# 300 EMERGENCY UNIT

## INDEX

### Description



## INTRODUCTION

### Preamble

300 .1.00 The Emergency Department (ED) is the front door of the hospital and for many people forms their primary contact with the health system. The Emergency Department therefore provides an important interface between the community and the hospital.

### General

300 .2.00 The core role of the Emergency Department is to provide timely, accessible and appropriate health services to people with acute illness or injury. The Emergency Department needs to be able to deal with large numbers of patients presenting with a range of conditions with varying degrees of urgency.

The Department also provides entry to patients with infectious diseases including SARS, etc. Design for Infection Prevention and Control is necessary, especially at the first point of contact ie Triage.

Provision of care in the Emergency department is provided on a priority basis with patients requiring more urgent care taking precedence over patients with less urgent

clinical conditions.

## Policy Statement

300 .3.00 The level of service available at individual Eds across the state will vary according to the role delineation of the service and the broader services available at the Hospital. However, all EDs must be able to provide a minimum standard of care to patients presenting there, irrespective of the number and level of Inpatient Units in the Hospital.

Current NSW Health policy advocates the adoption of a network model of services, encompassing both rural and metropolitan services, to enable Area Health Services to meet community need and offer access to a full range of services.

During the planning process it is recommended that Project Planning Teams refer to the following relevant documents:

+ Emergency Department Services Plan, NSW Health, 2001;

+ Emergency Department Strategic Directions - Priorities and Planning Guidelines for the NSW Health System 1997 - 2000;

+ Emergency Department Access Block - Working Party Report, NSW Health, 1999.

+ Working Group for Mental Health Care in Emergency Departments - Final Report and Recommendations. NSW Health, 2003.

## Description of the Unit

300 .4.00 The function of the Emergency Department (ED) is to receive, assess, stabilise and manage patients who present with a wide variety of conditions of varying urgency and complexity. They may self-present or be referred.

The range may include cases from major trauma, surgical conditions, medical conditions such as strokes and heart attacks, gynaecological/obstetric problems, broken bones, skin wounds, communicable/non-communicable infections as well as mental health conditions.

Most units will treat adults and children.

While the caseload may be predictable, changing levels of demand must be anticipated.

The ED also provides for the reception and management of disaster patients as part of the Unit's role within the Disaster Plan for each region.

300 .5.00 The following standards are intended only as a guide. Any additional facilities need, shall satisfy the local Operational Policy.

300 .6.00 It is recommended that Hospitals that do not provide an Emergency Service display a prominent exterior sign at the Main Entrance stating this and giving the location of the nearest Hospital with an Emergency Service.

# PLANNING

## Operational Models

300 .7.00 The following issues should be considered in developing the operational model for the Unit, as they will all impact on appropriate space provision.

300 .8.00 NATURE OF THE SERVICE

A. ROLE DELINEATION OF THE HOSPITAL SERVICES INCLUDING ITS EMERGENCY SERVICE

Although the basic nature of the service may be the same, there are different requirements for major referral hospitals, district hospitals, major trauma centres, and paediatric specialist hospitals. Peer hospitals will generally have similar requirements, with variations for activity and other factors.

B. URBAN VS RURAL LOCATION

Whether the Hospital is located in an urban or rural location will have an influence on factors such as flexibility of the service, provision of retrieval services, security issues, sharing of staffing and alternative resources.

The demand for mental health services and the impact of acute mental health presentations to the ED may have significant implications for operational policies and ED design depending on factors such as availability of mental health clinical advice, availability of a medical practitioner, number of staff on duty, access to acute mental health beds, and availability of patient transport services.

C. ACCESS TO INPATIENT HOSPITAL BEDS AND TO ALTERNATIVE SERVICES

The degree of difficulty in admitting patients to the Inpatient Units, and the local philosophy for managing incoming patient load will affect the required holding capacity of the Unit. Where complex pre-discharge care is done within the ED, space and facilities will be required to suit the function.

D. PHILOSOPHY OF CARE OF THE EMERGENCY DEPARTMENT AND THE HOSPITAL

ED services vary in the way acute care is coordinated between the community, ED and Inpatient Services. While some hospitals may have various routes of entry for acute patients, others may channel all acute patients through the ED. There is also variation in the degree of assessment and treatment completed in the ED prior to transfer to an Inpatient Unit. Hospitals will also need to choose whether to have key diagnostic services (particularly Medical Imaging) adjacent, or whether to provide satellite services within the ED.

E. ACADEMIC AND TEACHING ROLES

This factor will influence the requirements for meeting rooms, office space and general administrative space.

F. STAFF STRUCTURE

This will have an impact on the nature, size and location of Staff Stations, as well as office, administrative space, staff facilities such as staff rooms and amenities including locker/change rooms, toilets and showers.

G. NATURE OF PATIENT CASEMIX, INCLUDING ACUITY AND COMPLEXITY

Features of patient casemix that affect design requirements include numbers, demographics and the nature of the presentations.

Patients with specific needs include:

+ The elderly;
+ Children
+ Chronically disabled people;
+ Patients in custody;
+ Patients with:
  - Minor or major injury;
  - Industrial illness and injury;
  - Sport-related injury;

- Drug and alcohol-related presentations;
- Mental illness;
- Complications of pregnancy etc;
- Chemical, Biological and Radiological (CBR) exposure;
- infections or who are immunosuppressed.

300 .9.00 STRUCTURE OF THE SERVICE

While ED care basically includes reception, assessment, stabilisation and treatment, there are various ways in which these components of the service can be provided for different groups of patients. Examples of different models that may influence facility design include:

A. FAST-TRACKING GROUPS OF PATIENTS OR TYPE OF PRESENTATION

Operational Policies may include early identification of specific patient groups to be assessed and treated via a separate track to other ED presentations. This may occur at the triage point, or immediately after triage but in a separate space. Examples of patient presentations include contagious diseases, minor injuries, mental health emergencies, ambulatory paediatrics, hip fractures etc. Assessment and treatment may be carried out by general ED staff, or by a specific team tasked (or called in) for this purpose.

B. GROUPING BY ACUITY

Some facilities will plan their workflow so that patients of similar acuity (urgency) or staff intensity are treated together. This may lead to facilities with separate areas for resuscitation, acute monitored beds, acute non-monitored beds and ambulatory treatment spaces. There may be separate entry-points (or triage points) for the different areas. Staff may be separately allocated to different areas for each shift, and may require separate Staff Stations and private workspace.

