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DEPARTMENT OF HEALTH

DOH Health Facility Guidelines 2022

Part B – Health Facility Briefing & Design
415 Sub-acute Aged Care Unit

Executive Summary

Sub-acute Aged Care Unit provides accommodation and support for the elderly who are unable to live independently and occasionally require medical support. Those accommodated within this unit may experience a general deterioration in function over time, possibly living with a range of chronic diseases or minor disabilities. Such disabilities may include mobility issues or dementia.

The facility's care may be classified as low-care or high-care, depending on the demand for services and resources within the facility but with similar or identical design. Accordingly, those being accommodated may be referred to as Residents or Patients. For dementia or behavioural issues, services can be tailored even further. Also refer to the separate FPU's for Mental Health Unit – Older Persons within these Guidelines.

Low-level care provides a supported environment for residents with services including:

- Accommodation-related services
- Personal care services such as daily living activities, support in rehabilitation if needed and access to health and therapy services as required

High-level care involves support with most daily activities, 24-hour nursing staff, and other medical specialists on call. Services provided include:

- Personal care in daily living
- Allied health services
- Accommodation
- Furnishings and bedding
- Cleaning services and laundry
- Meals and refreshments

Stay at the Sub-acute Aged Care Unit may be short term (such as respite care) or long term, changing from low care, to high care over time.

Respite care can be offered through a Sub-acute Aged Care Unit, which is a temporary or casual residential care to support older persons for a period of time.

Nursing care is not the only service given in this Unit. Residents receive personalised attention, food, cleaning services, as well as furnishings and equipment.

Sub-acute Aged Care Unit may be provided in different settings:

- Attached as an FPU to a General Hospital
- Attached as an FPU to a Rehabilitation Hospital
- Attached to a stand-alone Nursing Home
- Stand-alone and independent within the community

A specialised version of Sub-acute Aged Care Unit may have a short-term role for Geriatric Evaluation and Management (GEM) intended to monitor and evaluate the patients over a period of time to determine the optimum level of support required and the best long-term accommodation type recommended.

When these facilities are attached to a Nursing Home or are fully stand-alone, they are typically referred to as Aged Care Homes or Care Homes.

Based on the different conditions and levels of care provided in a Sub-acute Aged Care Unit, terms such as “Patient” or “Resident” are used interchangeably below.

Relevant local authority statutory requirements are to be complied with.

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1. Sub-acute Aged Care Unit

1.1 Introduction

Sub-acute Aged Care Unit is a form of Residential Aged Care Facility (RACF), providing housing and support for the elderly, or seniors who are unable to live independently and occasionally but not constantly require medical support. Many variables influence how persons are classified as 'elderly', including local and organisational definitions, as well as societal and cultural judgments.

The term 'elderly' is generally understood to apply to those in their senior years, who may experience a general deterioration in function throughout time, possibly living with a range of chronic diseases or minor disabilities.

The facility's care may be classified as low-care or high-care, depending on the patient's demands for services and resources within the facility but with similar or identical design. For dementia or behavioural issues, services can be tailored even further. Also refer to the separate FPU's for Mental Health Unit – Older Persons within these Guidelines.

Low-level care provides a supported environment for residents with services including:

- Accommodation-related services
- Personal care services such as daily living activities, support in rehabilitation if needed and access to health and therapy services as required

High-level care involves support with most daily activities, 24-hour nursing staff, and other medical specialists on call. Services provided include:

- Personal care in daily living
- Allied health services
- Accommodation
- Furnishings and bedding
- Cleaning services and laundry
- Meals and refreshments

Stay at the Sub-acute Aged Care Unit may be short term (such as respite care) or long term, leading from low care, to high care over time.

When an older person cannot remain at home, with support from family members, respite care can be offered through a Sub-acute Aged Care Unit, which is a temporary or casual residential care to support older persons for a periods of time.

Nursing care is not the only service given in this Unit. Residents receive personalised attention, food, cleaning services, as well as furnishings and equipment.

Sub-acute Aged Care Unit may be provided in different settings:

- Attached as an FPU to a General Hospital
- Attached as an FPU to a Rehabilitation Hospital
- Attached to a stand-alone Nursing Home
- Stand-alone and independent within the community

When these facilities are integrated with a General of Rehabilitation Hospital, they are referred to as Sub-acute Aged Care unit. This may be regarded as a component of integrated care, serving to

accommodate people in the right settings, preventing hospitals from being un-necessarily occupied by the elderly, who do not need to be in a very expensive acute care setting.

A specialised version of Sub-acute Aged Care Unit may have a short-term role for Geriatric Evaluation and Management (GEM) intended to monitor and evaluate the patients over a period of time to determine the optimum level of support required and the best long-term accommodation type recommended. Some patients may continue in the Sub-acute Aged Care Units, whilst some may be transferred to an Inpatient Unit – General, Nursing Homes or Mental Health Unit – Older Persons.

When these facilities are attached to a Nursing Home or are fully stand-alone, they are typically referred to as Aged Care Homes or Care Homes.

The Sub-acute Aged Care unit size, design, functional requirements, and ties with hospitals will be determined by its catchment population and scope of services. Facilities and equipment will be as needed to provide the scope of services and operational policy requirements.

Based on the different conditions and levels of care provided in a Sub-acute Aged Care Unit, terms such as “Patient” or “Resident” are used interchangeably below.

Relevant local authority statutory requirements are to be complied with.

