cord and acquired brain injury.

It should be read in conjunction with the Australasian Health Facility Guidelines (AusHFG) generic requirements including Standard Components described in:

- Part A: Introduction
- 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.

This HPU should also be read in conjunction with the following as there are many areas of similarity:

- HPU 140 Allied Health / Therapy Unit which describes related facilities
- HPU 340 Adult Acute Inpatient Unit.

1.3 POLICY FRAMEWORK

Before undertaking a project, planners and project staff should familiarise themselves with individual jurisdictional plans, policies, and service specific guidelines. Key references include:

Subacute Care

- Australian Institute of Health and Welfare, 2013, Development of nationally consistent subacute and non-acute admitted patient care data definitions and guidelines.
- Resources relating to planning and design to support people with dementia (relevant to all clinical units):
    - Alzheimer's WA, Dementia Enabling Environments (including for Hospitals)
    - Dementia Australia
    - The Dignity Manifesto of Design for People Living with Dementia
    - Fleming R & Bennett KA, 2017, Environmental Assessment Tool, Dementia Training Australia.
    - NSW Agency for Clinical Innovation, 2014, 'Key Principles for Improving Healthcare Environments for People with Dementia'.
    - Victorian Department of Health, 2021, Dementia Friendly Environments.

Rehabilitation Inpatient Units

- Australasian Faculty of Rehabilitation Medicine (AFRM), Standards for the provision of Inpatient Adult Rehabilitation Medicine Services in Public and Private Hospitals.
- NSW Agency for Clinical Innovation, 2019, Principles to Support Rehabilitation Care.
- Royal Australasian College of Physicians and AFRM, 2023, Bariatric Rehabilitation - Position Statement.
- Royal Australian College of Physicians, Standards for Rehabilitation Services – Facilities and Equipment
- Stroke Rehabilitation Units: Lipson-Smith et al, 2019, 'A Framework for Designing Inpatient Stroke Rehabilitation Facilities: A new Approach Using Interdisciplinary Value-Focused Thinking'.

GEM / Older People's Health Units

- Australian Commission on Safety and Quality in Health Care (ACSQHC), 2021 Delirium Clinical Care Standard.
- Dementia friendly environments – refer to Subacute Care references above.
- National Ageing Research Institute, The Hospital Environment Audit Tool (HEAT)
- NSW Agency for Clinical Innovation, 2021, Aged Health Services in NSW.
- Victorian Department of Health, 2022 Geriatric Evaluation and Management.

Palliative Care Inpatient Units

- Australian Government, 2018, National Palliative Care Strategy.
- McLaughlan et al, 2022, 'Designing Palliative Care Facilities to Better Support Patient and Family Care: A Staff Perspective'.
- National Safety and Quality Health Service (NSQHS) Standards and the National Consensus Statement, 2023, Essential elements for safe and high- quality end of life care.
- Palliative Care Australia, 2024, National Palliative Care Standards for Specialist Palliative Care Providers.

- Palliative Care Australia, 2022, National Palliative Care Standards for All Health Professionals and Aged Care Services.
- Palliative Care Australia, 2018, Palliative Care Service Development Guidelines.

Other jurisdictional specific policy information is contained in the Further Reading section of this HPU.

1.4 DESCRIPTION

The definitions provided below have been sourced from the Australian Institute of Health and Welfare (AIHW) and Independent Health and Aged Care Pricing Authority (IHACPA). Service and facility planning for subacute care units must always be undertaken in partnership with patients as well as family, carers and support networks, and must incorporate technology to support their involvement.

1.4.1 Subacute Care

Subacute care is specialised multidisciplinary care in which the primary need for care is optimisation of the patient's functioning and quality of life. A person's functioning may relate to their whole body or a body part, the whole person, or the whole person in a social context, and to impairment of a body function or structure, activity limitation and/or participation restriction.

Subacute care comprises the defined care types of rehabilitation, palliative care, geriatric evaluation and management, and psychogeriatric care.

Rehabilitation

Rehabilitation care is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with an impairment, activity limitation or participation restriction due to a health condition. The patient will be capable of actively participating.

Rehabilitation care is:

- delivered under the management of or informed by a clinician with qualifications and training in rehabilitation medicine.
- evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record, that includes negotiated goals within specified time frames and formal assessment of functional ability.

GEM / Older People's Health

Geriatric evaluation and management (GEM) is care in which the primary clinical purpose or treatment goal is the improvement in the functioning of a patient with multi-dimensional needs associated with medical conditions related to ageing, such as tendency to fall, incontinence, reduced mobility and cognitive impairment. The patient may also have complex psychosocial problems.

Geriatric evaluation and management are:

- delivered under the management of or informed by a clinician with specialised expertise in geriatric evaluation and management.
- evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record that covers the physical, psychological, emotional and social needs of the patient and includes negotiated goals within indicative time frames and formal assessment of functional ability.

The term GEM is used to describe a specific model of care in the context of subacute care funding, however, there are a variety of terms used across jurisdictions to describe these units including subacute aged care, geriatric rehabilitation and older people's health. The term 'aged care' is often confused with residential aged care, so for the purposes of this document these units are referred to as 'Older People's Health'.

Palliative Care

Palliative care is care in which the primary clinical purpose or treatment goal is optimisation of the quality of life of a patient with an active and advanced life-limiting illness. The patient will have complex physical, psychosocial and/or spiritual needs.

Palliative care in a healthcare setting is:

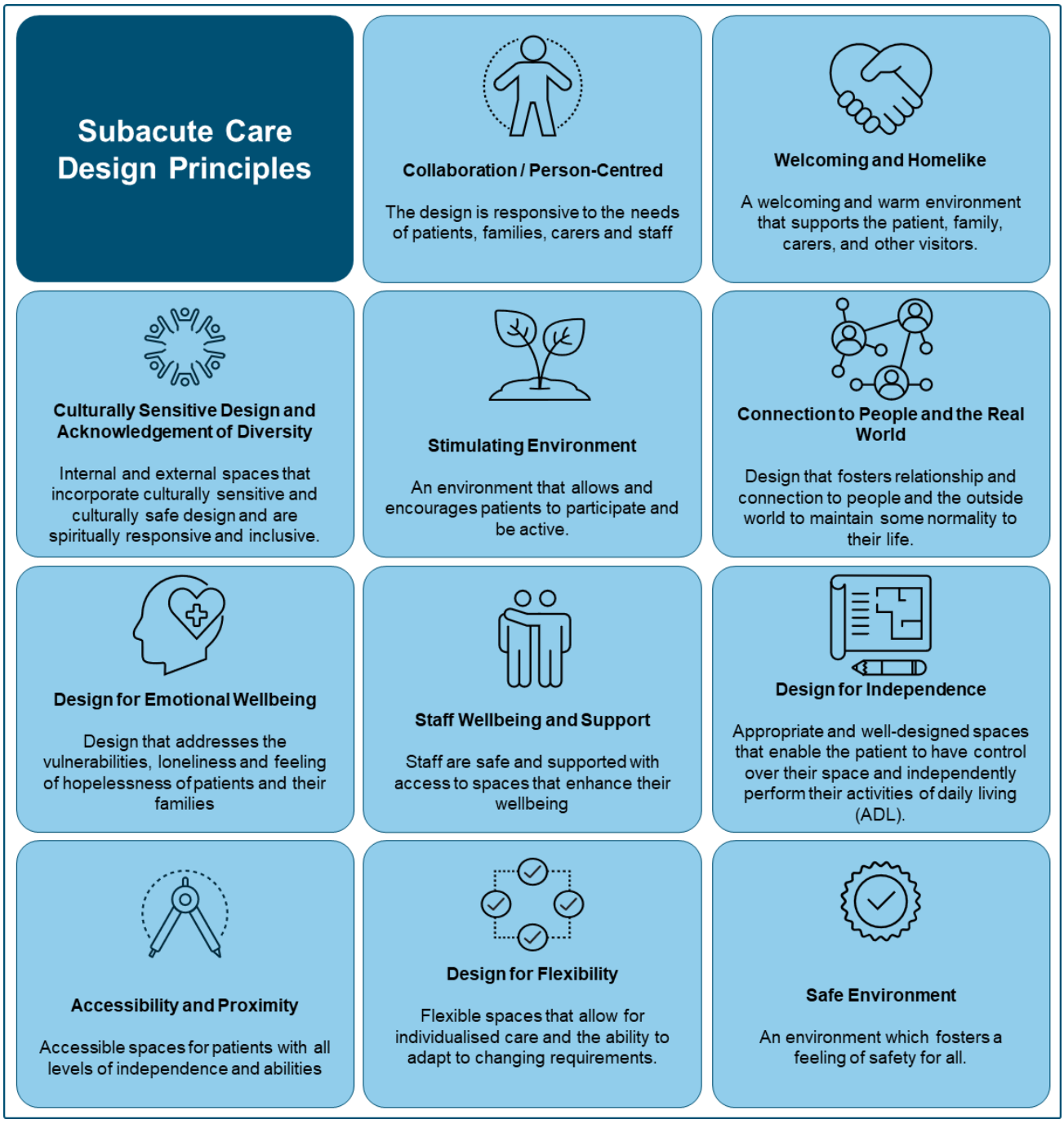
- under the medical governance or informed by a specific medical clinician with specialised expertise in palliative care and delivered by a highly functioning specialist and multidisciplinary team.
- evidenced by an individualised multidisciplinary assessment and management plan, which is documented in the patient's medical record, that covers the physical, psychological, emotional, social and spiritual needs of the patient and negotiated goals.

Whilst the main focus of palliative care is improving the quality of life of the patient, the palliative team also supports families, carers and support networks including addressing their practical needs, providing bereavement counselling and grief support.

1.5 OVERARCHING PLANNING AND DESIGN PRINCIPLES

The physical environment of a subacute care inpatient unit will impact on the patient, family and carer experience, the ability to implement new and changing models of care, the provision of an efficient service, the safety of patients and staff working within the unit, and support for staff wellbeing.

Overarching planning and design principles are outlined below for all subacute care inpatient units and will underpin the detailed planning and design process.



Design Principle	How this may be achieved
Collaboration/ Person-Centred	• Involve patients, family, carers, support networks and staff as partners in the planning and design process. Consider the changing needs of the patient and family/support network throughout the care process.
Welcoming and Homelike	• Provide a non-institutional appearance that mimics the home environment. • Provide opportunities for patients to personalise and have control over the space. Providing a sense of control and ownership over the space is important for patient wellbeing and motivation. • Ensure the size and scale of communal areas are comfortable and appropriately scaled, avoiding an overwhelming atmosphere while creating a more residential-style feel. • Provide adequate space for food preparation, family gatherings and cultural practices. • Provide adequate space for storage of personal belongings including clothing and lockable storage for valuable items. • Support family to stay overnight with the patient.
Culturally Sensitive Design and Acknowledgement of Diversity	• Ensure delivery of a collaborative design process that incorporates engagement with local Indigenous and other cultural representatives. • Provide spaces that promote respect, diversity (including cultural, disability, age/life stage and sexual diversity), cultural safety and inclusion. • Support communal spaces for cultural groups (with consideration of impact on the remaining unit especially those with smaller scale family and cultural support). • Provide support for large numbers of family/friends to gather as a person is dying on a palliative care unit. This includes sufficient spaces for food preparation, family gatherings and cultural practices.
Stimulating Environment	• Provide access to outdoor spaces and nature. • Provide access to natural light and views from within the unit. • Provide multiple opportunities for rehabilitation and/or therapeutic activities (indoor or outdoor, formal, or informal sessions, for individuals or groups). • Consider activities that enhance physical activation and quality of life such as animal assisted therapy and pet visitations. • Provide indoor and outdoor spaces that support meaningful connections with family, friends, and carers.
Connection to People and the Real World	• Provide spaces which allows connection to people as this is a central element to rehabilitation and palliative care practice. • Support proximity and legibility of spaces allowing the patient and family/visitors to use these spaces with ease. • Support shared spaces with other patients, families, and visitors to enhance social connectedness. • Support extended family gatherings, and appropriate accommodation options, particularly for family travelling from regional, rural or remote areas, in line with local operational policies. • Support the use of technology to promote connections with people and the outside world.
Design for Emotional Wellbeing	• Create spaces that safeguard the psychological, emotional, and spiritual needs of the patient. • Integrate the principles of trauma-informed care into design to promote safety, wellbeing, and healing. • Include soothing and calming indoor and outdoor spaces such as healing or Zen gardens. • Provide spaces that allows for privacy, care, treatment and grief support for vulnerable family members and carers.

Design Principle	How this may be achieved
	• Separate quiet spaces from communal spaces to support patient relaxation and prevent sensory overload such as from noise and crowds.
Staff Wellbeing and Support	• Provide adequately sized meeting spaces with video capabilities for private meetings and for multidisciplinary teams and family. • Provide spaces designed to support engagement and connection with patients, family and friends. • Support for staff, student and carer training. • Provide the team with workspaces, offices, and therapy rooms appropriate to their roles and tasks, and that support an interdisciplinary approach. • Provide adequate break space/private rest areas and amenities for staff.
Design for Independence	• Provide access to ADL spaces and independent care within the unit. • Deliver appropriate and well-designed spaces that promote ADL practice (rehabilitation and older people's units) for individual and group work e.g., laundry, bathrooms with bath, outdoor spaces, space for education and therapy groups, social connection and unstructured, self-directed leisure. • Provide access to Independent Assessment Suites (rehabilitation) where required, in line with the endorsed models of care.
Accessibility and Proximity	• Promote inclusivity and cater to individuals with varying abilities. Ensure that spaces are accessible for people with mobility challenges, visual or auditory impairments, neurodiversity and other disabilities. • Incorporate universal design principles to create environments that are usable by all individuals, regardless of age, ability, or status. • Enable patient to access rehabilitation and therapy spaces when they are not being assisted by staff where appropriate. • Ensure appropriate connections to relevant acute/diagnostic services such as medical imaging. • Connection with other spaces that promote the translation of therapy goals to the inpatient unit environment. • Support for virtual models of care to facilitate ongoing care for patients and families, particularly those living in regional, rural or remote areas, post discharge.
Design for Flexibility	• Deliver flexible areas that can readily respond to different patient needs or group requirements. • Provide spaces that integrate therapy with activities of daily living. • Support the unit to align with/mimic the discharge destination to facilitate the transition to discharge. • Provide private spaces for assessment, counselling sessions, etc. which can also be used for other functions such as small meetings or interviews.
Safe Environment	• Provide internal and external spaces where patients can safely participate in activities and access staff assistance when required. • Provide a balanced response to supporting patients' independence and privacy while maintaining sight lines/appropriate observation. • Implement design features to minimise the risk of falls, such as slip resistant flooring, handrails, and well-lit spaces. • Ensure adequate storage for lifters and other equipment so they are not stored along corridors or in the patient's rooms. • Ensure that emergency response systems are integrated into the design to provide a quick and effective response in case of emergencies. • Provide an environment which minimises the risk of transmission of healthcare associated infections.

02 PLANNING

2.1 OPERATIONAL MODELS

2.1.1 Rehabilitation Inpatient Units

Service Model

Rehabilitation services are essential in enhancing the functional independence of a patient with an impairment, activity limitation or participation restriction. A rehabilitation inpatient unit will provide an environment to deliver time-limited and goal-orientated care through combined and coordinated care from medical, nursing, and allied health staff.

The setting in which rehabilitation occurs will be influenced by the patient's needs and service availability. The rehabilitation of many patients now starts in the acute hospital environment with specialist input provided by the rehabilitation team (e.g., stroke, orthopaedics etc.). Rehabilitation will typically be commenced as early as possible in the patient's care journey and the continuum of care will continue beyond the acute and subacute inpatient settings. Selected rehabilitation occurs in an outpatient setting or at home. Ideally, all services are organised as a single rehabilitation service so that care is coordinated across the range of inpatient, outpatient, and community settings.

Types of Patients

While the model of care delivered within a unit will be influenced by the role delineation/service level, a larger proportion of the workload will involve reconditioning following an acute medical or surgical intervention. In 2021/22, the highest volume of rehabilitation inpatient care episodes across Australia and New Zealand (NZ) were for reconditioning, ortho-factures and stroke (AROC Annual Report Australia, 2022; AROC Annual Report NZ, 2021).

Over the last 10 years, the level of complexity and acuity of patients being managed on rehabilitation inpatient units has increased. This is partly due to changing models of care whereby less complex patients are discharged from hospital earlier with follow up through rehabilitation in the home (RITH) and/or virtual care models. A high proportion of patients within rehabilitation inpatient units will be highly dependent on staff for transfers, mobility, and activities of daily living (ADLs) and a significant volume of patients will be wheelchair users.