C. GROUPING BY FUNCTION

Patients may be managed in different areas according to the nature of service they require eg acute treatment, complex investigation, complex discharge planning. Patients may be triaged to the appropriate area from a central arrival point, or possibly from separate ambulance and ambulant entry points. Within each Functional Area, patients would be prioritised according to acuity. In this model, separate staffing for each area is required, which again would involve separate workspaces for staff.

D. OTHER SPECIAL FUNCTIONS

Short Stay Ward/Emergency Medicine Unit/ Observation Unit may be adjacent or incorporated into the ED footprint. If managed by ED staff, there may be sharing of additional administrative and staff facilities.

E. SUB-SPECIALTY UNITS

Units such as Toxicology and Hyperbaric Medicine will require specialised design features.

## Operational Policies

300 .10.00 GENERAL

Operational Policies have a major impact on facility requirements and the capital and recurrent costs of Health Care Facilities. These policies should be clearly articulated so that the facility design can reinforce the new practices.

Operational Policies will vary between Units depending on a wide range of factors.

Users must define their own Operational Policies.

Refer to Part B of these Guidelines for further information regarding Operational Policies.

STAFFING LEVELS

Staffing levels will vary for each ED, depending on Operational Policies, services provided by the centre, availability of staff, case mix and activity levels.

STORAGE

The amount and type of storage space to be provided will vary depending on the size of each ED. Careful analysis of storage requirements and good management in organising the stores and supply systems are essential.

## Planning Models

300 .12.00 Architectural Planning of the Unit should reflect local service and operational models and OHS issues.

When designing for patients who may be behaviourally disturbed or cognitively impaired the implications for safety should be considered. This includes safety implications for staff, patients and visitors.

When designing departments that treat paediatrics as well as adults, suitable play and waiting areas must be provided. It is recommended that these areas be part of, but in a separate section of the main waiting room. They should be within sight of the Triage Nurse Staff Station. Paediatric treatment areas should also reflect paediatric needs.

Where fast tracking of patients is dictated by the model of care proposed, then the layout should ensure that a clear flow of traffic from triage to points of consultation and treatment will not interfere with the functioning of the remainder of the ED. These may be located in a discrete area close to the triage and/or waiting space, without interfering with the operation of the more high intensity /acuity areas of the Unit.

Similar planning measures could be applied to other specialist treatment zones or rooms that will allow for efficiencies in the use of the more expensive spaces within the Unit.

Where patients are grouped by acuity, consideration should be given to the staffing implications of the layout. It is possible, for example, to arrange different levels / types of treatment spaces around a single Staff Station, each retaining their own discrete area.

Consideration should also be given to the possibility of flexible spaces. During less busy periods, efficiencies may be gained by contracting to a smaller part of the whole Unit. With careful planning this should be managed without the need to change the work patterns of the Unit as a whole, or impinge on the proposed model of care.

Where patients are grouped by functional modalities, a similar approach can be used, to enable the layout of the Unit to reflect the proposed service. In this model, the central arrival and triage area should be located to ensure traffic flows to the different functions of the Unit are not confusing and that they are kept separate.

Careful planning of Staff Areas will ensure that resources are used efficiently.

A variety of successful models for the management of special functions such as Short Stay wards are currently in use. The location of such Units and their relationship to the ED needs to be reflected in their planning.

## Functional Areas

300 .13.00 The ED is comprised of the following Functional Areas:

+ Entrance /Reception/Triage - comprising the functions of:

  - front of house,

- first point of arrival and assessment for patients;

+ Patient Care Areas - including:

- Assessment and Treatment Areas including the Patient Care Areas such as Resuscitation, Seclusion Room and Decontamination Facility;

- Short-Stay Ward/Emergency Medicine Unit/Observation Unit;

- Primary Care Area - for patients with low acuity conditions;

- Stepdown Area - for patients awaiting test results, considered safe, but requiring observation prior to admission or discharge.

+ Staff Areas - including Support Areas such as Clean and Dirty Utility Rooms Stores etc;

- Staff amenities, administrative and teaching functions;

+ Ambulance Service facilities.

## General

300 .14.00 In addition to standard treatment areas, some Units may require additional, specifically designed areas to fulfil special roles, such as:

+ Management of:

- paediatric patients;

- major trauma patients;

- behaviourally disturbed patients;

- patients following sexual assault;

- patients with gynaecological or obstetric conditions.

+ Undergraduate and postgraduate teaching;

+ Transport and retrieval services;

+ Telemedical services.

## Functional Areas

300 .15.00 KEY RELATIONSHIPS - INTERNAL

The Entrance/Reception Area is the focus of initial presentation and hospital administrative functions. The Ambulance Entry should be separate from the Public Entry. A triage nurse should be able to have good visual access to both public and ambulance entries. In a larger facility, two triage positions may be required.

The Reception Area will accommodate the following functions:

+ Reception of patients and visitors;

+ Registration interviews of patients;

+ Collation of medical records;

+ Printing of ID labels;

+ Receiving the public;

+ Handling general enquiries;

+ Processing loans of surgical aids;

+ Receiving money.

The Reception/Clerical Area should be designed with due consideration for the safety of staff. Staff in this area will need access to a duress alarm. The counter should provide seating and be partitioned for privacy for the interview function. Refer Part C of these Guidelines for further information regarding counter design.

The Reception / Triage and Staff Station shall be located where staff can observe and control access to Treatment Areas, Pedestrian and Ambulance entrances, and Public Waiting Areas. There should be direct communication with the Reception / Triage Area and the Staff Station in the Acute Treatment / Observation Area.

The main aggregation of clinical staff will be at the Staff Station in the Acute Treatment/Resuscitation Area. Most of the other clinical areas should be grouped around this area, unless the service and planning model (as discussed above) dictates a more discrete location for some functions.

The support and staff areas should be accessible to the Clinical Areas but should not impair the clinical function of the Unit.

There must be close proximity between the Resuscitation / Acute Treatment Areas for non-ambulant patients, other Treatment Areas for non-ambulant patients and other Treatment Areas for ambulant patients, so that staff may be relocated at times of high workload.

### 300 .16.00 TRAFFIC FLOWS

The ED is a busy area, with a wide variety of activities and people, where time delays may be life threatening. It is important that the design allows for rapid access between Functional Areas with a minimum of cross traffic.

Visitor and patient access to all areas should not traverse Clinical Areas. Patients who need to be transferred to other Units, such as Imaging or Inpatient Wards should not traverse other Clinical Areas. It is important that patients' visual, auditory and olfactory privacy is maintained whilst at the same time recognising that staff need to observe patients.

### 300 .17.00 GENERAL LOCATION

Decisions regarding the Unit location have a major influence on the cost and operational efficiency of the ED staff.