1.2 Functional & Planning Considerations

1.2.1 Operational Models

The Sub-acute Aged Care Unit will operate on a 24-hour basis. The scope of services and operational policy, which includes the patient/resident mix, number of beds, and the Model of Care to be used, will determine how clinical and personal care services are delivered.

1.2.2 Models of Care

The Model of Care will represent the number of beds intended for the facility, as well as the ratio of high and low level care, spaces dedicated to dementia, and other behavioural disorders. Multiple models of care may be used in a Sub-acute Aged Care Unit.

Non-Institutional Model

For the provision of care and treatment, small clusters of rooms for a limited number of residents (typically 6–12) may be considered. Private rooms and bathrooms connect onto a common living and dining area for the residents. In comparison to institutional hospital models, the family-style setting offers enhanced quality of life and increased happiness among staff, family, and residents.

Strong links to community support agencies and regular social activities involving family will improve socialization; promote living skills and general wellbeing.

Remedial Model

The emphasis of this model's care is on preserving individuals' autonomy within their recognised talents and functions. Self-care and management are encouraged, with care and support provided only when absolutely necessary. Multidisciplinary assessment and goal-setting with low-intensity therapy, as well as aid with daily living activities, aim to maximise a resident's independence and function.

Secure Care Model

This form of care focuses on assuring residents' safety while maintaining a peaceful and stable environment with minimal change and overstimulation. Residents with dementia and behavioural difficulties require constant monitoring and security. Residents with dementia or other psychogeriatric difficulties should be assessed on a regular basis and their treatment optimised to their needs in order to reduce hospitalisations and improve quality of life. Security features should

be in place to enforce limited access in and out of these specified locations, as well as open and tranquil spaces.

1.2.3 Unit Planning Models

Location

The Sub-acute Aged Care Unit may be on any floor level. However, ground floor is regarded as ideal, with access to outdoor, safe and secure courtyards and gardens. This will allow for the ease of transit between spaces, especially because inhabitants are expected to have more mobility concerns. Regardless of the floor level of the unit, residents should have access to outdoor therapeutic and recreational spaces with adequate safety measures in place.

External Planning

The Sub-acute Aged Care Unit, if provided at the ground level, should blend in with its surroundings. The provision of secure gardens and other recreational places with weather protection must be considered while planning external spaces. A section of the garden might be built to enable for increased security measures to be implemented during periods of acute distress or delirium. Fencing should be as unobtrusive as possible, and practical landscaping and gardening alternatives can help make it more so. Outdoor space should be allowed at 8m2 per resident, if provided at the ground level. If the unit cannot be on the ground level, then large safe balconies or terraces should be provided at the ratio of 2m2 per resident.

To produce a balanced environment, low maintenance and robust surfaces that complement the natural environment should be chosen, allowing individuals with limited mobility to enjoy the surroundings.

Other arrangements should be made to allow patients to participate in daily activities wherever possible. Bedrooms and living rooms should have a 'regular' domestic feel.

Internal Planning

Bed spaces that allow for personal and treatment needs to be attended to are required. Single or double occupancy bedrooms should be gender divided. Clusters of spaces should be defined for the amount of care required by residents. Each cluster of bedrooms should include a recreational and lounge space for therapy and activities. From the lounge area, access to external spaces should be provided with sufficient weather protection.

Dining and lounge areas should be communal and a central space for congregation and socialising.

Additional considerations include:

- Clearly defined residential areas readily identifiable by patients who may be disorientated or confused.
- An effective balance between opportunities for resident privacy and the need for staff to monitor them.
- Provision of flexible-use spaces that will accommodate a variety of activities.
- Inclusion of amenities to support families, carers and official visitors.

Size of the Unit

The size of the Sub-acute Aged Care Unit will be determined by the Service Plan and Operational Policy taking into consideration the needs of the facility and other external facilities. The sample Schedule of Accommodation provided in this FPU is developed for a 30-bed unit with capabilities to provide low- and high-level care and secure for residents with dementia.

Communal areas, should be provided in proportion to the number of residents they are serving according to the following guide:

- Lounge/Dining/Activity Areas – 7m² per resident
- Outdoor areas (Courtyards/Garden Areas) – 8m² per resident

1.2.4 Functional Zones

Occupational Therapy, Physiotherapy, Psychology, Speech Pathology, and Social Work may be provided within the unit in conjunction with general medical treatment, in accordance to the Service Plan.

The Sub-acute Aged Care Unit will consist of a number of Functional Zones:

- Entry/ Reception with
  - Waiting areas, separate Male/ Female
  - Office for administrative staff
  - Consult/ Interview room/s
  - Public amenities
- Residential Bed Areas with
  - Bedrooms, Low care
  - Bedrooms, High care
  - Ensuites for each bedroom, including larger Ensuites for assistance
- Resident Activities Areas including:
  - Dining Area with collocated Servery/Kitchen
  - Lounge/ Activity Areas
  - Multi-function Activity room
  - Occupational Therapy Room (optional)
  - Laundry – Resident
  - Courtyards and gardens
- Clinical Support Areas including:
  - Bay for resuscitation trolley
  - Cleaners Room
  - Clean and Dirty Utilities
  - Disposal room
  - Staff Station and hand-over room
  - Stores for patient property, equipment and general supplies
- Staff Areas consisting of:
  - Offices for administration, management and clinical staff
  - Meeting Room/s
  - Staff Room
  - Stores for photocopier, stationery and files
  - Staff Toilets, Shower and Lockers

The above zones are briefly described here:

Entrance/ Reception Area

Residents, family, and guests have immediate access to the facilities through the Entrance. It should be simple to access and transfer from a private or patient transport vehicle, with enough weather protection to shelter a minibus.