A large proportion of patients on the unit may be older or elderly patients with chronic conditions and co-morbidities, and with additional disabilities independent of the reason for admission. There is also an increasing number of younger patients with complex support requirements and psychosocial issues who require significant support to assist them with their transition home. This has translated to changes in the staffing requirements within rehabilitation units including increased demand for psychology, social work, and occupational therapy.

The range of patients being treated on the unit must be considered. It may be appropriate to differentiate between patients of working age and older patients, with regard to treatment goals, such as return to the workforce or return to optimum independence in their home or residential aged care.

Key Elements of the Service Model that Impact Planning

The Rehabilitation Inpatient Unit is an inpatient environment with some unique features including:

- The length of stay is typically longer than an acute inpatient unit with an average of 17.8 days in Australia in 2022 (AROC, 2022).
- Many allied health staff working in the unit will be permanent staff members. This will have an impact on space required for write-up, case discussion and handovers, and a larger number of students.

- Family members may (and are encouraged) to be involved in direct care and trained to continue and supervise treatment after discharge. Carers may need access to overnight accommodation (patient bedroom or elsewhere) and a quiet retreat of their own. Accommodation for carers is of particular importance for patients from rural areas and also for female companions/carers for patients in particular cultural groups.
- Independence and optimal functional recovery are promoted by facilitation of usual activity in a home-like environment. For example, when able, patients are encouraged to dress in day clothes and to make use of day facilities, including communal lounge, dining and outdoor areas for recreation when not undergoing therapy.

Specialised Rehabilitation Units

A range of specialist rehabilitation inpatient services will usually be provided on a state-wide (national in NZ) basis and may comprise:

- acquired brain injury (ABI) units
- burns rehabilitation units
- spinal cord injury units
- paediatric rehabilitation units.

These units have specific facility needs generally outside the scope of this document, although non-specialist units may provide services to these patients if no specialised unit is readily accessible. Telehealth services and virtual rehabilitation can support these models so that specialist input is provided.

Stroke services may be delivered by a dedicated team in a dedicated area within an acute inpatient unit, such as neurology. Stroke units may provide early rehabilitation but are not defined as a rehabilitation unit. Patients may be transferred from the stroke unit to the rehabilitation unit once medically stable and if further inpatient rehabilitation is required.

Facilities may have enhancements over and above those listed above, subject to jurisdiction-specific service plans and needs.

2.1.2 Older People's Health Subacute Care Inpatient Units

Service Model

Care of the older person is delivered across multiple settings including within the home/residential aged care, community, outpatient, and inpatient settings. Care should be delivered in the least restrictive setting that will promote independence and reduce the risk of functional decline and adverse events. The boundary between acute, subacute and community care has changed significantly in recent years with a number of conditions now safely managed in the community. In moving from one care setting to another, it is important that the care is provided in an integrated way that meets the patient, family and carers' needs.

In Australia, the Commonwealth and States/Territories have a shared responsibility in the delivery of care and services to older people. The Australian Government Department of Health and Aged Care's 'Joint Statement' clarifies the roles and responsibilities for the delivery of health care for people receiving aged care services.

Almost all clinical units across a hospital (with the exception of paediatrics and maternity) will have an increasing number of older people as patients. Although this HPU is specifically focussed on subacute care inpatient units, many of the principles will be relevant to other clinical units including acute inpatient units, emergency departments etc, to ensure that the physical environment addresses the needs of older people. This includes designing areas that older people can navigate easily and that consider the cognitive impairments, hearing loss, visual deficits and/or mobility problems that older people may have.

The service model provides specialist assessment and management by an interdisciplinary team comprising medical, nursing and allied health. Given the complexity of this patient cohort, access to the full range of health services is generally required, including psychology and neuropsychology. A care plan will be developed in partnership with the patient, family and carers, and will incorporate the following elements through a person centred and goal-oriented approach:

- team-based interdisciplinary assessment and planning
- geriatric medical input
- focus on the older person's medical, psychological, functional and social capabilities
- restoration of function or compensation for lost function
- comprehensive discharge planning.

Type of Patients

Older People's Health Subacute Care Inpatient Units are typically focussed on restoring or enhancing independence of frail, older people who have been deconditioned and made dependent by acute illnesses, or disabled by fracture, stroke, or other acute events. Patients will present with a diverse range of primary diagnoses; however, orthopaedic, and neurological conditions will account for a high proportion of admissions, along with general medical conditions, cardiac and pulmonary diseases. In a subacute setting, the emphasis shifts from managing the acute illness to eliminating obstacles to the person's return to home or residential care, and enabling them to reach an optimal level of independence.

Due to the growth in community-based management of patients, the patients that are managed on subacute care inpatient units typically have higher levels of acuity, complexity, co-morbidities, and dependency. Patients will often require acute and sub-acute care simultaneously where patients have intermittent acute illnesses that need to be treated in situ. This may be through combined acute and sub-acute units or dedicated subacute units with inreach from acute care services. Due to this blurring of boundaries between acute and subacute care, there needs to be a balance of providing a home-like and friendly environment while also supporting the delivery of complex care.

Key Elements of the Service Model that Impact Planning

The following service model elements must be taken into account during the planning and design process for these units:

- The involvement of family, carers and peer groups are an essential component of care. Interactions between family and carers must be enhanced through the provision of appropriate private spaces and communal areas, as well as consideration of accommodation. As noted for rehabilitation services, this is of particular importance for patients from rural areas and particular cultural groups. Access to the outside world using technology will become increasingly important as patient isolation increases due to loss of life partners.
- A high proportion of patients with dementia will be admitted to these units. A well-designed environment can reduce confusion and agitation, improve orientation, encourage social interaction, reduce depression and the stress experienced by staff and families involved in providing care to these patients with complex needs. Further information is provided in Sections 1.3 and 2.2.1.
- Independence and optimal functional recovery are promoted by facilitation of usual activity in a home-like environment. For example, when able, patients are encouraged to dress in day clothes and to make use of day facilities, including communal lounge, dining and outdoor areas for recreation when not undergoing therapy.
- Many allied health staff working in the unit will be permanent staff members, requiring appropriate allocation of therapy areas, staff work areas and amenities including for students.

2.1.3 Palliative Care Inpatient Units

Service Model

The World Health Organisation (2020) defines palliative care as 'an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual.'

Palliative care is provided through a continuum of care which encompasses assessment, symptom management and end of life care, to support people to live as well as possible, for as long as possible.

Palliative care can be provided at home, in aged care facilities, in general unit wards or in the community. The focus of this HPU is purpose-built, specialist adult palliative care units within a healthcare facility building or a stand-alone facility within or outside of a healthcare complex. Palliative care plays a vital role in improving the quality of life for patients and their families and carers. The focus of care is not just the person but also extends to the families and carers, creating an entire kinship group experience. Palliative care must also be culturally safe, and trauma informed.

It is acknowledged that the types of palliative care and support that an individual requires may be:

- informally administered through home-based care provided by family/carer which may be supported by community organisations, cultural leaders, spiritual support, or various outreach services
- provided in non-palliative healthcare areas, such as in acute inpatient, intensive care, neonatal care, paediatric, or aged care units
- formally structured, such as those provided by a specialist palliative care team or other specialist medical, nursing, or allied health teams in a specialised palliative care facility which is the focus of this HPU.

The type of palliative care or end of life care provided will evolve over time as the individual's medical, biopsychosocial, and spiritual needs change. The provision of specialised palliative care in a healthcare setting may only be a small component of the continuum of care for some patients.

Type of Patients

Specialist adult palliative care is for patients aged 18 years old and over. However, admission of younger patients is at the discretion of the clinicians and in consultation with the patient and family. Oftentimes, the location is also a factor as the family might prefer to have their child closer to home rather than a specialised adolescent facility located further away. It is also acknowledged that in some jurisdictions, there are no palliative care units for patients 16 and 17 years of age and therefore, although uncommon and not ideal, they are sometimes admitted to adult units. In these exceptional circumstances, young people should be cared for in a single room and accommodation for family made available.

Key Elements of the Service Model that Impact Planning

Conceptualising spaces suited to patients requiring palliative care in a healthcare setting will be guided by the models of care and jurisdictional requirements, however, there are a number of key requirements common to all palliative care units:

- Although some specialised palliative care units are located separate from acute facilities, the patients may require acute focus for reversible causes of pain and symptom management which necessitates functional connections with acute services such as medical imaging or surgical services.
- Palliative care is person and family/carer centred care, and the design of the environment must consider the changing needs of the patient and family/carer throughout the care process including decision-making at the end of life.

- Dying is primarily a social and cultural experience, with a medical component. It is a natural human process which includes care, social, cultural, spiritual, and clinical elements and all elements require consideration.
- Patient's length of stay does not necessarily relate to the acuity of care or patient's needs. It may be longer term to avail the whole spectrum of palliative care whilst still receiving life-prolonging therapies; or shorter term for patients with a terminal stage of the illness and requiring end of life care only. The care may be short and intense, or very long and protracted.
- Homeliness as well as an atmosphere of respect, support, compassion, privacy and kinship in spaces away from the bedside are as important as the patient's room. In addition to meeting rooms, informal areas are required for people to take a quiet break on their own or with a small number of support people. These spaces should include access to beverages and comfortable seating.
- Gardens and outdoor spaces have multiple recognised benefits to palliative care patients and families by enhancing their experiences which are far broader than the function of providing a view or awareness of day/night cycles in other inpatient units.
- Activities that enhance activation and quality of life such as animal assisted therapy and pet visitations require consideration.
- Family bereavement care commences while the patient is in palliative care and support around grief, including anticipatory grief occurs prior to death. On-site facilities should be provided, where possible, for respite care.

Paediatric and Adolescent Palliative Care and Hospice Care

Palliative and hospice care of children and adolescents is not the focus of this document. Although the HPU is focused on adult palliative care, the principles of planning and design will be similar and can be applied to paediatric/adolescent palliative care units.

Specific requirements for paediatrics/adolescents will be based on project-by-project planning and design which include:

- Considering specific needs of children/adolescents and their families during respite care, symptom management, and end-of-life care.
- Considering the broad demographics of paediatric and adolescent patients (newborn to 18 years) and include design elements that will appeal across age groups including furniture, fittings and equipment (FF&E) suitable for children/adolescents, suitable interior décor, contemporary artworks and ICT connection to assist in their day-to-day living and therapeutic activities.
- Providing a space, ICT connection and equipment to allow a specialist paediatric palliative care team to assist families caring for a child receiving palliative care in the home. It will also assist the specialist paediatric palliative care team to provide support and education to other healthcare providers in urban, rural, regional and remote, as provided by the Quality of Care Collaboration Australia.
- When provided in a combined adult and paediatric palliative care facility, single rooms to accommodate younger patients and their families, carers and visitors are required.

When provided as part of a combined adult and paediatric/adolescent palliative care unit, the zone may also be multipurpose and used for other patients with special needs if not being used for paediatrics/adolescents.

Refer to HPU 540 Paediatric / Adolescent Unit, Section 3.5.4 Interior Decor for further guidance on design elements and artwork considerations for paediatric/adolescent spaces.

2.1.4 Allied Health / Therapy Services

Rehabilitation and Older People's Health Subacute Care

The service plan or model of care should identify if therapy areas such as gyms, hydrotherapy, other allied health facilities, ADL and outpatient clinics are to be built as dedicated support spaces for the subacute service only. Alternatively, the facilities may also be used by inpatients from other units and general outpatients. This will impact on the facilities provided, the key functional relationships, and ability to access these other service units. Review of access to all available therapy spaces on the individual site should be considered to maximise utilisation of facilities.

The size of the dedicated therapy area for this unit should reflect the number of beds in the unit, the role delineation, level of service, and length of stay. Shared access by other services must be considered against the anticipated volume of activity, acknowledging the significant growth in outpatient rehabilitation services. Inreach services to acute units should also be considered to ensure appropriate assessment and treatment areas are provided.

Given the high volume of patients from rehabilitation and older people's health inpatients units accessing therapy areas, it is recommended that these areas are collocated with the units. This facilitates greater intensity of rehabilitation, optimises efficiency associated with patient and staff travel, supports nursing staff to be more involved in therapy and encourages access by patients including after hours. The areas provided should support access to multiple opportunities for rehabilitation including formal and informal groups of different sizes such as small groups of two to three people (e.g., lounge nooks, small therapy areas) through to larger groups within gymnasiums and communal lounge areas.

Specific allied health/therapy areas are detailed in Section 2.4.4 Functional Areas.

In a rehabilitation unit, the patient is expected to continue with ongoing self-directed exercises outside formal therapy sessions. Continuous rehabilitation over the seven-day week is considered to improve outcomes and shorten lengths of stay. Therefore, access to external spaces and some exercise or multifunctional spaces outside normal hours, and external space, is an important factor to consider. The availability of staff to provide supervision, will also require consideration.

The above facilities are addressed in detail in HPU 140 Allied Health / Therapy Unit which provides details on a campus-wide service.

Palliative Care

As palliative care has multiple care pathways, a wide variety of interventions should be made available to patients. Allied health therapies provide benefits associated with prolonging functional independence, relieving symptoms and complications and improving quality of life. Allied health professions that provide therapy to patients in palliative care units include, but are not limited to, Pharmacy, Social Work, Psychology, Occupational Therapy, Physiotherapy, Exercise Physiology, Dietetics, Speech Pathology / Speech-Language Therapists, Art Therapy, Music Therapy, and Diversional Therapy. Complementary therapies may also be provided, such as Massage Therapy, and Animal Assisted Therapy.

Many, but not all, of the rehabilitative interventions in palliative care units are performed in the patient's bedroom. The types of activities will change according to the disease progression and the condition of the patient. This may include range of motion exercises, patient repositioning to relieve dyspnoea or pain, exercises to augment self-care activities and mobility, and other interventions to maintain independence or prevent falls.

Depending on the patient cohort and models of care, a multifunction therapy room/space may provide a dedicated area for activities such as exercise, yoga, and meditation. Other opportunities for physical activity and independent exercise should also be provided such as walking along unimpeded corridors and access to an outdoor area.

For palliative care units that provide massage therapy, this may require a separate dedicated room or can be provided in the patient's bedroom. For animal assisted therapy, the facility design should allow pets/therapy animals to access the patient's area easily without passing through the entire unit. Parking close to the unit must be considered, as well as access to appropriate areas for animals to toilet.

2.1.5 Virtual Models of Care

The provision of virtual models of care is continuing to grow in line with innovations in technology and specific models will need to be determined on a project-by-project basis.

Contemporary Rehabilitation in the Home (RITH) models are provided through a combination of care in the home and virtual care. Virtual care is not a direct substitution for inpatient care given it is challenging to replicate the nursing care and intensive therapy services provided in an inpatient unit, however it may be appropriate for patients and their family/carers who are highly motived to engage in RITH. These models will require accommodation for the team providing care in the home and/or virtually, access to fleet cars, storage for equipment and appropriate work areas and ICT equipment and set up to support virtual care models.

In palliative care units, virtual care allows families/carers and their support network to be involved with preparation of patient care and treatment plans without having to visit the site. Care support may also be provided by a specialist palliative care team to patients and their families receiving palliative care in the home. This is beneficial for patients who are in large metropolitan areas with significant geographic distance from the specialist paediatric palliative care unit or those who live in remote or rural locations.

Virtual care can also support the integration of the multidisciplinary team including specialists, allied health and primary care staff to enhance holistic comprehensive care and improve continuity of care.

2.1.6 Robotics and Other Technologies

The use of robotics and other technologies to support rehabilitation services is increasing. This includes robotics, sensor technology, virtual reality and gaming technology that allow for precise, measured, and varied repetition of movement that can be adjusted according to the needs of the patient. These technologies are typically associated with large items of equipment accommodated within therapy areas that require access to power and sufficient space include appropriate clearances to support safe access for patients.

The use of ceiling mounted hoist and robot assisted gait training are becoming increasingly common in rehabilitation units and may be considered for older people's health units with significant volumes of patients with non-weightbearing conditions. There is increasing evidence relating to the use of robotic intervention for gait training in patients with subacute stroke (Cho et al, 2018). This equipment partially or totally supports a patient's body weight and allows high-intensity gait training for non-ambulatory patients, which is challenging for a therapist to achieve alone. It also provides benefits associated with patient safety through the prevention of falls and supports more efficient delivery of therapy services.

Virtual reality technologies are utilised in palliative care units as part of diversional therapy and for distraction from pain. There are significant variations of technologies utilised across jurisdictions based on models of care, availability of resources and trained staffing availability. Functional Wi-Fi is required to allow smooth functioning of these technologies.

2.2 OPERATIONAL POLICIES - GENERAL

The operational policy issues detailed in this section should be considered when identifying the models of care to be implemented as they will all impact the configuration of the unit and overall space requirements.