The ED should be located for easy access, usually on the ground floor. It should be close to public transport, and adequately signposted.

The location should, as much as possible, maximise the choices of layout. In particular, the locations of access points must be carefully considered.

The location on the site should primarily be dictated by the key relationships set out below. Clear and separate traffic flows should be provided for Ambulance traffic and public traffic. These should not interfere with other traffic patterns on the site.

In some instances, the ED will be the only access to the rest of the hospital after hours. Consideration should be given to ensuring access to the hospital is available for public after hours.

### 300 .18.00 CAR PARKING

Some car parking spaces should be close to the entrance of the ED, well lit and available exclusively for patients, their relatives and staff. Protected parking areas should be available very close to the ED for on-call staff.

Secure parking for afternoon and night shift staff is required. Refer Part C of these Guidelines.

Undercover car parking should be available for:

+ An appropriate number of ambulances;
+ Taxis;
+ Private vehicles that drop off/pick up patients adjacent to the ambulance entrance;
+ Police vehicles;
+ Fire Brigade vehicles;
+ Community Health vehicles.

300 .19.00 SIGNAGE

The ED should be clearly identified from all approaches. Signposting that is illuminated is desirable to allow visibility at night.

Refer to Part C of these Guidelines.

## Functional Relationships

300 .20.00 KEY RELATIONSHIPS - EXTERNAL

The ED will require ready access to the following key functional areas:

300 .21.00 + MEDICAL IMAGING

Emergency is a heavy user of imaging services. Immediate access to imaging services is important for the convenience and safety of patients. Easy access to CT scanning, Ultrasound and Nuclear Medicine modalities will enhance the ED's effectiveness. A system of electronic display of images within the Unit is desirable.

Alternatively an imaging service can be included within the Unit. If this is the case the Medical Imaging Unit should have a general x-ray table, upright x-ray facilities and an additional overhead gantry in the Resuscitation Area is recommended. The presence/absence of a film processor is dependent upon close proximity to the main Medical Imaging Unit or the use of digital radiology.

300 .22.00 + OPERATING UNIT

Direct access to the Operating Unit is desirable to allow quick transfer of patients for emergency surgery. Ideally this should be via corridors that are not generally accessible by the public.

300 .23.00 + CARDIAC SERVICES INCLUDING CCU AND CARDIAC CATHETER LABS

Easy access to the CCU is desirable to allow prompt transfer of patients to specialist care in this Unit.

300 .24.00 + PATHOLOGY

Rapid access to Pathology services is highly desirable to minimise turnaround times for laboratory investigations. Mechanical or pneumatic tube transport systems for specimen and electronic reporting of results are recommended. Point of care access for electrolyte and blood gas analysis are highly desirable.

300 .25.00 + MEDICAL RECORDS

Access to medical records is required so that patients' previous medical histories are

obtainable without delay. A system of mechanical or electronic medical record transfer is desirable to minimise delays and labour costs. Access to medical records must be available 24 hours per day or via a secure route.

300 .26.00 + INPATIENT ACCOMMODATION UNIT

Easy access to the Inpatient Unit is desirable to allow for transfer of patients who are admitted to overnight accommodation.

300 .27.00 + OUTPATIENTS AND AMBULATORY CARE UNIT

Small hospitals may choose to locate the Outpatients Department (OPD) adjacent to the ED so that reception and administrative functions can be shared. In larger hospitals there is unlikely to be a functional relationship with OPD. However, there would generally be advantages to close access to the Ambulatory Care Unit from ED, as some patients will be discharged via that service.

300 .28.00 + PHARMACY

The ED should be located within close proximity of the Pharmacy Unit to enable patients with limited mobility to have prescriptions filled.

300 .29.00 + MORTUARY

Ready access to Mortuary is desirable to allow for easy transfer of deceased patients out of view of the general public and visitors.

300 .30.00 + SECURITY

Should a security office be included in a capital development, where possible this should be located close to the ED. In this situation, the ED should be designed so that the Security Services have clear visual access of the waiting spaces and public entry to the unit.

300 .31.00 + HELI-PAD

If a helipad is to be located on the site, a clear and defined path from the helipad to the ambulance entry of the ED should be provided.

300 .32.00 + INTENSIVE CARE

ED patients are often transferred to ICU so ready access is required.

## Short-Stay Ward or Emergency Medical Unit (EMU)

300 .11.00 This type of facility is increasingly being provided either within or adjacent to Eds for the prolonged observation and ongoing treatment of ED patients who are planned for subsequent discharge (directly from the ED). Patients may be kept in this Unit for complex diagnostic testing, for complex problem-solving or for medical stabilisation.

The length of stay in the Unit is generally between 4 and 24 hours, although local policy may require longer stays. Discharge may sometimes be via the Ambulatory Care service of the hospital, so physical proximity is desirable. The Unit may also be situated separately to the ED, although functionally linked.

According to local Operational Policy, dedicated beds for this purpose will be separately designated and staffed. The types of patients planned to be admitted to this Unit will determine the number and type of beds provided, and the design of associated monitoring and equipment. Staff Stations, work and storage and other support areas will need to be available - either shared or separately provided.

## Corridors

300 .33.00 Adequate corridors are essential to the effective functioning of the Unit. The careful planning of corridors of appropriate width allows swift patient and staff movement between key functions and is fundamental to a successful planning solution.

Corridor widths for different uses are more fully described in Part C.

## Disaster Planning

300 .34.00 The ED is the 'front line' facility in the case of a disaster. The local Disaster Plan should be considered in the design of the Unit. Requirements may differ between metropolitan and rural units. Flexible planning is required to accommodate the large workloads, critically ill and/or infectious patients, relatives, friends and hospital staff involved in managing a disaster situation. The flexibility to expand into adjoining areas such as Outpatients, or Main Entry should be considered.

Depending on it's designated role the ED may also become a communication hub during formal disaster function. Consideration should be given to allocating a suitable space with adequate communications ports to be used as a disaster management base and to allow briefing of the press. Direct telephone lines bypassing the Hospital switchboard should be available for use in internal and external emergencies or when the hospital PABX is out of service.

A disaster may result in a high volume of ambulance traffic to the ED. In addition, the communications base may be utilised by the Police as a communications centre.

The ED plan should also accommodate a Disaster Equipment Store that is easily accessible and contains sufficient supplies to fully equip the disaster team for either on-site or off-site function.

Disaster planning is discussed in more detail in Part B Section 80 of these Guidelines.

## Doors

300 .35.00 Doors in this Unit need to allow for easy access for patient trolleys with several staff attending. This should also be durable and able to withstand repeated harsh treatment.