Residents who require emergency medical care require an entrance that can easily accommodate an ambulance cart and support staff. An intercom and viewable CCTV should be installed between the Entry, Emergency Entrance (if it is distinct from the main entrance), and the Reception and Staff Station. Separating the Entrance and Reception Areas from the main Facility, coded-entry facilities

should be implemented. This will prohibit residents who require high-level care or close supervision owing to falls risks or psychological conditions from entering and exiting the facility easily.

Consult/ Interview Rooms

Consult/Interview Rooms will be available for nursing, allied health, medical, and support workers to interview and assess patients, family, or carers, as well as examine patients as needed. For the safety of consulting staff and patients, duress/emergency alarms should be installed in these rooms.

Existing residents should be able to reach the Consult/Interview Rooms from both the entrance and the remainder of the facility for consultation and therapy.

Patient Areas

Patient Areas will include:

Patient Bed Rooms (Low Level Care)

Single or double occupancy bedrooms are recommended; the ratio of these types will vary based on the scope of services and operational policy. Single bedrooms provide solitude, but double bedrooms can better utilise workers, especially if seniors require a high level of care, and provide residents with companionship. Gender separation is required in dual occupancy rooms.

Bedrooms should be designed and furnished to act as a 'at home' place, with features such as a pin-up board and display shelves that tenants may customise. An external outlook is necessary from each room.

While domestic-style beds are favoured for ambiance, low-height bed attendants should be aware of work safety and health concerns. The space, fit out, and equipment requirements will be better determined by allocating rooms to low- or high-level care duties.

High/ Secure Care Areas

Depending on the Scope of Services, a High/Secure Care Area will accommodate residents in an acutely distressed mental state, suffering delirium or dementia patients prone to wandering. This area will require personnel supervision and strong visibility. Its placement and design should allow for quick staff reaction in the event of a patient emergency and avoid residents passing through other open areas. This room should enable secure separation from the rest of the Facility when needed.

Bedrooms, ensuites, toilets, dining spaces, lounge and activity areas, and outdoor areas on a lesser size than the rest of the facility, but sufficient to create a comfortable environment for residents, depending on the number of patients the area is to accommodate.

Ensuites/ Toilets

Each bedroom will have its own bathroom. Ensuites must have enough space for a wheelchair and various types of walkers to manoeuvre. Transfer benches, commodes, grab rails, and shower stools must all be considered so that they can be installed permanently or according to resident needs.

High-level care ensuites may need to be accessible from the corridor in case of emergencies or assistance. Staff should be able to open privacy locks if necessary. Residents should be able to contact for help or in case of an emergency by placing call buttons at at least two locations within the Ensuite, one of which is accessible from the toilet.

Toilets must also be provided near social areas and outdoor spaces throughout the facility. The same concerns apply, including space needs, access, and call alternatives for personnel in the event of an emergency or assistance request. Doors in general toilets should glide for tenants' convenience and to prevent obstruction in either direction, in or out of the toilet.

Dining Area and Servery/ Kitchen

Meals will usually be served in a shared Dining Area. The space should be large enough to accommodate all residents and caregivers. Tables should be mobile and height adjustable to accommodate persons who use wheelchairs or other mobility aids.

Only personnel should have access to a secure Servery/Kitchen, which should be positioned close to the meal serving area and Dining Area. The food service area should have a beverage bay that is accessible to residents and is monitored and supplied by staff. Hand washing and bathroom facilities are available near the Dining Area's entry/exit point. The Dining Room and Servery/Kitchen should have impermeable and easy-to-clean walls and floors.

Low care facilities or parts of the facility may have kitchen and meal preparation areas accessible by residents. The Dining Area may be used for other activities when not in use for meals.

Lounge/ Activity Areas

When more space is needed, lounge/activity areas can be placed adjacent to dining areas. There must be at least two discrete social places, one for quiet activities and the other for louder recreational activities. Activity rooms can be designed as multi-purpose facilities with a variety of uses. These Rooms should have access to the outside world, as well as floor to ceiling windows and doors to ease the transition. Hard impermeable, easy to clean flooring should be used in activity areas.

Lounge Areas may have carpeted flooring for comfort and to assist with noise dispersion. It should also have an external outlook. Lounge areas should be outfitted with a television, music player, bookcases, and storage for indoor card and board games, among other things.

Multifunction Activities Rooms

Separate social spaces shall be provided for quiet and noisy activities. Activities Rooms may be provided as multi-function spaces for flexibility of use including arts and craft activities, music and TV areas. Access to an external area for use in all types of weather from at least one Activities Room is desirable. The spaces involving wet activities shall include:

- Hand-washing
- Workbenches/ Tables (movable)
- Storage and Displays
- Bench and sink

Courtyard/ Garden Areas

For both mental and physical wellness, elderly residents require external courtyard and garden areas. Seats and tables on benches should be made of strong surface materials and secured to the ground. In inclement weather, covered space for shade and patient use should be provided. Access to restroom facilities near the Courtyard/Garden Areas and secure storage for activities equipment should be considered.