Operational policies should be developed as part of the project planning process. Refer to AusHFG Part B Section 80 for further information.

2.2.1 Patient Management Considerations

Bariatric Patients

The unit should provide a physical environment that supports the optimal care of bariatric patients, with appropriate consideration of staff safety.

Bariatric facilities and equipment are routinely provided when a patient's weight exceeds 150kgs.

A standard bariatric bedroom and ensuite supports the management of patients up to 250kgs. These rooms may be flexibly used for other patient care including where significant additional equipment is required or space to accommodate a bed should a carer need to stay overnight. The provision of 'super' bariatric bedrooms and ensuites, for the management of patients up to 450kg, should be restricted to selected healthcare centres only, to ensure that safe and effective care is provided. The size and location of equipment, fitting and fixtures makes this room almost impossible to safely use for other patient care.

Considerations include:

- The number of bariatric bedrooms provided will be determined by an analysis of activity and the catchment population.
- The design and fit out of therapy spaces, including appropriate equipment and the need for ceiling mounted hoists.
- Provision of space to store bariatric equipment, including beds, which are larger in size.
- Corridors, lift access, and door widths should be sized to accommodate bariatric equipment including beds and wheelchairs.

Patients with Dementia and Delirium

Patients experiencing **acute confusion states (e.g. delirium) and dementia** will be managed on all subacute care units, particularly older people's health units.

The Dignity Manifesto of Design for People Living with Dementia outlines evidence-based design principles to better support people with dementia. The following design strategies are recommended for subacute care inpatient units to achieve these principles and ensure the unit supports people's wellbeing, autonomy, and independence, whilst promoting movement, engagement and meaningfulness.

- Maximise exposure to daylight.
- Minimise glare.
- Provide adequate and appropriate artificial lighting with the opportunity for varied lighting including some constant low-level lighting for nighttime and ability for patients and carers to control the lighting (refer to Section 3.5.2 for further information regarding lighting).
- Provide non-slip and slip resistant floor coverings to minimise falls.
- Minimise clutter.
- Use acoustic strategies to minimise noise including from televisions and other patients, families, and carers.
- Avoid use of contrast within floor surfaces, e.g., patterns and/or features.
- Ensure easy and visible access to toilets including directional night lighting and contrasting colour for toilet seats.
- Use signage, colour and contrast for wayfinding and orientation. The design should support patients to readily see where they want to go e.g., bedroom, ensuite, kitchen, lounge, outdoors etc.
- Create a familiar environment using carefully selected artworks. Refer to Section 3.5.4 Arts Integration for further guidance.

- Promote access to outdoors and nature.
- Access to specialised therapy including animal assisted therapy.
- Design circulation areas to provide a walking route that allows patients to move about the unit with opportunities for engagement and access to areas to sit with visitors, whilst providing the ability to control entries and exits and minimise the extent of unsupervised space.
- Locate and design outside areas to ensure they can easily be viewed by patients (and accessed where appropriate).
- Support good observation from staff stations and bases.
- Provide the ability to lock down or reduce access to rooms including storage rooms, exits, utility rooms etc.
- In general, limit the number of exits from the building so that staff can be aware of the location of patient and visitors.

Movement sensing and falls prevention technology is rapidly improving. Project teams are advised to refer to the latest technology, associated evidence, and other facilities that are using these systems for current advice.

If patients experiencing extreme behavioural and psychological symptoms of dementia (BPSD) are anticipated to be managed on the unit, consideration will need to be given to the design of the unit to ensure the safety of the patient, staff, other patients and family/carers. Patients experiencing extreme BPSD are typically managed in a single room and require access to a range of secure indoor and outdoor spaces to support meaningful activities. The unit should support functional segregation of different areas to help manage the mix of patients, as further described in Section 2.5.3.

Patients receiving palliative care may experience delirium while in the palliative care unit especially towards the end of life. When experiencing delirium the patient may be agitated, restless and may be a falls risk. A shared bed room with an adjacent staff base for observation may be necessary for patients who need constant close observation allowing staff to monitor multiple patients at the same time. Provision of overnight accommodation for one or more carers to stay with the patient should also be considered to assist with patient orientation and observation.

Further information is provided in the references under Section 1.3.

Patients with Other Cognitive Impairments and /or Unpredictable Behaviours

Patients may at times exhibit unpredictable **behaviours**, particularly patients with brain injury and acute confusion conditions, and will include younger and older patients. This requires careful consideration to support the safety of staff and other patients.

Features that should be considered in the design of the unit to safely accommodate these patients include:

- good observation from staff stations and bases
- design must not create entrapment or concealment points
- locating senior staff work areas close to the unit to provide support where required
- use of mobile duress systems
- covered service panels (gases, suction, etc.)
- use of patient monitoring devices
- tamper-proof fittings.

Design strategies should be informed by a risk assessment that considers the anticipated patient cohort. Design strategies should be implemented in conjunction with operational responses such as managing the patient in a single bedroom, removing equipment from the bedroom, locating the patient near the staff station and ensuring optimal line of sight or close observation.

2.2.2 Clinical Support Services

Medications Management

Models for managing medications may vary to match local policies or complement patient management strategies (e.g., self-medication programs). Pharmacy staff should be consulted in determining the appropriate model.

Options for administering medications within the units include:

- lockable medication trolleys
- lockable bedside lockers
- automated dispensing systems – fixed or mobile solutions.

Some services report the use of a locked draw at the bed side a useful way to manage medications in this longer stay environment. Other services report that this type of model can prove inflexible when patients are encouraged to be out of their bedrooms for extended periods as part of their therapy program. Appropriate investigation and analysis of automated dispensing units is recommended prior to confirmation of the preferred system and should be part of a 'whole of hospital' approach. If automated dispensing systems are to be used, consider the dimensions of the units (either fixed or mobile) and the provision of power and network connections. Mobile dispensing units will need to be docked for recharging or may run on batteries.

The preferred approach for clinical pharmacists and nursing staff to access electronic medication management systems will require confirmation to inform the ICT requirements.

Security and control of access to medication stores should comply with local legislative/jurisdiction requirements.

Where a palliative care facility is participating in Voluntary Assisted Dying (VAD) / End of Life Choice (NZ), VAD substances must be prescribed, recorded, supplied, administered, stored, and disposed of as per specific requirements of local jurisdictional legislations, policies, and directives.

Pharmacies which are part of the palliative care unit servicing regional and remote areas will require public access to support patients who are cared for through hospital in the home care.

Medical Imaging

Given the trend towards higher acuity patients being managed on subacute care units, there will be a high volume of patients requiring access to medical imaging. The most common modalities are general X-ray and ultrasound.

Where subacute services are not located on an acute hospital site, clinical planning processes should consider the optimal model for access to imaging services given the high cost and disruption associated with transporting patients.

Pathology

Access to pathology services will be required for blood and other specimen tests. Time and cost considerations relating to offsite pathology services should be considered.

2.2.3 Non-Clinical Support Services

Operational approaches to non-clinical/'back of house' support services require definition during the planning process. This will include the management of food services, linen, waste, cleaning and supplies.

Food Services

The food services model for the health facility will impact planning and design requirements. For example, some facilities will require a bay to store a meal trolley while food trays are distributed to patients, whereas for other facilities, the meal trolley will be transported directly to patient bedrooms and then returned to the kitchen while a separate trolley will be used to collect finished meal trays. Some units may support the plating of meals in the communal dining area.

Consideration also needs to be given to patients requiring modified diets and/or enteral feeding, which will need to be stored on the inpatient unit.

Linen

The delivery and collection of clean and dirty linen will be operationally separated to reduce infection risks.

Linen bays will be provided to store clean linen, and dirty linen will be placed in dirty linen skips in the dirty utility rooms ready for collection.

Waste Management

Operational policies for waste management and waste minimisation should be supported, particularly with regard to:

- waste flows
- types of sizes of various containers for waste
- types of waste including material recovery through recycling
- provision and location of dirty utility rooms and disposal rooms
- provision and location of recycling bins
- location of sharps containers.

The management of clinical and related wastes should be in accordance with:

- AS/NZS 3816:2018 Management of Clinical and Related Wastes (Standards Australia)
- Part D: Infection Prevention and Control.

Cleaning

Appropriately located cleaner's rooms are required for direct access to cleaning equipment, cleaning agents and consumables.

Storage of bulky cleaning equipment is usually shared between several inpatient units.

The unit must support appropriate cleaning processes for shared equipment. All furniture, fittings and equipment (FF&E) must be compatible with required cleaning and disinfection processes.

2.2.4 Storage of Equipment

It is important to accurately assess equipment storage needs. The types and numbers may vary depending on the bed numbers and types of patient care provided.

Rehabilitation and Older People's Health units require a large range of equipment for trial and use with patients, some of which may be located in a separate equipment pool shared by all services. The model for provision of loan equipment must be confirmed with the service. High turnover, short use items may be located on site for ease of access and other specialised equipment e.g., customisable wheelchairs, are typically outsourced to a specialist provider.

Manual handling equipment is of prime importance and needs to be stored close to the point of use such as in equipment bays off corridors.

A storeroom/s will be required for less frequently used items and many items will be bulky and need floor parking space. Storage areas should be lockable, and the design should enable easy retrieval and return of equipment through doors sized for the purpose. Power for charging of equipment will also be required in this area. Many services operate a loan equipment store for use by inpatients and outpatients. This will usually be located on the health care site with access for vehicles so that easy pick up and return can occur.

The use of pressure relieving mattresses can be significant in the rehabilitation, older people's health, and palliative care inpatient environment. Depending on the mattresses used and the model of provision, additional storage may be needed to store standard mattresses when a consignment product is being used. Other mattresses may just fit over an existing mattress so that storage is not an issue.

Storage and recharging of batteries, particularly lithium style batteries, will require consideration of fire protection strategies.

Separation of clean and dirty equipment will be needed. Where loan equipment stores are provided on site, appropriate areas will be required to support the receipt of equipment and aids returned to the unit, cleaning of returned items, and maintenance/repair of equipment and aids.

2.2.5 Patient Clothing

Patients will be encouraged to wear day clothes. As the length of stay may be extended, access to a patient laundry may be needed. It may be used by the patients themselves (under supervision if required) or by their families and carer, and for activities of daily living purposes by the occupational therapists.

Provision of a laundry in palliative care is also important for facilities that admit paediatric patients and those with patients and visiting families from remote communities.

There are strict requirements relating to infection prevention and control associated with laundries. Refer to local jurisdictional policies and AS/NZS 4146 Laundry Practice.

2.2.6 Staffing

The multidisciplinary staff establishment, permanent and visiting, may include:

- physicians: specialists, registrars and residents
- nursing staff: unit manager, clinical nurse consultants, clinical nurse educators, registered nurses, enrolled nurses, assistants in nursing and other auxiliary nursing staff
- allied health staff: clinical and neuropsychologists, occupational therapists, physiotherapists, speech pathologists / speech-language therapists, social workers, dieticians, pharmacists, podiatrists, prosthetists and orthotists; exercise physiologists cultural liaison officers; allied health assistants; diversional and recreational therapists; art therapists, music therapists
- health care interpreters
- digital/virtual therapists
- horticultural therapists (may be provided by diversional and recreational therapists)
- complementary therapies staff such as massage therapists
- spiritual and pastoral care staff including chaplains
- ICT and engineering staff
- support staff: clerical, wards persons, interpreters, food services and housekeeping staff
- students from all disciplines
- volunteers.

Staffing levels will vary for each unit, depending on the size of the unit and the operational policies. For rehabilitation services, refer to the Australasian Faculty of Rehabilitation Medicine, 2019, Standards for the Provision of Inpatient Adult Rehabilitation Medicine Services in Public and Private Hospitals for further information.

2.3 OPERATIONAL POLICIES – REHABILITATION AND OLDER PEOPLE'S HEALTH

2.3.1 Activities of Daily Living (ADL) Assessment

Access to a range of simulated home-like environments may be needed to assess a patient's level of functioning and to prescribe the equipment needed to support them on discharge. These areas are also used for patient retraining and practice of ADLs prior to discharge.

For some services, the use of dedicated ADL areas is decreasing given the trend toward assessing patients in their own home environment and providing support and allied health/therapy in the home. This supports a 'real life' context and direct assessment of the required local modifications. However, the provision of ADL areas is essential for some units to support efficient patient assessment and ongoing practice in preparation for discharge.

Where ADL areas are required to support the model of care, key spaces include kitchen and bathroom facilities. Where possible, kitchens can be multipurpose spaces and accessed to support other activities such as small groups when not needed for ADL assessments. This should be located in close proximity to the bedroom areas and on the same floor where possible to motivate patients to attend. Patient laundry facilities and clothesline options may be considered for extended ADL training depending on the patient cohort and service model. There are strict requirements relating to infection prevention and control associated with laundry services. Considerations relating to the laundering of patient clothing, the use for ADL assessment/rehab purposes and laundering of clinical requirement will require compliance with local jurisdictional policies and AS 4146 Laundry Practice.

These specialised facilities are typically located on a rehabilitation unit and may be used by a range of other services on site.

In addition, general spaces throughout the unit will be used to assess ADLs. These spaces include bedrooms, lounge and dining areas.

2.3.2 Independent Assessment Suite

A small unit may be included to provide both the patient and carer an opportunity to simulate life at home before discharge. This may be to trial a patient's level of independence and safety prior to discharge and/or to trial a family/carers ability to care for a patient. The suite will consist of a bedroom, ensuite, kitchen, lounge and dining area. The rooms are connected to the nurse call system but will not be fitted out as a typical inpatient bedroom. As these spaces are not standard inpatient bedrooms, they may not be included in the bed numbers for the unit.

These units are often provided as part of rehabilitation inpatient units but reducing in use for older people's health units. This is partly due to the preference to undertake assessment and contextual therapy in the patient's own familiar environment. This will depend on the geographical catchment for the service given the ability to undertake patient assessments on the unit is preferred where there is a high volume of patients from regional and remote areas.

2.4 OPERATIONAL POLICIES – PALLIATIVE CARE INPATIENT UNITS

2.4.1 Family Gatherings

Large gathering space for family to address their cultural needs may be required. Adequately sized outside spaces/gardens/yarning circle adjacent to the communal lounge area may need to be considered to accommodate large groups.

Where facilities for large gatherings are provided, consider the scale and associated noise. Ensure that these spaces do not interfere with the privacy and quieter requirements for other cultures.

2.4.2 Voluntary Assisted Dying (VAD) / End of Life Choice

The Voluntary Assisted Dying Act (in all Australia States) and the End of Life Choice Act (New Zealand) enables people at the end of their life who meet strict eligibility criteria to access voluntary assisted dying. Although voluntary assisted dying **is not part of palliative care practice**, participating palliative care units may offer and provide VAD for patients with life-limiting illnesses.

Refer to jurisdictional legislations, policies and directives for specific requirements for prescribing, recording, supplying, administering, storing and disposal of voluntary assisted dying substances in palliative care units.

2.5 PLANNING MODELS

2.5.1 Location

Ideally, subacute care units should be located on the ground floor to optimise connection to outdoor areas and promote access for therapy, socialisation, and restorative purposes. It is acknowledged that this is not always possible on a constrained acute hospital site. Regardless of the location, access to outdoor areas is essential.

As noted in Section 2.1.4, it is also recommended that subacute care units are directly collocated with the associated allied health/therapy areas including gymnasiums.

Where a unit is located in a stand-alone location, there should be a dedicated weather-protected entry, and a drop-off and pick-up parking facility.

While many subacute care units may be located on non-acute healthcare sites, the increasing complexity and acuity of patients, means many patients still require other support (e.g. medical imaging or the involvement of other medical specialists). Collocation with an acute site makes access to these services easier.

There are, however, benefits associated with locating subacute care units on non-acute sites. These include quieter locations, greater opportunities for ground floor and outdoor access, and ease of access for family and visitors. Consideration may be given to locating diagnostic support services on a non-acute site where sufficient utilisation is anticipated to minimise the high cost of transporting patients. Non-acute sites are also appropriate for services focussed on managing patients in the home and the provision of virtual models of care where patients do not require 24-hour nursing care.

Consideration should be given to models of care which collocate inpatient rehabilitation services with outpatient rehabilitation services as a step-down model to support continuity of care. However, it is generally recommended that inpatient and outpatient gyms are not shared due to infection control risks, different equipment requirements, patient compatibility and challenges with patient flow, booking and managing competing needs

All units should be located so that staff are not working in isolation or are required to traverse unoccupied areas at night.

2.5.2 Unit Size

The total number of beds in a unit will vary, depending on the defined service needs of the individual healthcare facility and should be informed by clinical services planning with consideration of efficient staffing models.