An airlock/lobby should be provided for external doors.

For more detail, refer Part C of these Guidelines.

## Environmental Considerations

300 .36.00 ACOUSTICS

Many functions undertaken within an ED require consideration of acoustic privacy including:

+ Discussions / interviews with clients;

+ Exclusion of disturbing or distracting noises during client consultations / activities including noise in other Treatment Areas;

+ Isolation of noisy areas such as public waiting;

+ Staff discussions regarding patient information.

Solutions to be considered include:

+ Selection of sound absorbing materials and finishes;

+ Use of sound isolating construction;

+ Planning by separating quiet areas from noisy areas;

+ Changes to operational management. Consider implications for safety when designing for patients who may be behaviourally disturbed or cognitively impaired, this includes safety implications for staff, patients and visitors.

### 300 .37.00 NATURAL LIGHT

Natural lighting contributes to a sense of wellbeing, assists orientation of building users and improves service outcomes. The use of natural light should be maximised throughout the Unit.

### 300 .38.00 PRIVACY

Client privacy and confidentiality are important considerations to be addressed. The facility should be designed to:

+ Ensure confidentiality of client discussions and records;

+ Provide discrete Sub-Waiting Areas for clients wishing or needing to be separated;

+ Enable the reason for attendance to be kept confidential eg through use of generic Consultation Rooms. This is particularly important for services such as mental health, sexual health, drug and alcohol etc;

+ Appropriately locate windows and doors to ensure privacy of clients.

DÉCOR

Décor includes furnishings, style, colour, textures, ambience, perception and taste. Décor can assist in relaxing clients and preventing an institutional atmosphere. However, cleaning, infection control, fire safety, client service and the client's perception of a professional environment must always be considered.

Some colours and patterns can be disturbing to some clients. Bold primaries and green should be avoided in areas where clinical observation may occur such as Consultation / Treatment Areas.

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## Finishes

300 .40.00 FLOOR FINISHES

The floor finishes in all Patient Care Areas and corridors for Emergency should have the following characteristics:

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

Generally Offices, Seminar Training Rooms, Meeting Rooms, and Clerical Areas should be carpeted.

More detail is provided in Part C of these Guidelines.

300 .41.00 CEILING FINISHES

Refer to Part C of these Guidelines.

300 .42.00 WALL PROTECTION

Due to the large number of users and trolley movements in the ED particular care must be taken to provide appropriate wall protection.

The walls also need to be resistant to damage by aggressive persons who may kick, punch or throw items against the walls. This applies particularly in areas where behaviourally disturbed patients may be managed.

Refer to Part C of these Guidelines for further information.

## Handwashing - Clinical

300 .43.00 Handbasins for handwashing should be available within each Treatment Area and should be accessible without traversing any other Clinical Area.

Handbasins for handwashing should be readily available and conveniently located throughout the Unit.

More detail on handbasin provision is provided in Part D of these Guidelines, Room Data Sheets and Room Layout Sheets.

## Infection Control

300 .44.00 As the diagnosis or infectious status of patients may not be known on admission, standard precautions must be used at all times. The design and layout should allow for the movement of patients to an isolation room within the unit due to suspected or known infectious disease.

Where Class N isolation rooms are provided, these should be located to minimise passing traffic and so that any air expelled from the room does not impinge on other patients or staff.

## Safety and Security

300 .45.00 A list of Safety and Security Considerations for EDs is attached to this document.

Safety and security is covered in detail in Part C of these Guidelines.

GENERAL

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

As the first point of address for visitors to the Unit, the Reception/Triage Area is a high risk area for violence. Careful thought should be given to the design of this area to minimise this risk.

Refer to Part C for further information.

## Security

300 .46.00 SECURITY PERSONNEL

Uniformed security personnel may be required at very short notice to assist with a safety or security issue. Their base should be positioned either within or immediately adjacent to the ED, with rapid communication links.

## General Provisions for Children

300 .47.00 Unless a specialised Paediatric Hospital exists in the immediate vicinity, children will comprise approximately 25% of attendances in most general EDs. Special design considerations to cater for paediatric attendances include:

+ Protection of the children's clinical area from disturbing sounds or sights from other patients in the ED;

+ The provision of sufficient visitor space and facilities for parents or carers and siblings;

+ Provision of a colourful and welcoming physical environment, with appropriate furniture and colour treatments;

+ Provision of a separate waiting space, protected from the sights and sounds of the general waiting area (but still observable by staff);

+ Close access to separate Procedure Areas for simple procedures which may be upsetting to other children;

+ Ideally, the availability of transit routes to radiology or wards that do not traverse other clinical areas;

+ Consideration of providing a separate Bathroom, within or adjacent to the Paediatric Clinical Area, with size-appropriate toilet and bathtub.

## Building Service Requirements

300 .48.00 CLOCKS

The accurate tracking of time within the ED is critical.

A wall clock should be visible in all Clinical Areas and Waiting Areas. Times displayed in all areas must be synchronised. Clocks in Resuscitation Areas require the facility to track elapsed time (one for each bed).

See Room Data Sheets and Room Layout Sheets for more detail.

300 .49.00 COMMUNICATIONS

As a rapid patient turnover and multidisciplinary work environment, Eds are high-volume users of a wide range of telecommunications and information technology tools.

Communications functions include both auditory and visual, and include interactions both within and outside the ED. Communications functions relate to both patient care and to departmental administration.

Communications requirements and the associated technology are rapidly growing and developing. Planning should anticipate new and developing technologies and future functions, and make allowances for growth and development in this area. In particular, the provision of data connection points should be sufficient to allow unimpeded access and to anticipate future needs.

Specific functions to be provided for may include:

+ A dedicated direct phone line for referring medical practitioners;
+ A dedicated cordless phone or phone jack for access to patients' bedsides.
+ Public telephones with acoustic hoods in the Waiting Area.
+ A direct line to a taxi company.

Modalities to be provided for include:

+ Personal and departmental voice communication telephones;
+ Cordless phones or pagers;
+ Overhead PA systems and intercom;
+ Observation with CCTV;
+ Electronic data transfer;
+ Electronic and facsimile image transfer;
+ Physical transfer using pneumatic tubes and automated trolley systems.
+ Nurse call system;
+ Patient emergency system;
+ Location finding duress alarm systems.

300 .50.00 An electronic Emergency Department Information System will be required to support clinical management, patient tracking and departmental administration. Sufficient terminals should be available to ensure that queuing does not occur, even at peak times. Generally, computers should be available for use at each bedside.