Residents may spend a significant portion of their later years in the unit, thus a family-style setting is perfect. This could include parts of the outdoor space dedicated to the care and maintenance of the residents themselves. To allow for close pleasure and increased functionality, garden beds can be raised to a sufficient height and surrounded by pleasant and enough seating.

Clinical Support Areas

Support Areas include:

- Cleaner’s Room
- Clean and Dirty Utilities
- Disposal Room

- Medication Room
- Storage for linen, consumable supplies, equipment for activities, daily living aids, files, patient property stationery, and a resuscitation trolley

Staff Areas

Staff Areas will consist of:

- Offices and workstations for the Unit manager and senior personnel required for administrative as well as clinical functions
- Staff Room
- Staff Station and handover room
- Toilets, Shower and Lockers

Administration and Office Areas should be secure allowing staff only access to prevent unauthorised entry and access to resident information and other secure documents. The Facility Manager's Office should be located within, or directly adjacent to resident areas and the Staff Station. Access to workstations for support staff, visiting medical and allied health staff should be considered in an area discreet from the Staff Station.

1.3 Functional Relationships

A Functional Relationship can be defined as the correlation between various areas of activity which work together closely to promote the delivery of services that are efficient in terms of management, cost and human resources.

1.3.1 External Relationships

The Sub-acute Aged Care Unit may be located in a community setting with close links to health facilities. The facility will require strong functional links to supply services including medications, food, linen, general consumable supplies and waste handling for deliveries and collections.

1.3.2 Internal Relationships

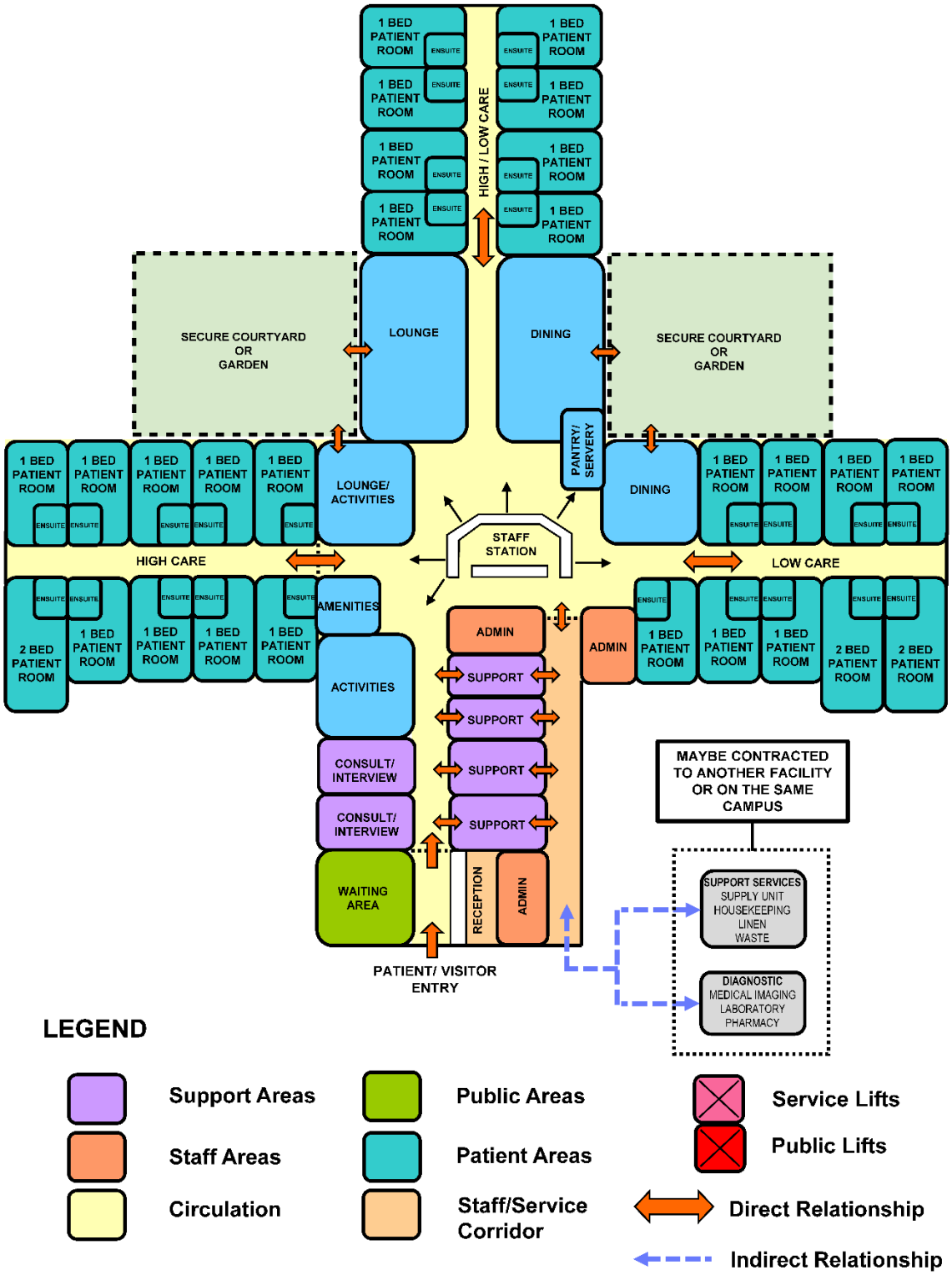
Optimum internal relationships include:

- Reception at the entrance with Waiting areas and access to Consult rooms
- Patient occupied areas on the perimeter with access to windows
- Dining, Lounge and Activities areas centrally located
- The Staff Station and support areas need good access and observation of communal areas, therapy areas and Patient area corridors
- Restricted access to medication areas
- Utility and storage areas need ready access to both patient and staff work areas
- Staff Offices and amenities located away from patient areas
- Public Areas should be on the outer edge of the Unit
- Links to other units if provided as a component of a General or Rehabilitation Hospital or Nursing Home

1.3.3 Functional Relationship Diagram

The Functional Relationships Diagram below best describes the relationships between the many components inside the Sub-acute Aged Care Unit.