Issues to be considered include:

- patient case mix/acuity
- maximum flexibility for the accommodation of different types of patients with regard to condition, age and gender

- staffing profile based on role delineation or service level and patient volumes (Nursing Hours per Patient Day).

2.5.3 Unit Configuration

Patients undergoing rehabilitation are encouraged to undertake a normal daily routine. This routine includes initiating visits to communal areas and therapy. In order to optimise this normalisation, consider a compact unit design that reduces travel distances from the bedroom areas to other shared zones.

The configuration of the unit should also consider requirements relating to patient observation. Depending on the size of the unit, the provision of decentralised/satellite staff stations should be considered to support optimal line of sight for both bedroom and communal areas.

The arrangement of the unit should support the ability to control entries and exits and avoid potential entrapment points, as well as supporting staff to have ready access to clinical and operational support areas e.g. storage and utility rooms. Where animal assisted therapy is part of the models of care, consider access of animals and their handlers.

A secure area may be required for units managing patients with extreme BPSD. Local jurisdictional policies will need to be referred to. Design requirements may include the provision of a small pod e.g. two beds that can be secured from the rest of the unit when required with consideration of:

- access to a separated and secure outdoor space
- access to a separate and secure lounge/dining/activity area
- a safe space for staff to work away from patients
- support for carers
- optimising patient observation
- optimising patient and staff safety including consideration of access requirements, staff duress and limiting entrapment points
- other principles of a dementia friendly environment (refer to section 2.2.1).

2.5.4 Bedroom Mix

Palliative Care

Single bedrooms are preferred in a palliative care unit to maintain privacy, comfort and allow family and support persons to visit and stay at any time. However, it is acknowledged that some patients prefer to share bedrooms.

As palliative care can be provided over a protracted time frame, space for a bed for carers is required.

Patients in palliative care units may also require close observation. It is important that these units have several vantage points where staff are able to see several rooms at the same time, especially as a high percentage of patients have delirium. Also, for this reason, shared bedrooms with an adjacent staff base may be provided. Maintaining visibility for staff as well as ensuring patient's privacy may be challenging but needs to be provided to ensure patient safety.

Rehabilitation and Older People's Health

Rehabilitation and older people's health units are typically provided as a mix of single and two bed rooms, however four bed rooms may be considered for units that will manage a number of patients requiring high levels of observation.

Key considerations relating to the appropriate proportion of single bedrooms include:

- the different use of bedrooms within these units compared to acute inpatient units given patients are encouraged to spend much of the day in areas outside of the bedroom e.g., in therapy, communal, outdoor areas etc.

- patient case mix with regard to acuity, dependency and clinical complexity
- volume of patients anticipated to require high levels of observation
- use of technology such as bed alarms
- requirements relating to a range of different types of patients, e.g., age, disability, mental health, neurodiversity and gender
- healthcare acquired infection rates and associated need for isolation facilities and ability to cohort patients
- local population catchment characteristics such as indigenous and cultural considerations
- capital funding - single rooms impose additional capital costs in regard to increased floor area including circulation space, additional ensuite requirements and associated fittings, plus longer runs required for medical gases and power. In addition, the need for greater floor area may impact on the land footprint required
- impact on recurrent costs with regard to staffing requirements, including nursing, cleaning and maintenance.

With a higher proportion of single rooms, there may be a greater impact on staff observation and staff travel distances. Depending on the configuration of beds and travel distances, it may become necessary to support decentralised staff stations and other support areas as noted in Section 2.5.3.

For further reading refer to Shannon et al (2018).

Single Bedroom Advantages and Disadvantages

Advantages:

- provides greater levels of patient privacy
- enables individual control over noise, light levels and temperature all of which facilitate better quality rest and sleep and reduced patient stress
- better addresses issues of age, gender, mental health, and patient compatibility, i.e., provides greater flexibility in bed management and reduced patient transfers/room moves
- facilitates family participation in the patient's episode of care, which may be an important component of the services model of care
- facilitates access and provision of pet and animal assisted therapy
- reduces patient distraction where therapy is occurring within the room
- increases ability to isolate and manage infectious patients
- reduces risk of exposure to infectious diseases
- enables separate accommodation of patients with poor hygiene or incontinence
- reduces the risk of patients being or feeling responsible for supporting other patients within the room e.g., those with a falls risk, unwell etc.
- provides a more appropriate environment for patients with unpredictable behaviours e.g., dementia, delirium or mental illness.

Disadvantages:

- no ability for patients to socialise and support one another
- patients may feel isolated and insecure or unsafe
- may provide less incidental activity (physical, cognitive and social) that promotes recovery
- staff may have decreased visibility of patients compared with open multi bed rooms. This may be significantly reduced with the use of internal glass walls containing internal venetians or roller blinds, as well as appropriately located safety mirrors.

- increases staff travel distances with potential impact on staffing requirements
- a greater number of ensuites plus the overall greater floor area will increase cleaning and maintenance costs over time
- increases capital cost associated with the increased floor area, additional ensuites and associated infrastructure requirements.

2.6 FUNCTIONAL AREAS

Functional areas of the Subacute Care Unit will comprise:

- entry, reception and waiting areas (where provided in a stand-alone location):
- inpatient areas
    - inpatient bedrooms
    - independent assessment suite (where provided)
    - shared patient areas
- therapy and related areas
- clinical support areas
- staff areas, including staff work areas and amenities.

2.6.1 Entry, Reception and Waiting

The provision of a dedicated entry, reception and waiting area will be dependent on the location, scale and availability of resources to staff a reception (e.g., ward clerk). Units providing a broader range of services, such as outpatient clinics and/or a day hospital will also need to be considered in terms of reception, waiting space and wayfinding.

Where a dedicated area is provided, visitors entering the unit should have clear view of the reception. The reception will have clear oversight of the entry and waiting areas and act as a control point to other areas of the unit.

The waiting area will accommodate patient equipment such as walking frames and wheelchairs. Consider alternative entry/exit points for therapy animals and other therapists with extra paraphernalia such as large musical instruments.

Unless provided nearby, a range of patient and visitor amenities will be required.

Main Entry and/or reception design should acknowledge the traditional lands on which the health service is built. As it applies in Australia, this may be interpreted as part of wayfinding and signage or may be incorporated as an artistic response to Country within the main entry door or reception area in general.

2.6.2 Inpatient Areas

Bedrooms should be located so that they can be easily monitored by staff.

The size and fit-out of **patient bedrooms** may need to consider:

- a range of patients (e.g., bariatric)
- observation of at-risk patients (e.g., falls risk or confused patients)
- possible capacity to accommodate a carer overnight. Consider the ergonomics of sleeping furniture for extended stay by family/carer.
- the longer length of stay with storage required to accommodate more clothing etc. and the requirement for lockable storage

- the requirement to accommodate equipment such as a walking frame or wheelchair within the room and sufficient space to use the aid around the room. Preferably, the wheelchair should be parked near the bed to facilitate independent access and use. Positioning of electrical services should assist a patient to independently charge batteries for wheelchairs/other equipment. Storage of patient equipment in rooms also prevents clutter in corridors. The provision of a desk within rehabilitation facilities supports completion of OT/speech therapy practice independently.
- use of mobile or ceiling mounted lifters
- inclusion of notice style boards within each room to provide a place for education material, activities schedule, and personal items such as cards, artworks and photos etc. These should be viewed by the patient when they are in bed or a chair.
- access to power to charge their own electronic devices
- inclusion of day and date clocks so that patients can organise their day.
- For palliative care bedrooms, consider:
    - natural ventilation where possible
    - direct connection to terrace/veranda/outdoor space to extend the carer zone externally
    - 'room in' space allowing for family/carer to stay overnight in the patient room and sleep adjacent to the patient at night. The joinery at the head of the bed should not be fixed to support flexibility for a carer bed that may include another hospital bed to be provided adjacent. Reclining chairs are not favoured as sleeping arrangements.
    - inclusion of a small fridge to store food and beverages for patients and carers.

Where an Independent Assessment Suite is provided, it will be planned to accommodate a couple.

Ensuites and Bathrooms

All beds require direct access to an ensuite shower and toilet. Larger ensuites are provided for bariatric patients and disabled patients to meet accessibility requirements. Door sizes should support safe access of mobility equipment for both the patient and assisting staff. Refer to the AusHFG standard components for ensuites.

Access to the ensuite should minimise the number of directional turns a patient has to make to reach the toilet, which should be visible from the bed.

Some patients may need to be showered on a shower trolley. It may be possible to arrange the ensuite, or a number of ensuites, so that this activity can be undertaken within the bed room suite rather than a centralised bathroom. The Building Code of Australia (BCA) requires one island-type plunge bath on each storey containing an inpatient area. However, if the method of bathing patients in inpatient areas is achieved via a means other than the use of an island-type plunge bath, a BCA Performance Solution Report prepared by the project architect may be sought to justify its omission. The Performance Solution Report must address BCA Performance Requirement FP2.1 in consultation with the relevant project stakeholders and must be approved by the BCA certifier during the design stage.

Shared or communal patient areas will comprise:

- lounge area/s
- dining/activity rooms
- outdoor areas (for mobility assessment, exercise and recreation).

The lounge area/s will be used by both patients and their visitors and may be provided as a number of smaller/decentralised areas to provide a more home-like scale. A TV will usually be located in this area or alternatively, the lounge space arranged in such a way that a smaller TV area is provided. The provision of a TV in the communal lounge should be discussed during planning and design given the widespread use of smartphones and tablets. Provision of Bluetooth or similar technology should be considered to allow access to audio by individuals.

Lounge and dining areas should be adjacent with direct access to an outdoor area. Furniture provided in this area is important. While seating is needed, many patients will use wheelchairs, including bariatric equipment so the space and layout will need to accommodate both fixed and mobile furniture.

For rehabilitation and older people's health units, the dining area should be able to accommodate at least two thirds of the patient population, plus the occasional carer. This space will also be used to accommodate group activities including diversional therapy and education. As patients may use a wheelchair, tables will need to accommodate these. This area should be centrally located and visible from areas where staff congregate to encourage independence, but supported use of this space outside of meal times and to encourage patients to leave their rooms for socialisation and activities. For longer stay patients, the opportunity to prepare food with family should be considered.

Ready access should be provided to a patient toilet, as well as resting areas/alcoves along corridors between the patient bedrooms and communal areas and therapy spaces. Consider visitor toilets and showers for patients in shared bedrooms and those who are from remote areas who are staying with the patient. In larger areas where visitors are likely to be supporting patients, toilet facilities should be provided. Consideration should be given to all gender facilities.

Planning and design information relating to outdoor areas is included within Section 4.2. Access to outdoor areas is important to support the provision of culturally sensitive and welcoming units, particularly for Indigenous patients or other cultures who may prefer to participate in therapy and sit with family outside. The outdoor area might include a shaded flat landscaped area, with barbeque amenities, that is designed to present a safe and accessible path of travel. Outdoor areas should also support therapy requirements including for patients to practice navigating rough/uneven terrain and other mobility obstacles. Outdoor areas may also be used to support assisted therapy sessions with animals provided by the facility or with pets brought in by family/support persons from home.

Access to private areas to support intimacy and sexual wellbeing should also be considered for long stay patients, particularly where there are patients managed in multi-bed rooms.

Accommodation for families may be provided depending on local jurisdictional policies and the rural/regional catchment for the service.

For some services, the provision of a discharge lounge may be provided to support patient flow and where access to a central hospital discharge/transit lounge is not available.

2.6.3 Therapy and Related Areas

Rehabilitation and Older People's Health

The design of these Inpatient Units should provide:

- full wheelchair access to all areas. Note that wheelchairs may vary in size to manage bariatric clients, or may be electric wheelchairs which have a different footprint size and need recharging.
- door widths in all patient accessible areas sized to accommodate mobility aids, trolleys and beds
- main corridors designed to allow the passage of two patients in wheelchairs
- handrails in shared areas and corridors
- access to stairs for gait assessment and to practise on crutches. In single storey buildings, mobile steps may be required.

Patients should have access to an accessible patient toilet near therapy areas.

Allied health areas will generally include the following; however, requirements will depend on the range of conditions to be treated and the extent of services to be provided:

- access to gymnasium space for one-on-one and group activities with equipment appropriate to the conditions to be treated. This may include the use of ceiling mounted and/or robotic assisted gait retraining systems for inpatient rehabilitation (these are not commonly used for patients on older people's health units). The gymnasium should support the ability to undertake 10m walking assessments with 2m at either end to support acceleration and deceleration.
- patient plinths in curtained bays (commonly double plinths). A ceiling mounted hoist may be needed above the plinth. A tilt-table may also be provided depending on the patient cohort.
- an outdoor mobility and gait training area. Outdoor exercise equipment may also be considered.
- therapy rooms for individuals and groups for static and dynamic activities
- interview and/or consult rooms for disciplines that require quiet, private spaces such as psychology and social work with consideration of appropriate areas to accommodate family members
- facilities for activities of daily living (ADL).

Where ceiling tracks are provided, it is essential that these are planned in consultation with staff working with the gym to ensure they meet the therapy requirements, such as positioning over a treadmill.

Depending on the service profile, additional areas may include:

- facilities for splint making and hand therapy
- space for the fitting and manufacture of pressure garments
- computer and vocational retraining
- virtual reality & robotics
- customised wheelchair prescription and assessment service
- garden therapy area.

A considerable proportion of assessment and treatment of inpatients, such as toileting and showering, may be conducted in bedrooms if facilities are available and appropriate.

The service model will determine the provision of a hydrotherapy pool. Access to a hydrotherapy pool, where provided, is highly desirable. However, there are difficulties associated with transport of patients, the need to provide access to integrate with community models of care and high maintenance and operational costs.

Virtual Reality (VR)-based diversional experiences may be developed in collaboration with artists or creative teams specialising in this technology. This modality is more bespoke than commercially available VR content and is particularly useful for patients over the age of 10 who experience repeated or longer in-hospital stays. Refer to section 3.5.4 Arts Integration for further guidance.

Palliative Care

Therapy spaces in a palliative care unit will require a different approach to that of a rehabilitation unit where structured rehabilitation exercises and activities are undertaken in a gymnasium (gym). Some palliative care patients may participate in gym activities, especially in units that are collocated with a rehabilitation unit.

Therapy areas provided will depend on the range of services and equipment to be provided. Consideration may be given to the provision of an indoor exercise room to accommodate exercise equipment for patients' use while supervised by staff and a multipurpose therapy room for a range of complementary therapies.

Virtual reality technology is becoming commonly used in palliative care for diversional therapy and distraction from pain. The use of virtual reality technology does not require a separate room but will require reliable Wi-Fi connection and headsets.

Volunteers are becoming more important in providing diversional and therapeutic activities in palliative care units. This may involve volunteers engaging patients, families and support persons in music, art, handicrafts and animal assisted therapies. Space for the volunteers' belongings and storage of their equipment and supplies needs to be available in the unit.

2.6.4 Clinical Support Areas

These areas will comprise:

- clinical workroom
- staff station - this will typically also accommodate the ward clerk. Decentralised staff stations may also be provided.
- clean store, medication store and dirty utility rooms
- beverage pantry
- resuscitation trolley bay
- linen trolley bay
- mobile equipment bay(s) for storing and recharging equipment including weigh scales, observation machines and patient lifters. This space may also be used to store workstations on wheels.
- storage for bulk clinical consumables
- equipment storage
- flower bay (typically provided on palliative care units but not on other subacute care units).

Depending on local jurisdictional requirements, consider the provision of a viewing or cool room for less acute palliative care facilities which do not have a mortuary on site.

Subacute care units require a range of storage areas and requirements will vary between units depending on the patient cohort, specific therapy equipment required and the provision of shared, centralised hospital stores for some equipment. Health services should specify the equipment type, quantity and proposed location of items during the planning stage so that appropriate spatial allocations can be provided. Consideration should be given to multiple shallow equipment stores rather than one central large storeroom for ease of access to equipment.

2.6.5 Staff Areas

Staff work areas will be provided in accordance with jurisdictional staff accommodation policies and the staff establishment, noting many staff will work part-time.

Access to facilities will be required for meetings and interaction with families and other external/visitors e.g., National Disability Insurance Scheme (NDIS) partners.

Case conferences and family meetings frequently involve a large number of people. Meeting rooms will need to accommodate patients in wheelchairs, family members and a number of staff. A 30-bed unit will typically require multidisciplinary team (MDT) meetings with a minimum of 20 people. Meetings with family members may, in some instances, need to accommodate the patient in a bed.

Video and teleconference facilities are important especially where units support remote sites. In metropolitan areas, these facilities may also allow families and support networks, unable to access the facility, to be part of the treatment and care planning as well as enable non-specialist medical teams, including primary care, to be included in the care plan.

The number of students of all disciplines will need to be considered to ensure that appropriate facilities are available, including access to 'hot desks', tutorial or meeting rooms etc.