Workspace design should include sufficient bench-widths or suitable suspension devices for terminals, keyboards, drives and printers. Additional computer terminals, software and peripheral devices should be installed to enable other departmental functions.

300 .51.00 In smaller Units, especially in more remote areas, telemedicine is becoming increasingly common and important for day-to-day operation.

Allowance should be made for connection of portable telemedicine equipment in all Treatment Areas.

300 .52.00 ELECTRICAL SERVICES

Refer to TS11 and Room Data and Room Layout Sheets for details of electrical needs

for this Unit.

300 .53.00 DURESS ALARMS

Should be provided in accordance with NSW Health Policy - refer Part C of these Guidelines.

300 .54.00 EMERGENCY CALL

All bed spaces and Clinical Areas, including toilets and bathrooms, should have access to an Emergency Call System so staff can summon urgent assistance. The Emergency Call System should alert to a central module situated adjacent to the Staff Station, as well as to the Staff and Tutorial rooms. The Nurse Call / Emergency call system is to comply with AS 3811.

300 .55.00 LIGHTING

The lighting design needs to provide for both comfort (patients and staff) and function, and should have inherent flexibility. There are different considerations for different types of Patient Care Areas and Staff Areas.

It should be possible to vary lighting conditions between individual beds and rooms.

Functional requirements for lighting of clinical treatment spaces include the ability to dim for comfort, the ability to focus strong light for bedside procedures, and there should be no colour distortion to ensure accurate assessment of skin tone.

If consistent with departmental function, overhead pendant lights should be centred appropriately over bed spaces in Treatment Areas.

300 .56.00 Waiting Areas and Staff Amenities Areas should have exposure to daylight wherever possible to minimise patient and staff disorientation.

Lighting should conform to Australian Standards.

300 .57.00 MEDICAL SERVICES

Medical gases should be provided in accordance with the Room Data Sheets and Room Layout Sheets.

300 .58.00 MONITORING

As the acuity of patients in hospitals increases, the need for monitoring of patients increases accordingly.

Bedside electronic monitoring needs to provide for both local visual display and electronic data or information transfer. Where possible, the bedside monitoring system should be integrated with (or interface with) the electronic patient information system (or future capacity for this should be provided).

Central monitoring should be available within each unit.

The design and complexity of bedside clinical monitoring will depend on the function of each Clinical Area. Local function will determine the proportion of acute beds that have bedside monitoring at any one time. However, the design should facilitate future flexibility in location of bedside monitoring.

Considerations include flexibility for patient and bed movements and both visual and spatial accessibility. Cabling should be accessible, but should not physically obstruct staff access to the bedside.

## Building Service Requirements

300 .59.00 NURSE CALL

Facilities must provide a call system that allows patients and staff to alert nurses and other health care staff in a discreet manner at all times.

Nurse call systems must be designed and installed to comply with AS3811 - Hard wired Patient Alarm Systems.

# COMPONENTS OF THE UNIT

## General

300 .60.00 The components of an Emergency Unit will vary for each facility. Components and allocated spaces will depend on the outcome of a needs analysis and a Service Plan that is based on the location, size and the needs of the area in which the ED is to be sited.

300 .61.00 This section must be read in conjunction with Part B Standard Components, Room Data Sheets and Room Layout Sheets. The following text describes only specific requirements not covered by these other documents.

## Standard Components

300 .62.00 Provide the Standard Components as identified in the Generic Schedule of Accommodation. Provision of Offices, Workstations and support areas will be dependant on the Operational Policy and service demand and may vary from the Schedule of Accommodation, however, room sizes should remain consistent. See also Planning Models and Functional Areas.

## Non-Standard Components

300 .63.00 Provide the Non Standard Components as described in this section, according to Operational Policy and service demand.

300 .64.00 BAY - PHONE/VENDING MACHINES

DESCRIPTION AND FUNCTION

An area for provision of vending machines and public telephones for use by patients staff and visitors. Vending machines providing a wide range of snacks and drinks are now available and may contribute to reduced stress levels in the waiting area especially in larger facilities where long wait times may be expected.

Refer to Part C of these Guidelines for further information.

LOCATION AND RELATIONSHIPS

Immediately accessible from waiting area.

300 .65.00 BAY - WHEELCHAIR/TROLLEY HOLD

DESCRIPTION AND FUNCTION

A bay for holding arriving and departing patients who rely on a wheelchair or trolley for transport.

LOCATION AND RELATIONSHIPS

The Wheelchair Trolley Bay must be close to the Staff Station, Triage or Work Area to ensure staff oversee the Bay. Patient dignity and privacy must be maintained while not compromising patient safety.

300 .66.00 COMMUNICATIONS BASE (ASNSW)

300 .66.00

The Communications Base is occupied by ASNSW officers to communicate between major hospital centres and the ASNSW Operations Centre for co-ordination of Ambulance movements. The communications base is also a critical co-ordination centre in the event of a disaster.

The Communications Base is occupied by 2-3 people maximum and provides space for all relevant communications devices such as telephone, radio systems and data communications. It should also provide space for writeup and 'downtime'.

The room should be immediately adjacent to the Ambulance entry of the Emergency Department with direct line of sight to incoming ambulance vehicles and the parking bay.

300 .67.00 ENTRY/AIRLOCK

DESCRIPTION AND FUNCTION

The Entry Airlock provides the main access point to the Unit. It will be used by a wide range of people including ambulant patients, relatives and friends. Users may be walking, in wheelchairs, on crutches or being carried by others. Patients will often arrive with a number of support persons. An Airlock minimises the effect of unfavourable weather on the interior environment of the Unit, and can be of assistance in managing security. The size of the airlock should allow for several people to enter before the second door opens.

LOCATION AND RELATIONSHIPS

The ED should be accessible by two separate entrances - one for ambulance patients and the other for ambulant patients.

It is recommended that each entrance area contains a separate airlock that can be sealed by remotely activating the security doors. Access to Treatment Areas should also be restricted by the use of security doors.

The Ambulance Entrance should be screened as much as possible for sight and sound from the ambulant patient entrance. Both entrances should direct patient flow towards the Reception/Triage Area.

The general entrance to the ED must be at ground floor level, well marked, illuminated, and covered. It shall provide direct access from public roads for ambulance and vehicle traffic, with the entrance and driveway clearly marked. If a raised platform is used for ambulance discharge, provide a ramp for pedestrian and wheelchair access.

The entrance to the ED shall be paved to allow discharge of patients from cars and ambulances. Temporary parking should be provided close to the entrance.