Sub-acute Aged Care Unit



1.4 Design Considerations

The Sub-acute Aged Care Unit's design philosophy should express a welcoming and inviting environment, encouraging community members to use the available resources for rehabilitation. It is necessary to develop a non-institutional, safe, and supportive environment. To enable the Unit to cater for shifting customer and service needs, the building design must be versatile and adaptive.

The design will be highly influenced by the Facility's Scope of Services and Operational Policy, which will take into account the levels and types of care to be delivered. The degrees and types of care to be offered, the ratio of resident care levels to one another, and the provision of secure care facilities for dementia and mentally troubled residents must all be considered in the Scope of Services and Operational Policy.

The design of the Unit and external spaces should be domestic in nature rather than formal or clinical. The Unit will need to provide a sufficient amount of space for recreation and treatment of patients. The design should:

- Create a therapeutic environment for patients which provide privacy, opportunities for recreation and self-expression.
- Provide for patient activities both indoors and outdoors with unobtrusive environmental boundaries.
- Provide staff with opportunities to discreetly monitor and observe patients.
- Provide a safe and secure environment for patients and staff including minimum number of entry points and non-intrusive safety provisions.
- Provide clear, high contrast directional signage around the facility both internally and externally.

1.4.1 Environmental Considerations

Acoustics

Resident communal spaces will require acoustic treatment to maintain noise control. Acoustic treatment should be applied in the Lounge, Dining and Activities Areas, Bedrooms and Assessment Areas.

Natural Light/ Lighting

Natural light is highly desirable within the facility, as well as windows permitting outside views to create a natural ambience in the area. Wherever possible, the use of natural light is to be maximized.

Generally provide a high level of national or artificial lighting as many elderly residents have vision difficulty in dimmed light.

Toughened laminated glass should be used on all windows in social areas. Because of the possibility of surface scratches, polycarbonate is not advised. Internal windows in resident-accessible spaces should be double-glazed, with flush-facing windows and frames.

Graduate the impact resistance of the glass in secure care spaces from toughest at the lowest level to weakest at the highest level. For low level glazing in patient areas, toughened laminated glass with a nominal thickness of more than 10.0 or equivalent certified is recommended. In situations where glass damage is likely, use smaller pane sizes. For a given thickness, smaller panes are intrinsically stronger than larger panes.

Privacy

The design of the Sub-acute Aged Care Unit needs to consider patient privacy and confidentiality incorporating the following:

- Discreet discussion spaces and non-public access to medical records.

- An adequate number of rooms for discreet discussions and treatments to occur whenever required.
- Privacy screening to all Physiotherapy plinths (if any), Examination Bays and Patient Bed Bays with sufficient space to permit curtains to be easily drawn whenever required.
- The location of doors to avoid patient exposure in Consult Rooms.
- Location of doors and windows to ensure residents' privacy and promote staff security.
- Window treatment to provide resident privacy from external and internal viewing.

1.4.2 Space Standards and Components

In new facilities, maximum room capacity shall be two patients per room.

Bed Spacing / Clearances

The room areas noted in these Guidelines are intended as minimums and do not prohibit the use of larger rooms where required.

All patient beds must comply with standard components for fittings, furniture, mechanical and electrical services and nurse call systems including the clearances that they imply.

In single bed rooms there shall be a clearance of 1200 mm available at one side and the foot of each bed and a minimum of 900mm clear on one side to allow for easy movement of equipment and beds. In multiple-bed rooms such as 2 bedded rooms, the minimum distance between beds shall be 2900 mm between centrelines of beds and 1200 mm at the foot of each bed.

1.4.3 Accessibility

Ensure all resident accessible areas will accommodate residents and visitors in a wheelchair.

1.4.4 Doors

Door openings to inpatient bedrooms shall have a minimum of 1350mm clear opening (although 1400mm is recommended) to allow for easy movement of beds and equipment.

1.4.5 Ergonomics/ OH&S

Ergonomics and Occupational Safety and Health (OSH) requirements must be considered in the design process and the selection of fittings and equipment in the Facility to ensure optimal operation of the Sub-acute Aged Care unit and the health and safety of the staff, residents and visitors. Patients of the Unit/ facility are likely to have full care requirements and place high physical demands on staff and carers.

The positioning of equipment, the heights and proportions of counters, and the size of work areas must all offer privacy and security for residents, visitors, and staff.

Consider a high contrast colour scheme allowing the elderly residents to better distinguish doorways, grab rails and similar elements.

1.4.6 Safety and Security

The Sub-acute Aged Care Unit must be secured to prevent unauthorised access through doors, windows, wall and ceilings. A security intrusion detector alarm should be fitted to monitor the Facility 24-hours a day.