Staff amenities will include lockers for unit-based staff who do not have dedicated office space and should be located in a secure location within the inpatient unit. Consideration may be given to the need for additional lockers for visiting staff and students.

A staff room will be provided for the unit or shared with an adjacent unit in smaller facilities. In addition, staff will have access to toilets. On site access to showers and change areas will be provided.

2.7 FUNCTIONAL RELATIONSHIPS

2.7.1 External

All Subacute Care Units

Principal relationships with other units include:

- ready access to and from acute medical and surgical inpatient units
- ready access to diagnostic facilities, such as medical imaging
- ready but separate access for delivery of food, linen, supplies and removal of waste
- ready access to staff amenities where not provided locally
- ready access and parking for pet and animal assisted therapy providers.
- easy access from the main entry and/or precinct entry
- easy access to loan equipment storage areas
- easy access to pool/fleet cars used by staff for home visits (including EV charging stations depending on local policies)
- easy access to a transit/discharge lounge (where provided)

Palliative Care Inpatient Units will also require:

- direct (where possible), undercover access to mortuary (where this is not possible consider optimal, non-public routes of travel during planning)
- ready access to pharmacy

2.7.2 Internal

All Subacute Care Units

Optimal internal relationships to be achieved include:

- staff station(s) and associated areas need direct access to and observation of patient areas
- utility and storage areas need to be readily accessible to both patient and staff work areas
- lounge, dining and therapy areas should be readily accessible from bedrooms so that travel distances are reduced
- communal areas should be centrally located where possible and visible from areas where staff congregate so that there is adequate oversight at all times, not just during meal times. This encourages patients to leave their rooms for socialisation, meals and activities to promote recovery.

- publicly accessible areas should be placed on the periphery of the unit
- shared areas, where provided, should be easily accessible by all the units.

If therapy areas are shared (i.e. inpatient and outpatient care), facilities will be located to provide access to external users without impacting the inpatient unit.

03 DESIGN

3.1 ACCESS

Design should minimise the number of entrances and ensure that staff and the public can access the unit at entrances adjacent to car parks in order to limit the time spent outside the facility at night. Visiting hours may be unrestricted and therefore consideration will need to be given to visitor access at all times.

Where a unit is provided in a stand-alone location, covered access is required from the main hospital for the delivery of food, supplies, linen, and for waste removal.

3.2 PARKING

Drop-off and disabled access parking should be available near the unit entry. In addition, access to a parking space that can be used by staff to transfer patients into their own or their family member's vehicle, would be of value. Ideally, this would be provided with some overhead weather cover.

A car space may be needed for patients to park their own car to assess how they transfer in and out of the vehicle. This is an assessment activity, and the location will need to suit.

For palliative care, consider proximity of parking for family/carers who visit at all hours.

Consider convenient parking areas for non-clinical staff or volunteers providing services to the unit such as art, music and other diversional therapies. Also consider convenient parking area for visiting therapy animals and pets from home to ensure quick and safe access to the unit as well as ensuring protection of the animals from hot bitumen or rain during inclement weather.

3.3 DISASTER PLANNING

In the case of disaster, open gym areas may be used to accommodate large numbers of casualties, but this will be considered by local services as part of broader disaster planning.

Refer to AusHFG Part B Section 80 for further information.

3.4 INFECTION CONTROL

The following aspects of planning, design, construction and fit-out contribute to effective infection prevention and control:

- hand hygiene facilities
- provision for the isolation of patients with a communicable disease
- provision of personal protective equipment (PPE)
- cleaning of shared equipment
- environmental cleaning
- linen handling
- separation of 'clean' and 'dirty' workflows
- air flow strategies
- storage
- waste management
- surface finishes.

Service planning should inform the number of isolation rooms required.

All patients will need to access therapy areas and cleaning regimes will need to support this pattern of use. Clean-up areas will be needed to clean patient equipment with space to hold dirty equipment.

Allowing for appropriate space between patients in communal rooms (e.g., dining rooms) is recommended to assist and maintain appropriate infection control.

Refer to:

- AusHFG Part D: Infection Prevention and Control
- AusHFG Isolation Rooms – Engineering and Design Requirements
- NHMRC, 2019, Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019).

3.5 ENVIRONMENTAL CONSIDERATIONS

Key environmental requirements for subacute care units include the provision of a home-like, non-institutional environment, the need to promote conditions for healthy sleep, support patient, family and carer privacy and enable wayfinding, acknowledging that a high volume of patients will have cognitive, visual and sensory issues.

3.5.1 Acoustics

Noise is a constant source of complaint from patients and may compromise patient comfort and recovery. In particular, noise at night may have a negative impact on the ability of patients to sleep. It is also an important factor in maintaining confidentiality of patient information.

Some patients managed in a subacute care inpatient unit may become distressed by noise and therefore acoustics management is important so that stress is reduced. The management of noise generated from staff stations and call systems will also need to be considered.

Solutions to be considered include:

- location of the unit
- use of sound absorbing materials and finishes
- sound-isolating construction
- separation of quiet areas from noisy areas.

3.5.2 Lighting

The lighting strategy for the unit needs to be carefully considered to support circadian rhythm, promote safety and comfort, and minimise disturbance to patients and family/carers staying with them.

Natural light contributes to a sense of wellbeing for all building occupants. Research studies suggest a link between greater levels of natural light and improved clinical outcomes.

Higher levels of natural light may help people better orient themselves in the building, thus enhancing wayfinding.

The use of natural light is essential in clinical areas including gyms.

Other key considerations include.

- ensure lighting is adequate during the day and at night
- support patient and carer control over the lighting. Where a carer zone is provided, they should be able to directly control the lighting in this area without impacting the lighting in the room.
- lighting should facilitate access to toilets at night: consider night lights, motion-sensor lights, dimmer switches

- avoid abrupt changes in illumination levels
- control glare by managing window treatments, floor and furniture surfaces e.g., non-reflective surfaces at ends of corridors
- provide indirect and ambient lighting wherever possible
- provide light switches at a height and style easy and practical for patient use.

3.5.3 Privacy

A major challenge in the design of inpatient accommodation is the balance required between ensuring that patients and staff can see each other, while also ensuring patient privacy.

Bedrooms and other areas occupied by patients should be designed and configured to give staff the greatest ability to observe patients, particularly unstable or vulnerable patients. Different styles of unit design offer varying degrees of visibility or observation.

The expected patient mix will be a prime factor in resolving the conflict between observation and privacy. For instance, the following types of patients have differing needs or desires:

- vulnerable elderly patients, especially in single rooms, may feel more secure if they can observe staff or can be observed by staff or other patients
- clinically unstable or high dependency patients require almost constant observation
- clinically stable but vulnerable patients require frequent observation
- supported, self-care patients may require passing observation only.

Factors for consideration include:

- use of windows in corridor walls and/or doors
- location of beds to maximise sight lines
- proportion of single bed rooms
- location of ensuites to provide privacy for patients while not limiting observation by staff.

3.5.4 Interior Design

Interior design includes furnishings, style, colour, textures, ambience, perception, and taste. This can help prevent an institutional atmosphere. However, cleaning, infection prevention and control, fire safety, and patient care must be considered.

Rehabilitation and older people's health inpatient units seek to equip a patient to resume activities of daily living and routine. A less institutional, comfortable environment is preferred, however this needs to be balanced with supporting patient safety and independence and optimal infection prevention and control practices. Wheelchairs and walking frames will need to be accommodated throughout the unit in addition to other chairs and sofas.

Palliative care units should be designed as close to residential style, comfortable accommodation as possible.

The interior design of these units should align with the principles of a dementia friendly environment (refer to section 2.2.1).

The requirements of local Indigenous peoples and other cultural groups must be considered to ensure the provision of a welcoming and culturally safe space. This will require consultation with representatives from the local Indigenous community and other cultural groups. Key design strategies may include the use of artwork, signage in relevant languages providing a welcome to the unit, appropriate provision of spaces to support family/carers, and outdoor spaces that support participation in therapy and time with family outside.

Arts Integration

Arts integration can support a range of wellbeing initiatives for staff and patients, for improved clinical outcomes, patient dignity and agency. Thoughtfully selected arts experiences can create an inclusive, more welcoming environment, reducing the institutional feel and promoting a sense of wellbeing, cultural safety, representation and social connectedness.

Artworks, music, literature and other modes of self-expression are an important feature of palliative care, older people's health, rehabilitation and therapy services, and are recommended to be professionally curated and artist led.

The below areas should be considered as a priority for arts integration:

- Reception and waiting areas
- Patient bedrooms
- Communal patient areas, including lounge and dining rooms
- Independent Living Unit
- Therapy areas

Options may include:

- Framed artwork, including painting, photography, works on paper
- AV technology to play music, or Smart TV to enable digital sharing e.g. home movies, slideshows
- Ambient and mood lighting
- VR and augmented-reality (AR) technology

Artwork for the subacute care unit is recommended to be selected in consultation with consumer representatives due to the unique sensitivity of the patient demographic to visual stimuli. Artworks can support conversation and connection between patients and care givers, improving psycho-social behaviours in clinical settings. This is supported when artwork content is familiar, joyful and comforting, and where feasible, is complemented by resources and/or labels.

For further advice on initiating the arts integration process from early planning, refer to the AusHFG Arts in Health Framework.

3.5.5 Wayfinding and Signage

All wayfinding should be easily understood by staff and the general public, whether patients or visitors, and including those with sensory and/or communication or language impairments. Where necessary and appropriate, languages other than English and/or consistent use of pictograms and symbols should also be used. Visual landmarks are also useful.

Wayfinding should also be considered from the perspective of out-of-hours use. Certain access points may be locked out of office hours or after visiting hours.

Consideration should be given to the use of signage, colour and contrast for wayfinding and orientation to support people with cognitive issues including dementia, delirium and physical disabilities. The design should support patients to readily see where they want to go e.g., bedroom, ensuite, kitchen, lounge, outdoors etc.

Refer to:

- AusHFG Part C Section 05 – Wayfinding
- NSW Health, Wayfinding for Healthcare Facilities.

3.6 SPACE STANDARDS AND COMPONENTS

3.6.1 Human Engineering

Human engineering covers those aspects of design that permit effective, appropriate, safe and dignified use by all people, including those with cognitive and physical disabilities. It includes occupational ergonomics, which aims to fit the work practices, furniture, fittings and equipment and work environment to the physical and cognitive capabilities of all persons using the building.

Height and accessibility need to be considered for patient hand-hygiene facilities, particularly for wheelchair users.

Refer to AusHFG Part C Section 04 Human Engineering.

3.6.2 Ergonomics

The unit should be designed and built to prevent the exposure of patients, staff, visitors and maintenance personnel to avoidable risks of injury.

Poorly designed recurring elements such as height, depth and design of workstations and counters, shelving and the layout of critical rooms have a great impact on the work health and safety of staff as well as the welfare of patients.

Refer to Part C Section 03 Space Standards and Dimensions for more details.

3.6.3 Access and Mobility

To promote patient safety and independence, corridors should remain a clear path of travel, noting resting places are ideal in long corridors. Provision of appropriate storage for manual handling aids (mobile hoists) and patient mobility equipment (wheelchairs of all types including bariatric and electric walkers) is critical to maintaining clear corridors. The space provided should enable items kept in this area to be stored and removed easily, and not of a depth that would require equipment to be ‘stacked.’

Corridor width and circulation space will need to address the use of larger mobility aides for bariatric patients. Corridors used by patients should be wide enough for two wheelchairs to pass i.e. 1800mm minimum clear space between handrails (on both sides of corridor).

Some examples of the average circulation space sizes required for ambulant persons using the following mobility aids are:

- one person using a walking stick – 750 mm width
- one person using elbow crutches – 900 mm width
- one person using two walking sticks – 800 mm width
- one person using crutches – 950 mm width
- one person using walking frame – 900 mm width.

For further information refer to:

- National Construction Code
- Australian and New Zealand Standards 1428: Set
- AusHFG Part C.

3.6.4 Building Elements

Building elements include walls, floors, ceilings, doors, windows, and corridors. These are addressed in detail in AusHFG Part C.

Windowsill heights should be low enough to permit a view to the outside by a patient lying in bed. This is usually 600mm above the finished floor level.

Ensure doorways are sufficiently wide and high enough to permit the manoeuvring of beds, wheelchairs, trolleys and equipment without risk of damage or manual handling risks. Door handles should be able to be operated single-handed.

3.7 SAFETY AND SECURITY

3.7.1 Safety

The unit should provide a safe and secure environment for patients, staff and visitors while retaining a non-threatening and supportive atmosphere conducive to the care provided.

Design and construction of the facility and selection of furniture, fittings and equipment should ensure that users are not exposed to avoidable risks of injury and mimic homelike conditions as much as possible.

Patients accommodated on subacute care units require special consideration in terms of safety. Although perhaps disabled or incapacitated, they are also encouraged to be mobile and self-sufficient. Unless otherwise approved, subacute care units should provide rails and hand holds in all corridors, ramps, stairs, bathrooms, and toilets to ensure safe accessible movement of people.

Hoists, both fixed and mobile, will be used throughout the unit to reduce or eliminate manual handling.

Fittings with visual contrast to equipment and building elements, such as doorways and floor surfaces, will enhance safety for people with sensory and cognitive deficits. This can include grab rails, toilets and cisterns that have a colour contrast and are clearly distinguishable from the wall and floor, rather than ‘white upon white’ or designed to blend in.

Accidents most often occur in rooms where sanitary facilities are located and therefore attention to floor coverings (e.g., colour, slip resistance) is essential.

Handrails and wheelchair accessibility are required. Ensuites are high risk areas. Handrails should be provided within the shower, toilet, and handbasin/vanity areas.

Patients may also have cognitive impairment. A system whereby a patient triggers an alarm if they leave the unit may be needed.

Movement sensing and falls prevention technology is rapidly improving. Project teams are advised to refer to the latest technology, associated evidence, and other facilities that are using these systems for current advice.

Consider an emergency call system in areas where staff may be isolated with patients with unstable health (e.g., ADL kitchens).

3.7.2 Security

The following specific security issues should be considered:

- the need for fixed and/or personal duress alarms in areas such as reception points and staff stations,
- access control particularly at night
- control and monitoring of visitors.

3.8 FINISHES

3.8.1 General

Finishes in this context refer to walls, floors and ceilings.

Refer to AusHFG Part C Section 03 Space Standards and Dimension for further details.

3.8.2 Wall Finishes

Adequate wall protection should be provided to areas regularly subjected to damage. Particular attention should be given to areas where bed, trolley and equipment movement occurs, such as corridors, bed head walls, treatment and gym areas, equipment and linen trolley bays.

In palliative care units, wall treatments to conceal services such as medical gases and other bed head services may be considered to support a more residential style appearance. This will require analysis of the impact on the depth of the bed head and associated clearances, as well as the cost impact.

3.8.3 Floor finishes

Floor finishes should be appropriate to the function of the space. Typically, vinyl is used in most areas of the unit.

Selection of floor finishes should take into account manual handling issues such as the high use of mobility aids including the impact of the flooring on push and pull forces for wheeled equipment and be adequate to avoid the potential for slips and trips caused by joints between flooring.

Refer to:

- AusHFG Part C Section
- NSW Health TS7 Floor Coverings in Health Care Buildings.

3.8.4 Ceilings

Acoustic tiles will be used in most areas across the inpatient unit excluding areas such as medication stores, wet areas and isolation rooms.

3.9 FIXTURES, FITTINGS & EQUIPMENT

Room Data and Room Layout Sheets in the AusHFG define fixtures, fittings, and equipment (FFE).

Refer to the Room Data Sheets (RDS) and Room Layout Sheets (RLS) and AusHFG Part C.

Equipment required to support subacute care services changes constantly. It is recommended that selection of patient equipment is done at later stages of the project so that the most up-to-date equipment is chosen.

Consideration must be given to the patient cohort being managed on the unit and should promote:

- a homelike environment
- independence and safe mobility
- patient and staff safety (refer to Section 3.7.1)
- consideration of older people's requirements, for example those with arthritis that may find some fittings challenging to use
- the principles of a cognitive/dementia friendly environment such as the use of a contrasting colour for toilet seats and provision of fittings that patients may be more familiar/safer with
- optimal infection prevention and control practices/ease of cleaning requirements.

3.10 BUILDING SERVICE REQUIREMENTS

3.10.1 General

In addition to topics addressed below, also refer to:

- Local jurisdictional policies and guidelines relating to Building Services and Environmental Design. A list of relevant references is included on the AusHFG website: External Resources | AusHFG (healthfacilityguidelines.com.au)

3.10.2 Air Handling Systems

Provision of natural ventilation to patient care areas should be approached with caution. The management of airflows and the creation of a stable environment are essential to the control of the spread of infection so, generally, air conditioning should be provided.