300 .68.00 AMBULANCE TRIAGE

DESCRIPTION AND FUNCTION

The Reception Triage Area is to receive and assess patients arriving in the Unit after basic clerical work has been completed. Patients will be interviewed and undergo clinical measurement before being allocated a triage category, which defines how quickly they must be treated.

LOCATION AND RELATIONSHIPS

The Reception / Triage Area should have clear a vision to the Waiting Room, the children's play area (if provided) and the Ambulance Entrance. The Reception / Triage Area may allow staff to perform observations and provide first aid in relative privacy.

300 .69.00 DECONTAMINATION SHOWER

DESCRIPTION AND FUNCTION

A Decontamination Shower is provided to shower patients who arrive in the Unit contaminated with toxic and/or infectious substances. It must include a flexible water hose, floor drain and contaminated water trap.

Consideration should be given to inclusion of a Personal Protective Equipment Bay with the decontamination shower.

LOCATION AND RELATIONSHIPS

Must be directly accessible from the Ambulance Bay without entering any other part of the unit.

300 .70.00 PATIENT BAYS - ACUTE TREATMENT

DESCRIPTION AND FUNCTION

Acute Treatment Areas are used for the management of patients with acute illnesses. Depending on the condition of each patient the bay may be monitored.

Acute Treatment Bays are provided for a variety of purposes including:

+ Paediatric use;

+ For patients undergoing nebuliser therapy;

+ For general purposes.

Equipping for each of these purposes will vary.

LOCATION AND RELATIONSHIPS

In a central location that is visible from the Staff Station.

All acute patient beds must be situated where they can be observed from the Staff Station. Access to the Clean and Dirty Utility Rooms, Procedure Room, Pharmacy Room, and Patient Shower and Toilet is necessary.

300 .71.00 PATIENT BAY - NON ACUTE TREATMENT

DESCRIPTION AND FUNCTION

For observation and treatment of patients who need further assessment or observation (up to 24hrs) before being discharged or admitted.

LOCATION AND RELATIONSHIPS

In a central location that is visible from the Staff Station.

300 .72.00 PATIENT BAY - RESUSCITATION

DESCRIPTION AND FUNCTION

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

LOCATION AND RELATIONSHIPS

The Resuscitation Room/Bay requires:

+ Immediate access from the Ambulance Entry;

+ Easy access from the Staff Station to allow effective communication and summoning of staff;

+ Separation from the Acute Treatment Areas to allow privacy for the patient and relatives, and uninterrupted work space and access for staff;

+ Easy access to Imaging, ICU and Operating Unit;

+ Easy access from the Ambulance Entrance but separate from patient circulation areas;

+ Easy access to the Acute Treatment/Observation Area from the Staff Station;

+ Space to ensure 360 degree access to all parts of the patient for uninterrupted procedures;

+ Circulation space to allow movement of staff and equipment around the work area;

+ Space for equipment, monitors, storage, wash up and disposal facilities;

+ Appropriate lighting;

+ Appropriate heating and isolation lock-down;

+ Equipment to hang IV fluids;

+ Maximum possible visual and auditory privacy for the occupants of the room, other patients and relatives;

+ Solid partitions between it and other areas (movable partitions eg curtains between bed spaces are recommended).

300 .73.00 PATIENT BAY - TREATMENT/RESUSCITATION

DESCRIPTION AND FUNCTION

This space is used in smaller facilities and fulfils the role of both Treatment and Resuscitation Bays.

LOCATION AND RELATIONSHIPS

Similar to Resuscitation.

300 .74.00 TREATMENT ROOM - SECURE ASSESSMENT

DESCRIPTION AND FUNCTION

An ED should have adequate facilities for the safe reception, assessment, stabilisation and initial treatment of patients presenting with acute mental health problems and behavioural disturbance. The main purpose of such an area is to provide a safe and appropriate space to interview and stabilise patients.

Ease of access to toilet facilities should be considered.

300 .75.00 TRIAGE CUBICLE

DESCRIPTION AND FUNCTION

A private cubicle where triage staff take a patient's history to allow allocation of a triage category.

LOCATION AND RELATIONSHIPS

Immediately adjacent and connected to Triage.

## Non-Standard Components

300 .76.00 X-RAY ROOM

DESCRIPTION AND FUNCTION

A room to conduct radiological examinations of patients to assist in their diagnosis. This room is optional and would only be provided in higher level facilities. In lower level facilities this need would be met by a mobile X-ray machine.

LOCATION AND RELATIONSHIPS

Directly accessible from or immediately adjoining the Resuscitation Bays.

300 .77.00 BAY - PATHOLOGY

DESCRIPTION AND FUNCTION

A designated area for performing laboratory investigations such as arterial blood gas analysis and microscopy.

LOCATION AND RELATIONSHIPS

Accessible from Resuscitation and Treatment Bays.

300 .78.00 LIBRARY

DESCRIPTION AND FUNCTION

A quiet area containing appropriate written, audiovisual and electronic reference materials.

LOCATION AND RELATIONSHIPS

This is an additive space which should be combined with another area eg Meeting Room.

300 .79.00 PLANTROOM

DESCRIPTION AND FUNCTION

Garage space for ambulance vehicles.

LOCATION AND RELATIONSHIPS

TBA

300 .80.00 STAFF OVERNIGHT ACCOMMODATION

DESCRIPTION AND FUNCTION

Motel style rooms with ensuite bathroom for overnight accommodation of staff.

LOCATION AND RELATIONSHIPS

In a quiet location with other Staff Areas near the perimeter of the Unit.

300 .81.00 STORE - CRUTCH

DESCRIPTION AND FUNCTION

An area for the storage of crutches, splints and other aids to mobility.

LOCATION AND RELATIONSHIPS

Close to, and easily accessible from the Plaster Room.

300 .82.00 STORE - DISASTER EQUIPMENT

DESCRIPTION AND FUNCTION

Store for equipment used in retrieval of patients, and for equipment that would be used in a CBR incident.

LOCATION AND RELATIONSHIPS

Close to Ambulance Bay and if appropriate, accessible to helipad.

300 .83.00 STORE - DRUG

DESCRIPTION AND FUNCTION

A room for the storage of drugs and medications. Secure storage and facilities for dispensing of medications is required.

LOCATION AND RELATIONSHIPS

Central to the Unit - easily accessible from Staff Station and bed bays, with observation of entry from Staff Station for security purposes.

300 .84.00 WASH BAY/SINK

DESCRIPTION AND FUNCTION

An area for staff to clean, replenish supplies and wash down ambulance vehicles.

LOCATION AND RELATIONSHIPS

Adjacent to Plant Room.

## Schedule of Accommodation

300 .85.00 A generic schedule of accommodation follows.