The patient population of this Unit requires special consideration in terms of safety as they may be disabled or incapacitated while being encouraged to be mobile and self-sufficient. Design and selection of finishes, surfaces and fittings must be assessed to determine the potential for accidents or hazards to both patients and staff. Consider:

- Slippery or wet floors
- Protrusions or sharp edges
- Stability and height of equipment or fittings
- Handrails and wheelchair access are mandatory

By combining related functions, controlling entry and egress from the Unit, and providing optimal surveillance for personnel, the layout of areas and zones will provide a high level of security. The Unit's perimeter should be guarded, and electronic access should be considered. Access to Public Areas must be carefully arranged to ensure that the safety and security of the Unit's staff areas are not jeopardized. When the Unit is not in use, zones may need to be locked. If areas are used by the public for classes, such as gyms, after-hours access management is required. Internally, all offices should have lockable doors, as should all storage rooms for files, data, and equipment.

Security measures for consideration may include:

- Electronic door controls and alarms to perimeter doors
- Coded-access entry
- Movement sensors
- Duress alarms at Entrance/Reception and in Assessment Areas
- Solid ceilings to prevent access

1.4.7 Drug Storage

Drugs prescribed for patients should not be stored in the patient bedroom. All drugs should be managed by the responsible nurses via a Medication Room.

Optionally Medication Room may be combined with a Clean Utility room as long as the requirements of both functions are accommodated.

Medication may be manually stored and managed, or alternatively automated Medication Management systems may be utilised.

Controlled or dangerous drugs must be kept in a secure cabinet within the Medication Room with alarm.

A refrigerator, as required; to store restricted substances, it must be lockable or housed within a lockable storage area

The Medication Room must have space for parking a medication trolley.

1.4.8 Finishes

Finishes including fabrics, floors, walls and ceilings should be non-institutional as far as possible and promote a relaxing atmosphere. Surface finishes should be impact resistant and easily cleaned. It is essential that floor finishes are non-slip and do not create “drag” for patients using walking aids and wheelchairs.

The following factors should be considered when selecting finishes:

- Purpose of rooms
- Aesthetic appearance
- Acoustic properties
- Durability
- Ease of cleaning and infection control
- Fire safety
- Movement of equipment

- Anticipate and allow for possible incontinence

Refer also to Part C of these Guidelines.

1.4.9 Fittings, Fixtures & Equipment

Equipment, furniture and fittings should be selected and installed to be safe, robust and suitable for heavy usage.

Mirrors should have safety glass or other appropriate impact resistant and shatterproof construction and must not distort the reflected image. Mirrors should be fully fixed to a backing to prevent freeing of loose fragments of broken glass.

Height of light switches need to comply with accessibility codes. Handrails on both sides of corridors are recommended.

Refer also to Part C of these Guidelines.

Curtains / Blinds

Each Bedroom shall have partial blackout facilities (blinds or lined curtains) to allow patients to rest during the daytime.

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

If blinds are to be used instead of curtains, the following will apply:

Vertical blinds and Holland blinds are preferred over horizontal blinds as they do not provide numerous surfaces for collecting dust.

Horizontal blinds may be used within a double-glazed window assembly with a knob control on the bedroom side.

1.4.10 Building Services Requirements

This section identifies unit specific services briefing requirements only and must be read in conjunction with Part E - Engineering Services for the detailed parameters and standards applicable.

Information and Communication Technology

Unit design should address the following Information and Communications Technology issues:

- Electronic Health Records (EHR) which may form part of the Health Information System (HIS)
- Hand-held tablets and other smart devices
- Picture Archiving Communication System (PACS)
- Paging and personal telephones replacing some aspects of call systems
- Data entry including investigation requests
- Bar coding for supplies and records
- Data and communication outlets, servers and communication room requirements
- Optional availability of Wi-Fi for staff, patients and waiting visitors

Staff Call

The Unit must provide an electronic call system next to each inpatient bed to allow for patients to alert staff in a discreet manner at all times. Additionally, call systems must be installed in all treatment areas, therapy areas and staff areas.

All calls are to be registered at the Staff Stations and must be audible within the service areas of the Unit including Clean Utilities and Dirty Utilities. If calls are not answered the call system should

escalate the alert accordingly. The Staff Call system may also use mobile paging systems or SMS to notify staff of a call.

Duress Call

In the early planning stage of the project, the provision of both fixed and individual mobile duress equipment with location finders should be considered.

Patient Entertainment Systems

Patients may be provided with the following entertainment/ communications systems according to the Operational Policy of the facility:

- Television
- Telephone
- Radio
- Internet (through Wi-Fi)

Heating Ventilation and Air-conditioning (HVAC)

The air temperature in inpatient areas should be capable of being maintained along with relative humidity, both should be adjustable.

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

Medical Gases

The minimum provision of Medical Gases in the Sub-acute Aged Care Unit will be as follows:

- For residents requiring low-level care– Not Required. If a resident requires medical gases, they should be transferred to a high care facility, nursing home or an Inpatient Unit.
- For patients requiring high level care- Oxygen

Hydraulics

Warm water shall be supplied to all areas accessed by patients within the Unit. Temperature to be maintained at 38°C ideally but must not exceed 43°C. This requirement includes all staff handbasins and sinks located within patient accessible areas. Sinks in Staff Areas shall be provided with hot and cold water services.

For further information and details refer to Part E – Engineering Services in these Guidelines.