Refer to AusHFG Part D: Infection Prevention and Control.

3.10.3 Electrical Services

It is essential that services such as selected lighting, telephones, computers at staff stations, duress alarm systems (including the central computer), and electronic locks are connected to the emergency power supply.

Provision of electrical connections for family/network support use are to be provided in patient bedrooms as well as common areas such as lounge to allow for recharging of personal devices.

Where charging facilities are likely to involve lithium style batteries, appropriate fire protection strategies will require consideration.

3.10.4 Information Technology and Communications

It is recommended that the following information technology and communications issues, and the associated infrastructure requirements, should be addressed to ensure long term flexibility:

- Wi-Fi to enable connection to distant family members
- Blue tooth or similar technology in common area and waiting room
- duress alarm systems: fixed and mobile as required
- nurse and emergency call systems
- voice/data to facilitate network access (telephone and computers)
- videoconferencing capacity and telemedicine including locations that provide shielding from natural light to devices and screening to provide privacy during patient/family care conferences
- appropriate ICT infrastructure to support virtual models of care in line with local jurisdictional policies (refer to the Further Reading section for further information)
- electronic medical records
- paging and personal telephones, replacing some aspects of call systems
- patient access to computers for therapy and personal use. Internet connection is also relevant to promote normal activities, for specific therapy purposes, and specific activities such as gaming and streaming for younger patients.
- technology to assist people with disabilities such as provision of Bluetooth enabled devices for hearing aids or earbuds/headphones for those who have hearing difficulties. This is particularly important in waiting and common rooms, activity rooms and multi bed bedrooms.
- bar-coding for supplies and records
- e-learning and simulation
- e-medication management and e-storage systems (e.g., automated dispensing systems).

3.10.5 Medical Gases

Provision of fixed medical gases and suction to all bedrooms in a subacute care inpatient unit, as in general acute units, should be considered on a project-by-project basis. The patient profile may include oxygen dependent patients and patients with tracheostomies requiring regular suction as there is a trend to move patients to subacute care units as soon as possible.

The use of cylinders, rather than fixed services, may result in handling, storage and safety issues which need to be considered. Some portable systems will still be required to transfer patients.

The provision of at least oxygen, medical air and suction outlets in each single bedroom provides a flexible approach. Where the case mix does not support this provision, services may consider equipping a selected number of rooms so that an extended range of patient care can be provided. Fixed service gases are not required in the Independent Assessment Suite. Medical gases and suction may also be needed in gym areas.

3.10.6 Ceiling Structure

Structural capacity will generally be provided to support ceiling hoists in bed rooms and gym areas. It is recommended that ceiling hoists are installed in a number of patients' bedrooms however this will be dependent on jurisdictional policies. Where provided, it is recommended that they are designed on a straight track from bed to ensuite to support optimal and ease of use.

Over time, services may consider extending the range of areas with the structural capacity to accommodate a ceiling track. For example, a track over a planned area within the inpatient unit may be used for remobilisation.

04 COMPONENTS OF THE UNIT

4.1 STANDARD COMPONENTS

Rooms and spaces are defined as:

- *Standard components* (SC) which refer to rooms and spaces for which room data sheets, room layout sheets (drawings) and textual description have been developed.
- *Standard components – derived rooms* (SC-D) 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:
www.healthfacilityguidelines.com.au/standardcomponents

4.2 NON-STANDARD COMPONENTS

Non-standard components are generally unit-specific and are described below:

DINING AND RECREATION ROOM(S)

Description and Function

The dining and recreation room provides an area for patients to have meals, socialise and undertake recreational activities. The area recommendations are based on 2m2 per occupant to accommodate the turning circle and footprint required for electric wheelchairs and chairs with longer wheelbases. The overall size will depend on the number of persons to be accommodated but should assume 75 percent of the patient population, plus occasional carers and staff.

A number of smaller dining spaces may be provided or flexibility to provide smaller, more intimate groups and a more domestic scale. Consideration must be given to staff oversight of a number of smaller spaces.

Location and Relationships

The dining/recreation room may be located adjacent to the lounge area and should have ready access to the outdoors, inpatient areas, and patient and visitors' toilet.

Considerations

Fittings and furniture for this area should include:

- individual tables with seating for up to four people, with space for wheelchairs of all types
- tables that have the capacity to be joined to seat up to ten people
- domestic style furnishings that may include sideboards and audio equipment
- large screen television, video game console and computer activities
- Bluetooth or other technology for hearing impaired users of the space to hear the TV
- wall and door protection for chairs and wheelchairs
- a hand basin (Type C) allowing wheelchair access for staff, patients, and family to wash hands
- access to patient and visitor toilet.

Depending on the activities to be undertaken, a recessed sink and cupboards may be appropriate for craft activities.

Secure storage space is recommended for storage of art materials and specialist equipment.

INDEPENDENT ASSESSMENT SUITE

Description and Function

Refer to Section 2.3.2 for further information. The provision of this suite is optional and will depend on the service model for the unit.

The Independent Assessment Suite is a small unit for the assessment of a patient's ability to manage after discharge. Carers may be involved in this process. Depending on the patient cohort, younger patients with family may be accommodated. The length of stay will vary from patient to patient. The provision of medical gases is optional as may be required for some patient cohorts that will be discharged on home ventilation programs.

The unit should provide a homelike and family friendly environment including ordinary domestic furniture, carpet, etc. A modern design supports greater flexibility to suit the majority of patients. The unit should be self-contained with regard to:

- bedroom area
- sitting and dining area - including space for a carer to stay overnight
- small kitchenette/meal preparation area
- separate ensuite accessible from within the unit.

Location and Relationships

The suite may be located at the periphery of the unit but should be readily accessible to staff. Access to an outdoor area is highly desirable.

Considerations

Fittings and furniture for this area may include:

- domestic single, double, or king single or bariatric bed
- bed for a carer (comfort must be considered given patients may be accommodated for 7-10 days in the suite). Recliner chairs are not recommended as sleeping accommodation for carers.
- coffee table
- bedside table(s) and lamp(s)
- television
- art work and shelves for flowers/photo frames or other personal items. Refer to Section 3.5.4 Arts Integration for further guidance.
- dining table and chairs (to seat two people)
- a small kitchenette
- access to an emergency call.

OUTDOOR AREAS

Description and Function

An outdoor area will support a range of activities both therapeutic and social such as meeting with family and friends and barbeques (BBQs). The therapy, social and quiet areas may be separated to minimise distraction for those undergoing therapy and to provide quiet spaces for reflection and respite for patients and visitors. Entry/egress operational policy and locking mechanisms to be finalised at a project level.

Outdoor spaces also provide an alternative space for the patients and their support network away from the patient's bedroom. They may also provide a flexible space for private counselling/debriefing and for celebration of life events such as birthdays, weddings, anniversaries, and memorials.

Access to outdoor areas is important to support the provision of culturally sensitive and welcoming units, particularly for indigenous patients who may prefer to participate in therapy and sit with family outside. Engagement with the local indigenous community and other cultural groups should be undertaken to ensure their cultural needs are incorporated within the design.

Location and Relationships

The outdoor area will ideally be accessed from shared lounge and dining areas so that access is possible at all times. Additional access, where possible, may be provided from the gym areas.

Appropriate staff oversight of the outdoor areas is essential.

In palliative care units, consideration should be given to bedrooms having direct access to the outdoor areas, to enable patients who are bed bound to easily access the outdoors.

Considerations

Outdoor areas for therapy should include appropriate areas for patients to be physically active and practice navigating rough/uneven terrain and other mobility obstacles including, steps, kerbs and hills. This area may also support practice for patients completing prescribed exercise programs, and for patients to practice transfers such as sitting to standing and getting in and out of cars.

Some units with long stay patients may consider the inclusion of outdoor exercise equipment that is considerate of the patient cohort, service needs and models of care, and the size of the area available. Consideration should also be given to the inclusion of raised beds for horticultural therapy activities and support for visits from pets.

Outdoor areas may also be used for animal assisted therapy sessions with animals provided by the facility or with pets brought in by family/support persons from home.

Undercover areas and appropriate sunshades are needed to provide protection from the weather. If a BBQ is provided, this would be stored undercover. For BBQ and other cooking facilities, the location and safety requirements must be carefully considered in response to a risk assessment.

Other considerations relating to outdoor areas include:

- Access to oxygen which can be provided as mobile cylinders or piped oxygen supply. Consider the location of oxygen outlets and secure storage of oxygen bottles while in use.
- Provision of power points for bed and electric wheelchair functionality and charging.
- Built-in irrigation or other watering system for plant/tree care.
- Consideration of ventilation to these areas so they can be accessed all year. A balanced approach is required to providing weather protected outdoor spaces as well as access to light, the sky and fresh air.

The design of outdoor areas should support the needs of those with cognitive issues including dementia. Refer to the following references for further information:

- Alzheimer's Australia SA Inc., 2010, Gardens that Care: Planning Outdoor Environments for People with Dementia.
- Department of Health & Human Services, Victoria. Garden design and outdoor spaces (health.vic.gov.au)
- Dementia Australia: https://www.dementia.org.au/.

Dedicated outdoor areas for staff respite will be provided on a project-by-project basis.

KITCHEN (PALLIATIVE CARE INPATIENT UNIT)

Description and Function

An area for patient and family to prepare or reheat meals. Multiple families may use the kitchen at the same time. The size and scale will be dependent on patient cohort and food service model.

The kitchen may also be used for patient occupational therapy, diversional therapy or dietetics intervention which may include food preparation, cooking and baking, and carer training, if included in the model of care.

Location and Relationships

The kitchen should be adjacent to dining spaces in the shared zone. It should be located so that it can be accessed easily by families and prepared meals can be served directly from the kitchen to the dining area safely.

Considerations

Consider the type of cooking equipment and appliances to be provided in the kitchen. The kitchen design should be homelike and suit the service requirements relating to patient/family groups using the space. The design should also be flexible to support a range of food service models which may change over time.

Meal hatches are not contemporary / homelike and are not encouraged.

Input should be sought from local cultural groups to ensure their cultural needs are incorporated. Safety requirements should be considered through response to a risk assessment.

MULTI-FUNCTIONAL QUIET ROOM (PALLIATIVE CARE INPATIENT UNIT)

Description and Function

A room to support the spiritual needs and cultural requirements of a culturally diverse community. The room may also be used as a quiet area for family and visitors to sit away from the patient's bedside.

Location and Relationships

The multi-functional quiet room should be in a discreet area away from public spaces to afford the patient and family/visitors some privacy.

Considerations

The design of room should be homelike, welcoming, and comforting. Consider comfortable furniture and dimmable lighting for users' comfort.

A foot wash area may be required depending on the local demographics and cultural requirements.

The requirements of local indigenous peoples must be considered to ensure the provision of a welcoming and culturally safe space. Refer to Section 3.5.4 for further information.

BAY – FLOWER (PALLIATIVE CARE INPATIENT UNIT)

Description and Function

Some palliative care facilities receive frequent deliveries of flowers. An enclosed bay should be provided for staff, relatives or visitors to fill or empty vases, and to arrange and dispose of flowers.

Location and Relationships

The flower bay will have direct access to the unit corridor.

Considerations

The room should include a deep sink, storage for vases and a waste bin for disposal of spent flowers.

This room should not be combined with dirty utility.

INDOOR EXERCISE AREA (PALLIATIVE CARE INPATIENT UNIT)

Description and Function

A room or open space with exercise equipment for patients to use with staff supervision from an exercise physiologist or physiotherapist to complete exercise therapy for palliative rehabilitation or to maintain their physical activity to prevent hospital acquired deconditioning. The equipment provided will be dependent on the patient cohort and activities to be performed in the room.

Location and Relationships

The area may be located at the periphery of the unit but should be readily accessible by patients. Access to an outdoor area is highly desirable.

Considerations

Provide a safe environment for all staff and consumers. Careful consideration should be given to the type of equipment and the degree of supervision required. Equipment should be carefully selected to provide appropriate activities for therapy and/or recreation without affording opportunities for injury to self or others.

MUTIPURPOSE THERAPY ROOM (PALLIATIVE CARE INPATIENT UNIT)

Description and Function

This room should be flexible use, to facilitate a range of activities and therapies including massage therapy, art and music therapies and aromatherapy.

Location and Relationships

The multipurpose therapy room should be in a discreet area away from public spaces. A patient toilet should be located nearby. Access to the outdoors from this area should be considered.

Considerations

Consider storage of items used for therapy including a small trolley.

05 APPENDICES

5.1 SCHEDULE OF ACCOMMODATION

Indicative schedules of accommodation (SOA) are included below for the three types of subacute care units addressed in this HPU. The assumed number of bedrooms provided, and the mix of bedroom types is indicative only. Actual requirements will be informed by clinical services planning and the range of considerations outlined in Section 2.5.

Solutions for the provision of therapy space may alter to respond to a particular design solution (e.g. a rehabilitation campus may provide centralised therapy areas that are shared).

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

5.1.1 Rehabilitation Inpatient Unit

Rehabilitation Inpatient Unit

The indicative SOA below reflects a 24-bed rehabilitation inpatient unit with 50% single bedrooms.

ENTRY, RECEPTION AND WAITING

This space will only be provided in selected circumstances (e.g., where the unit is provided in a stand-alone location). Where several rehabilitation inpatient units are collocated in a stand-alone location, this space will be shared.

INPATIENT AREAS – BED ROOMS

Room Code	Room Name	SC / SC-D	Qty	m2	Comments
1BR-ST-A1 1BR-ST-A2 1BR-ST-A3 1BR-ST-B1 1BR-ST-B2 1BR-ST-B3 1BR-ST-D	1 Bed Room – Inboard Ensuite	Yes	8	16.5	Indicative number of single bedrooms noted. Total number of beds and proportion of single bedrooms will depend on service requriements. If using an 8,400mm structural grid refer to 1BR-ST-A2, 1BR-ST-A3 (both with inboard ensuite), 1BR-ST-B2 or 1BR-ST-B3 (both with outboard ensuite) or 1BR-ST-D (back to back ensuite). For 1 Bed Rooms on a 7,800mm structural grid, refer to 1BR-ST-A1 or 1BR-ST-B1.
1BR-IS-N1 1BR-IS-N2	1 Bed Room - Isolation - Negative Pressure	Yes	1	16.5 (o)	Optional N Class Room. Requirement will depend on the service model and local policies for management of patients requiring airborne precautions. If using an 8,400mm structural grid refer to 1BR-IS-N2. For a 7,800mm structural grid, refer to 1BR-IS-N1.
ANRM	Anteroom	Yes	1	6 (o)	Optional. Provided as part of N Class rooms.
1BR-BA	1 Bed Room – Bariatric	Yes	1	18	Number of bariatric rooms provided will depend on the anticipated patient cohort.
1BR-SP-A1 1BR-SP-A2	1 Bed Room – Special	Yes	2	18	Indicative number noted - total number of special sized rooms will depend on the patient cohort. This room size caters for selected specialist rehabilitation services (e.g. spinal injuries), to support carers to stay within the room, to meet cultural requirements eg for patients where the family unit is highly involved in care and for those with a long length of stay.
2BR-ST-A1 2BR-ST-A2 2BR-ST-B	2 Bed Room – Inboard Ensuite	Yes	4	29	Indicative number of 2 bed rooms noted. The proportion of single bedrooms will depend on service requriements.If using an 8,400mm structural grid refer to 2BR-ST-A2 (inboard ensuite) or 2BR-ST-B (outboard ensuite). For 2 Bed Rooms on a 7,800mm structural grid, refer to 2BR-ST-A1.
4BR-ST	4 Bed Room - Inboard Ensuite	Yes	1	58	Mix of bedrooms will be determined at a project level, however one 4 bed room is commonly provided for this patient cohort for close observation.
	Independent Assessment Suite		1	25 (o)	Optional. Inclusion dependent on service model. Assumes open plan unit with bed room area, small lounge, dining and kitchenette. Ensuite allocation
ENS-ST-A1 ENS-ST-A2 ENS-ST-A3 ENS-ST-B ENS-ST-C	Ensuite - Standard	Yes	15	5	One ensuite for each 1 and 2 bed room; two per 4 bedroom. Additional required if Independent Assessment Suite included. Refer Note 5.
ENS-BA	Ensuite - Bariatric	Yes	1	7	Attached to 1 Bed Room – Bariatric.
ENS-SP	Ensuite - Special	Yes	1	6	Attached to 1 Bed Room – Special.
ENS-ACC	Ensuite - Accessible	Yes	1	7	Designed to AS1428. Caters for independent wheelchair patients.
BATH	Bathroom	Yes	1	15 (o)	Optional. Refer to HPU Section 2.6.2 and BCA requirements.
Discounted Circulation			**38%**		**Circulation areas are highly utilised in subacute care areas for therapy, exercise and to rest between destinations.**

INPATIENT AREAS – SHARED

Room Code	Room Name	SC / SC-D	Qty	m2	Comments
LNGE-20	Lounge – Patient	Yes	1	24	Allocated at 2m2 per person assuming 50% occupancy. May be divided into smaller areas to provide options for quiet time/private conversations vs social activies, and provide a home like scale. Areas should support multipurpose / flexible activities.
	Dining/ Recreation Room(s)		1	36	18 people at 2m2 assuming approximately 75% occupancy. Areas should support multipurpose / flexible activities. Include a non-clinical handwash basin.
BBEV	Bay – Beverage	Yes	1	4	Ideally collocated with dining room. Consider support for families to bring in meals depending on service model and storage of dietetic supplements etc.
BMT	Bay – Meal Trolley	Yes	1	4	Ideally collocated with dining room.
WCAC	Toilet – Accessible, 6m2	Yes	1	6	Adjacent to shared areas.
LAUN-PT	Laundry – Patient, 6m2	Yes	1	6 (o)	Optional, depending on length of stay, local models and infection prevention and control policies. This is often helpful for units with a high proportion of patients who have families who live remotely or patients with no family support. Note ADL laundry included below.
Discounted Circulation			**38%**		**Circulation areas are highly utilised in subacute care areas for therapy, exercise and to rest between destinations.**

OUTDOOR AREAS

Room Code	Room Name	SC / SC-D	Qty	m2	Comments
	Outdoor Space(s)		1	135	Dedicated outdoor spaces including green areas for subacute care unit. Area allocation is based on 7.5m2 per patient and 75% occupancy. Ideally accessed from shared lounge and dining areas. Areas may be distributed to support separated clusters / pods or areas used for therapy vs socialising. Refer to Section 4.2 of the HPU for further detail.