Note 1: FPU - Functional Planning Unit, number depends on service plan and activity level.

Note 2: Staff Station should be located centrally within Treatment Area, preferably with direct oversight of Resuscitation Bays. Direct access required to treatment spaces. It may be raised for uninterrupted vision of the patients. It may be partially enclosed to ensure that confidential information can by conveyed without breach of privacy and to provide security to staff and confidential information.

| ROOM / SPACE | Standard Component | Level 1 | Level 2 | Level 3 | Level 4 | Level 5/6 | Remarks |
|---|---|---|---|---|---|---|---|
| | | Qtyxm2 | Qtyxm2 | Qtyxm2 | Qtyxm2 | Qtyxm2 | * Optional |
| ENTRANCE / RECEPTION - | | | | | | | |
| ENTRY/AIRLOCK | | Shared | Shared | Shared | 1 x 10 | 1 x 10 | |
| RECEPTION | yes | Shared | Shared | Shared | 1x 20 | 1 x 20 | Staff to be able to observe & control access Entries and Treatment Areas. |
| WAITING ROOM | yes | Shared | Shared | 1 x 12 | 1 x 30 | 1 x 60 | Open, observed from Triage & Reception; play area for children, access to outdoors pref |
| PLAY AREA | yes | Shared | Shared | 1 x 3 | 1 x 10 | 1 x 10 | Defined area adjoining waiting area, or adjacent to paediatric treatment areas. |
| PARENTING ROOM | yes | Shared | Shared | Shared | 1 x 6 | 1 x 6 | Accessible from waiting areas. |
| BAY - PHONE/VENDING MACHINES | | Shared | Shared | 1 x 2 | 1 x 5 | 1 x 5 | Accessible from waiting areas. |
| BAY - WHEELCHAIR/TROLLEY HOLD | | 1 x 2 | 1 x 2 | 1 x 8 | 1 x 12 | 1 x 12 | |
| COMMUNICATIONS BASE (ASNSW) | | | | | | 1 x 12 | |
| AMBULANCE TRIAGE | | | | | 1 x 12 | 1 x 12 | |
| TRIAGE CUBICLE | | | | 9 | 9 | 9 | FPU |
| MEETING ROOM - 12M2 | yes | | | | 1 x 12 | 1 x 12 | For staff to interview/meet with family & friends of patients. |
| MEETING ROOM - 9M2 | yes | Shared | Shared | Shared | 1 x 9 | 1 x 9 | For staff to interview/meet with family & friends of patients. |
| TOILET - PUBLIC | yes | Shared | Shared | 2 x 2 | 4 x 2 | 4 x 2 | |
| TOILET - DISABLED | yes | 1 x 5 | 1 x 5 | 1 x 5 | 1 x 5 | 1 x 5 | May also include facilities for baby change. |
| DECONTAMINATION SHOWER | | 1 x 8 | 1 x 8 | 1 x 8 | 1 x 8 | 1 x 8 | Check Local Authority req'ts for waste water detention requirements. |
| DISCOUNTED CIRCULATION | | 30% | 30% | 30% | 30% | 30% | |
| TREATMENT AREA - | | | | | | | |
| PATIENT BAY - RESUSCITATION | | | | | 25 | 25 | FPU |
| PATIENT BAY - ACUTE TREATMENT | | | | | 12 | 12 | FPU |
| PATIENT BAY - NON ACUTE TREATMENT | | | | | 10 | 10 | FPU |
| PATIENT BAY - TREATMENT/RESUSCITATION | | 1 x 16 | 1 x 35 | 1 x 35 | | | Single room sized for 2 trolleys for resusc & general treatment - level 2 & 3 only. |
| TREATMENT ROOM | yes | | | | 14 | 14 | FPU. Multi functional - forensic/sexual assault, gynae,etc |
| TREATMENT ROOM - SECURE ASSESSMENT | similar | | | | 14 | 14 | FPU. Use for Mental Health patients - secure containment/assessment. Also for gen use. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| PATIENT BAY - ACUTE TREATMENT - PAEDIATRIC | | | | | 10 | 10 | FPU |
| PLAY AREA | yes | Shared | Shared | Shared | 1 x 8 | 1 x 8 | |
| TREATMENT ROOM - PAEDIATRIC | similar | | | | 1 x 14 | 1 x 14 | Similar to other Treatment Areas. Encl bays preferred for privacy & safetyof patients. |
| ANTEROOM | yes | | | | 1 x 6 | 1 x 6 | Accessible/adjacent to Isolation Room. |
| 1 BED ROOM - ISOLATION (CLASS N) | yes | | | | 15 | 15 | FPU. Encl Treatment Bays with neg pres ventil'n for isolatable infections. |
| TOILET - PATIENT | yes | | | | 4 | 4 | FPU |
| PROCEDURE ROOM | similar | | | | 1 x 20 | 1 x 20 | Similar to other Treatment Bays, acoustic & visual privacy req'd. |
| PLASTER ROOM | yes | | | | 1 x 14 | 1 x 14 | Splint & crutch store to be included in, or accessible to the plaster room. |
| STORE - CRUTCH | | | | | 1 x 2 | 1 x 2 | Close to Plaster Room |
| X-RAY ROOM | | | | | 1 x 30* | 1 x 30* | May not be req'd if ED near Imaging. Altern may be gantry over Resusc Bays in L5 & 6. |
| BAY - PATHOLOGY | | | | | 1 x 1 | 2 x 1 | |
| SHOWER - PATIENT | yes | 1 x 4 | 1 x 4 | 1 x 4 | 1 x 4 | 1 x 4 | Quieter part of unit, but accessible from treatment bays and rooms. |
| TOILET - PATIENT | yes | 1 x 4 | 1 x 4 | 1 x 4 | 1 x 4 | 1 x 4 | |
| BAY - HANDWASHING | yes | 1 x 1 | 1 x 1 | 1 x 1 | 1 | 1 | 1 Handwash Bay per 4 Treatment Bays - refer Part D. |
| DISCOUNTED CIRCULATION | | 40% | 40% | 40% | 40% | 40% | |
| SUPPORT AREAS - | | | | | | | |
| STAFF STATION | yes | Shared | Shared | 1 x 6 | 1 x 20 | 1 x 30 | 2sqm per staff; may store trolleys, resusc eqt, disposables, drugs, etc. Ref Note 2. |