1.4.11 Infection Control

Hand Basins

Handwashing facilities shall be provided in Dining, Activities, Lounges and Consult/Examination Rooms and located conveniently to patient Bed Rooms. Handbasins suitable for scrubbing procedures shall be provided for each Procedure and Treatment Room, as specified by the Standard Components. Where a handbasin is provided, there shall also be liquid soap, disposable paper towels and waste bins provided.

Handwashing facilities shall not impact on minimum clear corridor widths. At least one Handwashing Bay is to be conveniently accessible to the Staff Station. Handbasins are to comply with Standard Components - Bay - Handwashing and Part D - Infection Control in these Guidelines.

Antiseptic Hand Sanitiser

Antiseptic Hand Sanitisers should be located so they are readily available for use at points of care, at the end of patient examination couches and in high traffic areas.

The placement of Antiseptic Hand Sanitisers should be consistent and reliable throughout facilities. Antiseptic Hand Sanitisers are to comply with Part D - Infection Control, in these Guidelines.

Antiseptic Hand Sanitisers, although very useful and welcome, cannot fully replace Hand Wash Bays. Both are required. Refer also to Part D of these Guidelines.

1.5 Standard Components of the Unit

Standard Components are typical rooms within a health facility, each represented by a Room Data Sheet (RDS) and a Room Layout Sheet (RLS).

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

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

Group	Description
1	Provided and installed by the builder
2	Provided by the Client and installed by the builder
3	Provided and installed by the Client

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

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

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

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

1.5.1 Non-Standard Components

Non-standard rooms are rooms are those which have not yet been standardised within these Guidelines. As such there are very few Non-standard Rooms. These are identified in the Schedules of Accommodation as NS and are separately covered below.

Occupational Therapy Room/s

The Occupational Therapy Rooms are large rooms or workshops for a range of activities including table based, arts, crafts and woodworking. The Occupational Therapy rooms may be located adjacent to rehabilitation therapy areas, with ready access to waiting and amenities areas.

Fittings and Equipment required in this area may include:

- Benches with inset sink, wheelchair accessible
- Shelving for storage of equipment or tools
- Tables, adjustable height
- Chairs, adjustable height
- Hand-washing basin with liquid soap and paper towel fittings
- Pin board and whiteboard for displays
- Sufficient power outlets for equipment or tools to be used in activity areas

1.6 Schedule of Accommodation

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

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

The table below demonstrates the SOA for a 30 bed Sub-acute Aged Care Unit for role delineations (RDL) 3 to 6 including typical patient rooms and communal living areas.

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

1.6.1 Sub-acute Aged Care Unit with 30 Beds

In the sample SOA below, provision of Sub-acute Aged Care beds is divided into Low-level Care and High-level Care with a 50/50 split and a recommended 80% of single bed rooms. Quantity and mix of low care vs high care, single vs double occupancy is subject to the Service Plan of the facility.

ROOM/ SPACE	Standard Component Room Codes									RDLs 3 - 6 Qty x m^2			Remarks
Unit Size										**30 Beds**			
Entrance/ Reception													
Entry Lobby/Airlock	airle-10-d									1	x	10	Required for a stand-alone Unit
Reception/ Clerical	recl-15-d									1	x	15	
Waiting (Male/ Female)	wait-10-d									2	x	10	Separate Male and Female
Toilet - Public	wcpu-3-d									2	x	3	Separate Male and Female
Toilet - Accessible	wcac-d									1	x	6	
Consult/ Interview Room	cons-d									2	x	14	
Resident Bed Areas – Low-Level Care (15 beds)													
1 Bed Room – Low Care	1br-st-18-d similar									10	x	18	Mix and Qty depend on service demand.
1 Bed Room – Large (Low Care)	1br-lg-28-d similar									1	x	28	May be used for special needs patients. Qty depends on service demand.

ROOM/ SPACE	Standard Component Room Codes									RDLs 3 - 6 Qty x m^2			Remarks
Unit Size										**30 Beds**			
2 Bed Room – Low Care	2br-st-28-d similar									2	x	28	Mix and Qty depend on service demand. Minimum 20% of beds in single rooms.
Ensuite - Standard	ens-st-d or ens-st-c-d									12	x	5	1 per every patient room.
Ensuite - Super	ens-sp-d									1	x	6	For 1 Bed Room - Large. Special fittings required for bariatrics. Only required if bariatric room is provided.
Bay - Handwashing, Type B	bhws-b-d									4	x	1	1 per 4 beds; 1 at entry, 1 near staff station; Refer to Part D
Bay - Linen	blin-d									1	x	2	Quantity and location to suit each facility
Resident Bed Areas – High-level Care (15 beds)													
1 Bed Room – High Care	1br-st-18-d similar									11	x	18	Mix and Qty depend on service demand.
1 Bed Room – Large (High Care)	1br-lg-28-d									1	x	28	May be used for special needs patients. Qty depends on service demand.
2 Bed Room – High Care	2br-st-28-d similar									1	x	28	Mix and Qty depend on service demand. Minimum 20% of beds in single rooms.
Ensuite - Standard	ens-st-d or ens-st-c-d									13	x	5	1 per every patient room.
Ensuite - Super	ens-sp-d									1	x	6	For 1 Bed Room - Large. Special fittings required for bariatrics. Only required if bariatric room is provided.
1 Bed Room - Isolation - Negative Pressure	1br-isn-18-d									1	x	18	Class N rooms are mandatory and according to the ratios nominated in this FPU. It could be located within the High-level Care pod or Low-level Care pod. Minimum size is 18m2. Any isolation room may be combined with the mandatory Bariatric room to form and Isolation Bariatric room at 28m2 (1br-isn-28-d).
Anteroom	anrm-d									1	x	6	
Bay - Handwashing, Type B	bhws-b-d									4	x	1	1 per 4 beds; 1 at entry, 1 near staff station; Refer to Part D
Bay - Linen	blin-d									1	x	2	Quantity and location to suit each facility
Resident Activity Areas													
Dining Room	dinr-d similar									1	x	80	Based on 7.5m^2 per person in combined total for dining and activities area.
Pantry/ Servery	ptry-d similar									1	x	15	With serving counter
Lounge/ Activities Areas	lnac-30-d similar									1	x	100	Based on 7.5m^2 per person in combined total for dining and activities area.
Multi-function Activity Room	mac-20-d similar									1	x	45	Based on 7.5m^2 per person in combined total for dining and activities area.