CLINICAL SUPPORT

Room Code	Room Name	SC / SC-D	Qty	m2	Comments
BHWS-B	Bay – Handwashing, Type B	Yes	2	1	Located along corridors to suit layout and access.
SSTN-14	Staff Station	Yes	1	14	Used by all members of the Multidisciplinary Team.
SSTN-10	Staff Station - Decentralised	Yes	1	5 (o)	Optional, decentralised staff base. Many units use WOWs so staff are mobile and may not require a decentralised staff base. Location and no dependent on unit configuration. Locate to optimise line of sight to patient care areas. May be provided as smaller area for direct oversight of bedrooms/s.
OFF-CLN	Office – Clinical Workroom	Yes	1	20	Increased to support large multidisciplinary team.
BMFD-3	Bay - Multifunction Device	Yes	1	3	
MEET-20	Meeting Room, 20m2	Yes	1	20	Use for staff training, meeting (including Multidisciplinary Team meetings) and activities with families or patient education. Must support remote access. Number and size of meeting rooms will depend on the anticipated type, frequency and number of people attending meetings and training.
INTV	Interview Room	Yes	1	12	Wheelchair access needed. Appropriate fit out and ICT infrastructure required to support virtual models of care.
MED-14	Medication Room, 14m2	Yes	1	12	May be provided as a combined Clean Store / Medication Room depending on local jurisdictional policies.
CLN-10	Clean Store, 10m2	Yes	1	10	For storage of unpacked sterile consumables. May be provided as a combined Clean Store / Medication Room depending on local jurisdictional policies.
DTUR-12	Dirty Utility, 12m2	Yes	1	12	May need more than one depending on bed numbers and travel distances.
DISP-10	Disposal Room, 10m2	Yes	1	10	Locate on the IPU periphery for easy retrieval of waste. Should be shared with an adjacent unit where possible.
BLIN	Bay – Linen	Yes	2	2	Minimum 1:15 beds.
BMEQ	Bay – Mobile Equipment	Yes	2	4	No. dependent on assessed need and bed configuration. Likely to require a higher provision than an acute inpatient unit.
BRES	Bay – Resuscitation	Yes	1	1.5	
STEQ-20	Store – Equipment, 20m2	Yes	1	36	Assume 1.5m2 per bed. Close access to the unit / bedroom areas is required. Will include wheelchairs, lifters, mobility equipment and beds depending on hospital wide approach to equipment storage.
CLRM	Cleaner's Room	Yes	1	5	
Discounted Circulation			**38%**		

STAFF AREAS – OFFICE SPACE AND AMENITIES

Allocations are indicative only and need to be matched to the workforce profile and space allocated in line with jurisdictional policies.

The optimal location and requirements of Rehabilitation in the Home (RITH) teams should be considered. The inpatient setting is often a central hub for the integration of all rehabilitation services including those provided in the community or outpatient setting.

Room Code	Room Name	SC / SC-D	Qty	m2	Comments
OFF-1P-9	Office – 1 Person, 9m2	Yes		9	Number and area allocation will depend on staff profile and local jurisdictional policies. Must support videoconferencing / virtual care requirements including consideration of lighting, privacy, acoustics and ergonomics.
OFF-WS	Office - Workstation	Yes		4.5	Number and area allocation will depend on staff profile and local jurisdictional policies. Must support videoconferencing / virtual care requirements including consideration of lighting, privacy, acoustics and ergonomics.
SRM-15	Staff Room, 15m2	Yes	1	15	
WCST	Toilet – Staff	Yes	2	3	
BPROP	Bay – Property, Staff	Yes	1	2	
SHST	Shower – Staff	Yes	1	3 (o)	Optional. For most units, unless it is a stand alone facility, access to central staff amenities should be provided.
Discounted Circulation			**25%**		

THERAPY SPACE

This scenario assumes that therapy space is dedicated to support a 24-bed unit. These areas should be collocated with the inpatient areas, as further described in Section 2.1.4. Where space can be shared, this should be explored**.** Space allocations reflect an assumption of an active rehabilitation program (e.g. stroke, orthopaedic etc.).

The recommended gymnasium sizes are minimum indicative areas. Actual area allocations will need to be developed to suit project specific requirements with consideration of the typical number of patients and staff to be accommodated and the range of equipment needed depending on the patient cohort. Consideration must be given to the:

- Australian Faculty of Rehabilitation Medicine (AFRM) recommendations re minimum therapy requirements and the evidence demonstrating that increased therapy time translates to better patient outcomes
- increasing acuity and complexity of patients may limit the amount of therapy tolerated by some patients, however this also may translate to the need for more than one therapist assisting with a patient while in the gym, and a greater volume of mobility aids to be accommodated
- increasing provision of robotics which take up significant area and require appropriate clearances for access
- general rehabilitation inpatient units will typically also accommodate patients with more complex conditions such as Spinal Cord Injury, Acquired Brain Injury, Guillain-Barre Syndrome etc.

Where possible, gymnasium areas should be collocated with outdoor space.

No space allocations have been provided for prosthetic or orthotic services as it is assumed they may provide a visiting service only. Where these are provided on site, refer to HPU 440 for further information.

Allocations also assume that loan equipment is not held within the unit and instead stored in a central location.

Room Code	Room Name	SC / SC-D	Qty	m2	Comments
GYAH-ID	Gymnasium, Individual Treatment	Yes	1	86	**MINIMUM INDICATIVE AREA ONLY. Gymnasium area requirement must be informed by the type and number of equipment items to be provided. Consultation must be undertaken to confirm the number of patients and staff to be accommodated and the range of equipment needed depending on the patient cohort. For early planning purposes assume approximately 9m2 per equipment station / plinth.** It is assumed that this area will include a workstation area that supports patient observation / supervision (may be provided through WOWs) and, handwash basin. Resus trolley and linen bay are also assumed to be included but may be accessed within collocated unit.
GYAH-GP	Gymnasium, Group Therapy		1	35	Inclusion dependent on service model. Usually 6-8 patient would participate in these activities.
STEQ-14	Store -Equipment (Gym)	Yes	1	15	**MINIMUM INDICATIVE AREA ONLY**. Area requirement to be determined based range of equipment to be stored.
	Occupational Therapy Room		1	28	**MINIMUM INDICATIVE AREA ONLY. Area requirement to be determined based on number of patients and staff to be accomodated.** Assume approximately 7m2 per patient.
STEQ-14	Store - Equipment (OT)		1	16	**MINIMUM INDICATIVE AREA ONLY.** Area requirement to be determined based range of equipment to be stored. Typically includes wheelchairs, commodes, shower chairs and toilet seats.
	Splinting Room		1	16	Requirements will depend on the local service model. This will typically be used as a multipurpose splinting room / finishing workshop. Where areas for prosthetics and orthotics are required refer to HPU 440.
ADLB	ADL Bathroom	Yes	1	12	ADL areas may be accessed by other services so location requires consideration of patient flows.
ADLK	ADL Kitchen	Yes	1	12	ADL areas may be accessed by other services so location requires consideration of patient flows.
ADLL	ADL Laundry	Yes	1	8	ADL areas may be accessed by other services so location requires consideration of patient flows.
CONS	Consult Room	Yes		12	May be used by staff such as speech pathology and medical staff.
INTV	Interview Room	Yes		12	May be used by a range of staff such as social work, psychologists, dietetics etc. Lockable storage required where psychological testing provided. Appropriate fit out and ICT infrastructure required to support virtual models of care.
WCPT	Toilet – Patient	Yes	1	4	
Discounted Circulation			**38%**		

5.1.2 Older People's Health Subacute Care Inpatient Unit

The indicative SOA below reflects a 24-bed older people's health subacute care inpatient unit with 50% single bedrooms.

ENTRY, RECEPTION AND WAITING

Note 1: This space will only be provided in selected circumstances (e.g., where the unit is provided in a stand-alone location). Where several inpatient units are collocated in a stand-alone location, this space will be shared.

INPATIENT AREAS – BED ROOMS

Room Code	Room Name	SC / SC-D	Qty	m2	Comments
1BR-ST-A1 1 BR-ST-A2 1 BR-ST-A3 1BR-ST-B1 1BR-ST-B2 1BR-ST-B3 1BR-ST-D	1 Bed Room – Inboard Ensuite	Yes	8	16.5	Indicative number of single bedrooms noted. Total number of beds and proportion of single bedrooms will depend on service requriements. If using an 8,400mm structural grid refer to 1BR-ST-A2, 1BR-ST-A3 (both with inboard ensuite), 1BR-ST-B2 or 1BR-ST-B3 (both with outboard ensuite) or 1BR-ST-D (back to back ensuite). For 1 Bed Rooms on a 7,800mm structural grid, refer to 1BR-ST-A1 or 1BR-ST-B1.
1BR-IS-N1 1BR-IS-N2	1 Bed Room - Isolation - Negative Pressure	Yes	1	16.5 (o)	Optional N Class Room. Requirement will depend on service model and local policies for management of patients requiring airborne precautions. If using an 8,400mm structural grid refer to 1BR-IS-N2. For a 7,800mm structural grid, refer to 1BR-IS-N1.
ANRM	Anteroom	Yes	1	6 (o)	Optional. Provided as part of N Class rooms.
1BR-BA	1 Bed Room – Bariatric	Yes	1	18	Number of bariatric rooms provided will depend on the anticipated patient cohort.
1BR-SP-A1 1BR-SP-A2	1 Bed Room – Special	Yes	2	18	Indicative number noted - total number of special sized rooms will depend on the patient cohort. This room size caters for selected specialist rehabilitation services (e.g. spinal injuries), to support carers to stay within the room, to meet cultural requirements eg for patients where the family unit is highly involved in care and for those with a long length of stay.
2BR-ST-A1 2BR-ST-A2 2BR-ST-B	2 Bed Room – Inboard Ensuite	Yes	6	29	Indicative number of 2 bed rooms noted. The proportion of single bedrooms will depend on service requriements.If using an 8,400mm structural grid refer to 2BR-ST-A2 (inboard ensuite) or 2BR-ST-B (outboard ensuite). For 2 Bed Rooms on a 7,800mm structural grid, refer to 2BR-ST-A1.
	Independent Assessment Suite		1	25 (o)	Optional. Inclusion dependent on service model. Assumes open plan unit with bed room area, small lounge, dining and kitchenette. Ensuite allocation additional. Typically included within the total bed count. These are more common in rehabilitation than older peoples inpatient units.
ENS-ST-A1 ENS-ST-A2 ENS-ST-A3 ENS-ST-B ENS-ST-C	Ensuite - Standard	Yes	15	5	One ensuite for each 1 and 2 bed room; two per 4 bedroom. Additional required if Independent Assessment Suite included. Refer Note 5.
ENS-BA	Ensuite - Bariatric	Yes	1	7	Attached to 1 Bed Room – Bariatric.
ENS-SP	Ensuite - Special	Yes	1	6	Attached to 1 Bed Room – Special.
ENS-ACC	Ensuite - Accessible	Yes	1	7	Designed to AS1428. Caters for independent wheelchair patients.
BATH	Bathroom	Yes	1	15 (o)	Optional. Refer to HPU Section 2.6.2 and BCA requirements.
Discounted Circulation			**38%**		**Circulation areas are highly utilised in subacute care areas for therapy, exercise and to rest between destinations.**

INPATIENT AREAS – SHARED

Room Code	Room Name	SC / SC-D	Qty	m2	Comments
LNGE-20	Lounge – Patient	Yes	1	24	Allocated at 2m2 per person assuming 50% occupancy. May be divided into smaller areas to provide options for quiet time/private conversations vs social activies, and provide a home like scale. Areas should support multipurpose / flexible activities.
	Dining/ Recreation Room(s)		1	36	18 people at 2m2 assuming approximately 75% occupancy. Areas should support multipurpose / flexible activities. Include a non-clinical handwash basin.
BBEV	Bay – Beverage	Yes	1	4	Ideally collocated with dining room. Consider support for families to bring in meals depending on service model and storage of dietetic supplements etc.
BMT	Bay – Meal Trolley	Yes	1	4	Ideally collocated with dining room.
WCAC	Toilet – Accessible, 6m2	Yes	1	6	Adjacent to shared areas.
LAUN-PT	Laundry – Patient, 6m2	Yes	1	6 (o)	Optional, depending on length of stay, local models and infection prevention and control policies. This is often helpful for units with a high proportion of patients who have families who live remotely or patients with no family support. Note ADL laundry included below.
Discounted Circulation			**38%**		**Circulation areas are highly utilised in subacute care areas for therapy, exercise and to rest between**

OUTDOOR AREAS

Room Code	Room Name	SC / SC-D	Qty	m2	Comments
	Outdoor Space(s)		1	135	Dedicated outdoor spaces including green areas for subacute care unit. Area allocation is based on 7.5m2 per patient and 75% occupancy. Ideally accessed from shared lounge and dining areas. Areas may be distributed to support separated clusters / pods or areas used for therapy vs socialising. Refer to Section 4.2 of the HPU for further detail.

CLINICAL SUPPORT

Room Code	Room Name	SC / SC-D	Qty	m2	Comments
BHWS-B	Bay – Handwashing, Type B	Yes	2	1	Located along corridors to suit layout and access.
SSTN-14	Staff Station	Yes	1	14	
SSTN-10	Staff Station - Decentralised	Yes	1	5 (o)	Optional, decentralised staff base. Many units use WOWs so staff are mobile and may not require a decentralised taff base. Location and no dependent on unit configuration. Locate to optimise line of sight to patient care areas. May be provided as smaller area for direct oversight of bedrooms/s.
OFF-CLN	Office – Clinical Workroom	Yes	1	20	Increased to support large multidisciplinary team.
BMFD-3	Bay - Multifunction Device	Yes	1	3	
MEET-20	Meeting Room, 20m2	Yes	1	20	Use for staff training, meeting and activities with families or patient education. Must support remote access. Number and size of meeting rooms will depend on the anticipated type, frequency and number of people attending meetings and training.
INTV	Interview Room	Yes	1	12	Wheelchair access needed. Appropriate fit out and ICT infrastructure required to support virtual models of care.
MED-14	Medication Room, 14m2	Yes	1	12	May be provided as a combined Clean Store / Medication Room depending on local jurisdictional policies.
CLN-10	Clean Store, 10m2	Yes	1	10	For storage of unpacked sterile consumables. May be provided as a combined Clean Store / Medication Room depending on local jurisdictional policies.
DTUR-12	Dirty Utility , 12m2	Yes	1	12	May need more than one depending on bed numbers and travel distances.
DISP-10	Disposal Room, 10m2	Yes	1	10	Locate on the IPU periphery for easy retrieval of waste. Should be shared with an adjacent unit where possible.
BLIN	Bay – Linen	Yes	2	2	Minimum 1:15 beds.
BMEQ	Bay – Mobile Equipment	Yes	2	4	No. dependent on assessed need and bed configuration. Likely to require a higher provision than an acute inpatient unit.
BRES	Bay – Resuscitation	Yes	1	1.5	
STEQ-20	Store – Equipment, 20m2	Yes	1	36	Assume 1.5m2 per bed. Close access to unit is required.
CLRM	Cleaner's Room	Yes	1	5	
Discounted Circulation			**38%**		

STAFF AREAS – OFFICE SPACE AND AMENITIES

Allocations are indicative only and need to be matched to workforce profile and space allocated in line with jurisdictional policies.