ROOM/ SPACE	Standard Component Room Codes									RDLs 3 - 6 Qty x m^2			Remarks
Unit Size										30 Beds			
Occupational Therapy Room	NS									1	x	20	Optional
Courtyards/ Gardens	NS									1		*	*External Areas; based on 10m^2 per person.
Laundry - Patient	laun-pt-d									1	x	6	Optional; depending on Service Plan.
Toilet - Accessible	wcac-d									2	x	6	Minimum 1 for each male/female; locate near dining/ Activities area
Bathroom - Assisted	bath-d									1	x	16	Optional; provide according to service demand
Treatment Room	trmt-14-d									1	x	14	Optional; provide according to service demand
Support Areas													
Bay - PPE	bppe-d									1	x	1.5	Refer to Part D - Infection Control. Can be collocated with HWB.
Bay - Mobile Equipment	bmeq-4-d or bmeqe-4-d									1	x	4	Quantity, size dependent on equipment to be stored; opened or enclosed bay
Bay - Resuscitation Trolley	bres-d									1	x	1.5	Located near Staff Station
Clean Utility	clur-12-d similar									1	x	12	May be Interconnected with Medication Room
Medication Room	medr-10-d									1	x	10	May be Interconnected with Clean Utility
Clean Utility / Medication	clum-14-d									1	x	*	*Optional, if preference is to combine Clean Utility and Medication Room into a single room, minimum 14m2.
Dirty Utility	dtur-14-d									1	x	14	2 may be required to minimise travel distances
Disposal Room	disp-8-d									1	x	8	
Store - Equipment	steq-14-d similar									1	x	16	Size dependent on equipment to be stored
Store - General	stgn-8-d similar									1	x	10	Size as per service demand and operational policies
Store – Patient Property	stpp-d									1	x	8	
Cleaner's Room	clrm-6-d									1	x	6	Includes storage for dry goods
Staff Areas													
Staff Station	sstn-20-d									1	x	20	To oversee activities/ dining/ lounge areas
Office - Clinical / Handover	off-cln-d									1	x	15	May be collocated with Staff Station
Office - Single Person	off-s9-d									1	x	9	Unit Manager; Qty as needed.
Office – 2 Person, Shared	off-2p-d									2	x	12	Medical, Nursing, Allied Health; Qty as needed.
Store – Photocopy/ Stationery	stps-8-d									1	x	8	
Store – Files	stfs-10-d									1	x	10	May be combined with Photocopy/ stationery
Meeting Room - Medium/ Large	meet-l-30-d									1	x	30	Also used for Group/ Family Therapy

ROOM/ SPACE	Standard Component Room Codes									RDLs 3 - 6 Qty x m^2			Remarks
Unit Size										**30 Beds**			
Staff Room	srm-25-d									1	x	25	Includes food preparation area
Property Bay - Staff	prop-3-d									2	x	3	Separated for male and female. Number of lockers depends on staff complement per shift
Toilet - Staff	wcst-d									2	x	3	Separate Male and Female
Sub Total												**1328.0**	
Circulation %												**35**	
Total Areas												**1792.8**	

Please note the following:

- Areas noted in Schedules of Accommodation take precedence over all other areas noted in the Standard Components.
- Rooms indicated in the schedule reflect the typical arrangement.
- All the areas shown in the SOA follow the No-Gap system described elsewhere in these Guidelines.
- Exact requirements for room quantities and sizes shall reflect Key Planning Units (KPU) identified in the Clinical Service Plan and the Operational Policies of the Unit.
- Room sizes indicated should be viewed as a minimum requirement; variations are acceptable to reflect the needs of individual Unit.
- Offices are to be provided according to the number of approved full-time positions within the Unit.
- Class N Isolation rooms are mandatory and is provided per every 30 (±2) beds. Class P Isolation rooms are subject to Clinical Services Plan or demand.

1.7 Further Reading

In addition to Sections referenced in this FPU, i.e. Part C- Access, Mobility, OH&S, Part D - Infection Control, and Part E - Engineering Services, readers may find the following helpful:

- International Health Facility Guideline (iHFG) www.healthdesign.com.au/ihfg
- The Remedial model of care for older people: http://www. nursingtimes. net/a-new-model-of-care-for-the-older-person/5042747. article 2014
- Guidelines for Design and Construction of Residential Health, Care and Support Facilities; The Facility Guidelines Institute, 2018 Edition; refer to website: www.fgiguidelines.org