Room Code	Room Name	SC / SC-D	Qty	m2	Comments
OFF-1P-9	Office – 1 Person, 9m2	Yes		9	Number and area allocation will depend on staff profile and local jurisdictional policies. Must support videoconferencing including consideration of lighting, privacy, acoustics and ergonomics.
OFF-WS	Office - Workstation	Yes		4.5	Number and area allocation will depend on staff profile and local jurisdictional policies. Must support videoconferencing including consideration of lighting, privacy, acoustics and ergonomics.
SRM-15	Staff Room, 15m2	Yes	1	15	
WCST	Toilet – Staff	Yes	2	3	
BPROP	Bay – Property, Staff	Yes	1	2	
SHST	Shower – Staff	Yes	1	3 (o)	Optional. For most units, unless it is a stand alone facility, access to central staff amenities should be provided.
Discounted Circulation			**25%**		

THERAPY SPACES

This scenario assumes that therapy space is dedicated to support a 24-bed unit. Where gym space can be shared with adjacent unit such as rehabilitation unit, this should be explored.

Room Code	Room Name	SC / SC-D	Qty	m2	Comments
GYAH-GP	Gymnasium, Group Therapy		1	35	Requirements will depend on service model, provision of individual and/or group therapy, access to shared gymnasium facilities etc.
ADLB	ADL Bathroom	Yes	1	12 (o)	Optional.
ADLK	ADL Kitchen	Yes	1	12 (o)	Optional.
ADLL	ADL Laundry	Yes	1	8 (o)	Optional.
CONS	Consult Room	Yes		12	Interdisciplinary consult room. May be used by staff such as speech pathology and medical staff. Requirements will depend on local service provision as many patients will be asssessed at the bedside. Fit out to support flexible use for telehealth consultations.
INTV	Interview Room	Yes		12	May be used by a range of staff such as social work, psychologists, dietetics etc. Lockable storage required where psychological testing provided. Appropriate fit out and ICT infrastructure required to support virtual models of care.
STEQ-14	Store - Equipment, 14m2	Yes	1	10	Supporting gym.
WCPT	Toilet – Patient	Yes	1	4	
Discounted Circulation			**32%**		

5.1.3 Palliative Care Inpatient Unit

The indicative SOA below reflects a 20-bed palliative care unit.

ENTRY, RECEPTION AND WAITING

This space will only be provided in selected circumstances (e.g., where the unit is provided in a stand-alone location). Where several inpatient units are collocated in a stand-alone location, this space will be shared.

Room Code	Room Name	SC / SC-D	Qty	m2	Comments
WAIT-10	Waiting, 10m2	Yes	1	10 (o)	Optional. If not provided with adjacent unit.
RECP-10	Reception, 10m2	Yes	1	8 (o)	Optional. If not provided with adjacent unit.
WCAC	Toilet - Accessible	Yes	1	6 (o)	Optional. If not provided with adjacent unit.
Discounted Circulation			**25%**		

INPATIENT AREAS – BED ROOMS

Room Code	Room Name	SC / SC-D	Qty	m2	Comments
1BR-SP-A1 1BR-SP-A2	1 Bed Room - Special, Inboard Ensuite	Yes	17	18	Indicative no. of beds has been specified in a 20 bed unit. If bariatric bedroom to be provided, review ceiling hoist requirement. Some rooms may be larger to accommodate more than one family member / support persons staying overnight.
1BR-SP-A1 1BR-SP-A2	1 Bed Room - Special, Inboard Ensuite (Negative	Yes	1	18 (o)	Optional. Requirement for negative pressure isolation bed rooms will be decided on a project-by-project basis.
ANRM	Anteroom	Yes	1	6 (o)	Optional. Provided as part of N Class rooms.
2BR-ST-A1 2BR-ST-A2 2BR-ST-B	2 Bed Room - Inboard Ensuite	Yes	1	29 (o)	Optional. Indicative no. of beds has been specified in a 20 bed unit.
ENS-SP	Ensuite - Special	Yes	18	6	Attached to 1 Bed Room – Special & Negative Pressure Rooms. It may be possible to arrange a number of ensuites, so showering on a shower trolley can be undertaken within the bed room suite rather than a centralised bathroom.
ENS-BA	Ensuite - Bariatric	Yes	1	7 (o)	Optional. Attached to 1 Bed Room – Bariatric, if provided.
ENS-ACC	Ensuite - Accessible	Yes	1	7	Designed to AS1428. Caters for independent wheelchair patients and replaces standard ensuite.
BATH	Bathroom	Yes	1	15 (o)	Optional. Provision based on risk analysis.
Discounted Circulation			**38%**		

INPATIENT AREAS – SHARED

For the purpose of this example, a 20-bed inpatient unit has been assumed.

Room Code	Room Name	SC / SC-D	Qty	m2	Comments
LNGE-20	Lounge – Patient	Yes	1	20	Allocated for 50% capacity at 2m2. May be provided as separate spaces to accommodated separate groups.
PLAY	Play Area - Paediatric	Yes	1	5	For children visitors.
	Dining / Recreation Room		1	20	Allocated for 50% capacity at 2m2.
BBEV	Bay – Beverage	Yes	1	4	Ideally collocated with dining room.
BMT	Bay - Meal Trolley	Yes	1	4 (o)	Optional. Ideally collocated with dining room, if provided. Provision will depend on food services model. Space dependent on size and capacity of meal trolleys.
	Kitchen		1	15 (o)	Optional for diversional therapy and patient / family use. Provision depends on jurisdictional requirements and risk assessment. If required, provide instead of Bay - Beverage and Open Plan Bay - Meal Trolley.
WCAC	Toilet - Accessible	Yes	1	6	Adjacent to shared areas. For use by patients and visitors.
SHST	Shower - Visitor	Yes	1	3 (o)	Optional. May be provided if shared patient bedrooms are provided in unit.
LAUN-PT	Laundry - Patient	Yes	1	6 (o)	Optional, depending on length of stay and local models.
Discounted Circulation			**38%**		

OUTDOOR AREAS

Room Code	Room Name	SC / SC-D	Qty	m2	Comments
	Outdoor Space		1	120	Based on 7.5m2 per patient and 80% utilisation / occupancy. Outdoor spaces may be distributed to support separate clusters / pods.

CLINICAL SUPPORT

Room Code	Room Name	SC / SC-D	Qty	m2	Comments
BHWS-B	Bay - Handwashing, Type B	Yes	4	1	Located along corridors to suit layout and access. One HWB to be located adjacent to Kitchen and Dining area.
SSTN-14	Staff Station, 14m2	Yes	1	14	Adequate space required to accommodate eMR downtime computers, central station monitoring and USB printing devices.
	Decentralised Staff Workstation		1	2 (o)	Optional. No. as required. If provided, locate directly adjacent to bed room(s) requiring continuous close observation eg 2 bedroom.
OFF-CLN	Office - Clinical Workroom	Yes	1	15	Provided for multidisciplinary team.
BMFD-3	Bay - Multifunction Device, 3m2	Yes	1	3	
MEET-20	Meeting Room, 20m2	Yes	1	20	Use for staff training, meeting and activities with families or patient education. Must support remote access. Number and size of meeting rooms will depend on the anticipated type, frequency and number of people attending meetings and training.
INTV	Multifunctional Quiet Room	Yes	1	12	Wheelchair access needed. For family / support networks to have conversations, briefings, and meetings.
MED-14	Medication Room, 14m2	Yes	1	12	May be provided as a combined Clean Store / Medication Room depending on local jurisdictional policies.
CLN-10	Clean Store, 10m2	Yes	1	10	For storage of unpacked sterile consumables. May be provided as a combined Clean Store / Medication Room depending on local jurisdictional policies.
DTUR-12	Dirty Utility, 12m2	Yes	1	12	May need more than one depending on bed numbers and travel distances.
DISP-10	Disposal Room, 10m2	Yes	1	10	Locate on the IPU periphery for easy retrieval of waste. Should be shared with an adjacent unit where possible.
BLIN	Bay - Linen	Yes	2	2	Minimum 1:15 beds.
BMEQ	Bay - Mobile Equipment	Yes	2	4	No. dependent on assessed need and bed configuration. A range of equipment such as electric wheelchair, etc. May be increased if used to store WOW where used.
BRES	Bay - Resuscitation Trolley	Yes	1	1.5	
	Bay - Flowers, Enclosed		1	4 (o)	Optional.
STEQ-20	Store - Equipment, 20m2	Yes	1	20	Assume 1m2 per bed min.
CLRM	Cleaner's Room	Yes	1	5	
	Discounted Circulation		**38%**		

STAFF AREAS – OFFICE SPACE AND AMENITIES

Room Code	Room Name	SC / SC-D	Qty	m2	Comments
OFF-1P-9	Office - 1 Person, 9m2	Yes		9	Number and area allocation will depend on staff profile and local jurisdictional policies. Must support videoconferencing including consideration of lighting, privacy, acoustics and ergonomics.
OFF-WS	Office - Workstation	Yes		4.4	Number and area allocation will depend on staff profile and local jurisdictional policies. Must support videoconferencing including consideration of lighting, privacy, acoustics and ergonomics.
SRM-15	Staff Room, 15m2	Yes	1	15	Quantity and area allocation will be dependent on staff profile and local jurisdictional policies relating to staff work areas.
WCST	Toilet - Staff	Yes	2	3	Quantity and area allocation will be dependent on staff profile and local jurisdictional policies relating to staff work areas.
BPROP	Property Bay - Staff	Yes	1	2	Quantity and area allocation will be dependent on staff profile and local jurisdictional policies relating to staff work areas.
Discounted Circulation			**25%**		

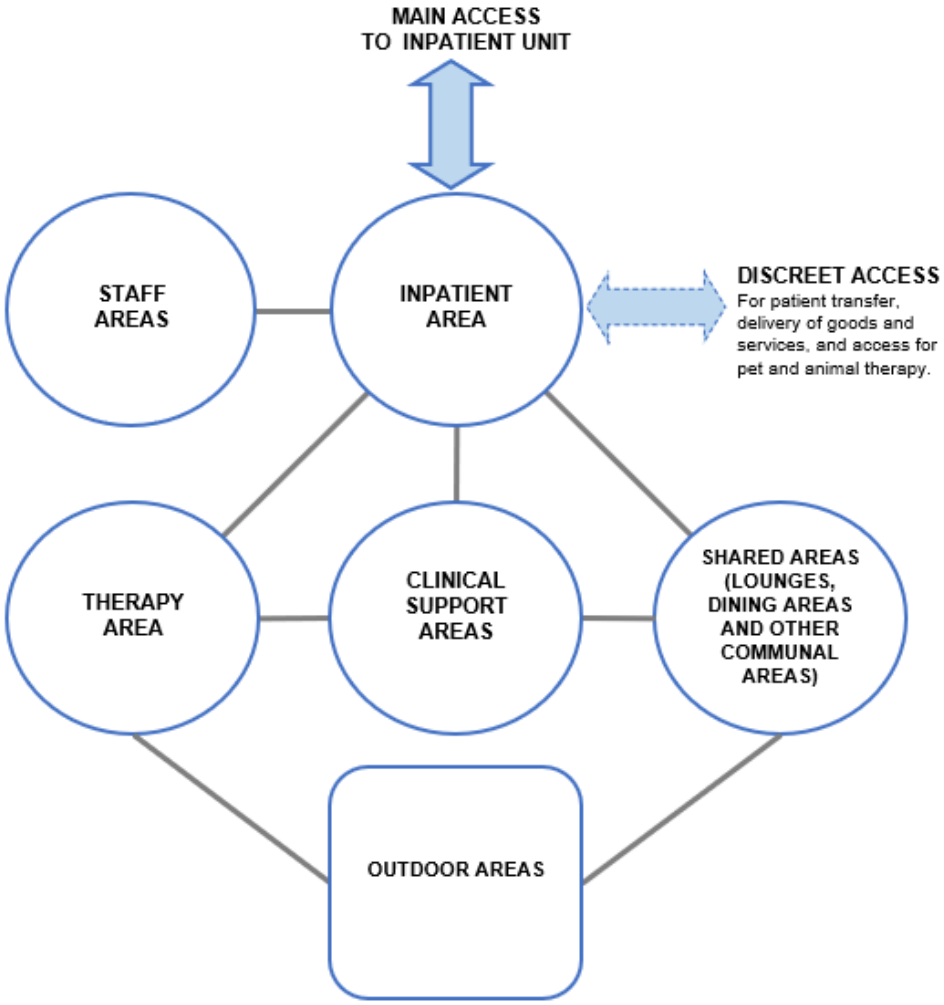
THERAPY SPACES

This scenario assumes that therapy space is dedicated to support a 20-bed unit. Where gym space can be shared with adjacent unit such as rehabilitation unit, this should be explored.

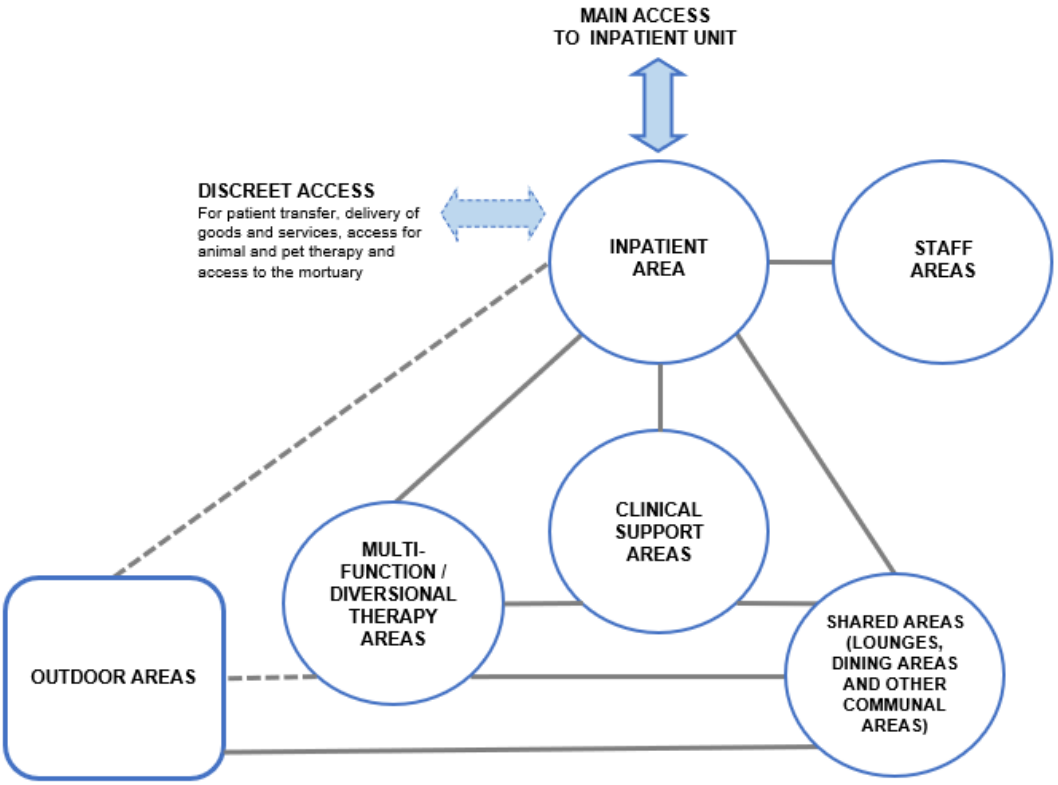
Room Code	Room Name	SC / SC-D	Qty	m2	Comments
	Indoor Exercise Room		1	15 (o)	Optional. Inclusion dependent on service model. Area allocation is indicative, actual requirements will depend on the range of services and equipment to be provided.
	Multipurpose Therapy Room		1	15 (o)	Optional. Inclusion dependent on service model. Area allocation is indicative, actual requirements will depend on the range of services and equipment to be provided.
WCPT	Toilet - Patient	Yes	1	4 (o)	Optional. Provide adjacent to therapy area.
Discounted Circulation			**32%**		

5.2 FUNCTIONAL RELATIONSHIPS - DIAGRAM

5.2.1 Rehabilitation Inpatient & Older People's Health Subacute Care Inpatient Unit



5.2.2 Palliative Care Inpatient Unit



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