| X-RAY VIEWING & REPORTING | yes | | | | 1 x 12 | 1 x 12 | |
| CLEAN UTILITY | yes | Shared | Shared | 1 x 4 | 1 x 12 | 1 x 12 | |
| DIRTY UTILITY | yes | Shared | Shared | Shared | 1 x 10 | 1 x 10 | |
| STORE - GENERAL | yes | Shared | Shared | Shared | 1 x 20 | 1 x 20 | |
| STORE - EQUIPMENT | yes | Shared | Shared | Shared | 1 x 20 | 1 x 20 | |
| STORE - DISASTER EQUIPMENT | | | | | 1 x 8 | 1 x 8 | |
| BAY - MOBILE EQUIPMENT | yes | Shared | Shared | 1 x 4 | 1 x 4 | 2 x 4 | |
| BAY - MOBILE EQUIPMENT (X-RAY) | yes | | 1 x 2 | 1 x 2 | 1 x 2 | 1 x 2 | |
| BAY/ROOM - BEVERAGE | yes | Shared | Shared | Shared | 1 x 8 | 1 x 8 | |
| BAY - LINEN | yes | Shared | 1 x 2 | 1 x 2 | 1 x 2 | 1 x 2 | |
| STORE - DRUG | | Shared | Shared | Shared | 1 x 5 | 1 x 5 | |
| DISPOSAL | yes | Shared | Shared | Shared | 1 x 8 | 1 x 8 | |
| CLEANER'S ROOM | yes | Shared | Shared | Shared | 1 x 5 | 1 x 5 | |
| BAY - RESUSCITATION TROLLEY | yes | Shared | 1 x 2 | 1 x 2 | 1 x 2 | 1 x 2 | Rapid emerg access reqd & from this area to patient areas; prefer adj to Staff Stn. |
| DISCOUNTED CIRCULATION | | 25% | 25% | 25% | 25% | 25% | |
| SHORT STAY WARD/ EMERGENCY MEDICINE UNIT | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| PATIENT BAY - NON ACUTE TREATMENT | | | | | 10 | 10 | FPU |
| ANTEROOM | yes | | | | 1 x 6 | 1 x 6 | Accessible/adjacent to Isolation Room. |
| 1 BED ROOM - ISOLATION ROOM (CLASS N) | yes | | | | 1 x 15 | 1 x 15 | |
| ENSUITE | yes | | | | 1 x 5 | 1 x 5 | For Isolation Room |
| TOILET - PATIENT | yes | | | | 1 x 4 | 1 x 4 | |
| SHOWER - PATIENT | yes | | | | 1 x 4 | 1 x 4 | |
| STAFF STATION | yes | | | | 1 x 12 | 1 x 15 | 2sqm per staff; may store trolleys, resusc eqt, disposables, drugs, etc. Ref Note 2. |
| BAY - LINEN | yes | | | | 1 x 2 | 1 x 2 | |
| BAY - HANDWASHING | yes | | | | 1 x 1 | 1 x 1 | |
| DIRTY UTILITY - SMALL | yes | | | | | 1 x 8 | |
| DISCOUNTED CIRCULATION | | 30% | 30% | 30% | 30% | 30% | |
| PRIMARY CARE AREA - | | | | | | | |
| CONSULT ROOM | yes | 1 x 12 | 1 x 12 | 1 x 12 | 12 | 12 | FPU |
| CONSULT - SEXUAL ASSAULT | similar | | | | 1 x 12 | 1 x 12 | Use for sexual assault consultations, may also be used for general purposes. |
| ENSUITE | yes | 1 x 5 | 1 x 5 | 1 x 5 | 1 x 5 | 1 x 5 | For one consult room or for consult room - sexual assault where provided. |
| CONSULT - ENT/ OPTHALMOLOGY | similar | | | | 1 x 12 | 1 x 12 | |
| CONSULT - DENTAL | | | | | | 1 x 12* | Determined on need/activity. |
| PATIENT BAY - ACUTE TREATMENT (NEBULISER) | | | | | 1 x 4* | 1 x 4* | Nebuliser chair area; inclusion determined on need/activity. |
| BAY - LINEN | yes | | | 1 x 2 | 1 x 2 | 1 x 2 | |
| BAY - HANDWASHING | yes | | | | 1 x 1 | 1 x 1 | |
| STAFF STATION | yes | | | | 1 x 10 | 1 x 12 | 2sqm per staff; may store trolleys, resusc eqt, disposables, drugs, etc. Ref Note 2. |
| DISCOUNTED CIRCULATION | | 20% | 20% | 20% | 20% | 20% | |
| STAFF AREAS - | | | | | | | |
| STAFF ROOM | yes | Shared | Shared | Shared | 1 x 20 | 1 x 30 | 1.5m2 per staff member. |
| CHANGE - STAFF - FEMALE | yes | Shared | Shared | Shared | 1 x 14 | 1 x 14 | Incl toilets, shwrs, lockers. Calc for max staff per shift; overview access from Rec/Ent |
| CHANGE - STAFF - MALE | yes | Shared | Shared | Shared | 1 x 12 | 1 x 12 | Incl toilets, shwrs, lockers. Calc for max staff per shift; overview access from Rec/Ent |
| OFFICE - SINGLE PERSON 9M2 | yes | | | | 2 x 9 | 4 x 9 | NUM + Secretary, CNC, CNE, depending on level of service. |
| OFFICE - SINGLE PERSON 9M2 | yes | | | | 1 x 9 | | Staff Specialist |
| OFFICE - SINGLE PERSON 12M2 | yes | | | | 1 x 12 | 1 x 12 | Director |
| OFFICE - 2 PERSON SHARED | yes | | | | 1 x 12 | | Registrars |
| OFFICE - 3 PERSON SHARED | yes | | | | | 3 x 15 | Staff specialist, Registrars, general use. |
| MEETING - MEDIUM/LARGE | yes | Shared | Shared | Shared | 1 x 15 | 1 x 25 | |
| MEETING - 12M2/MEDIUM | yes | Shared | Shared | Shared | 1 x 12 | 1 x 15 | For staff to interview/meet with family & friends of patients. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| LIBRARY | | | | | 1 x 3* | 1 x 3* | Optional - add to another space. |
| STORE - PHOTOCOPY/ STATIONERY | yes | Shared | Shared | Shared | 1 x 8 | 1 x 8 | |
| DISCOUNTED CIRCULATION | | 20% | 20% | 20% | 20% | 20% | |
| AMBULANCE SERVICE - | | | | | | | |
| RECEPTION | yes | | 1 x 5 | 1 x 5 | 1 x 5 | | |
| PLANTROOM | | | 35 | 35 | 35 | | ASNSW Plantroom - 40m2 per bay. |
| WASH BAY/SINK | | | 1 x 40 | 1 x 40 | 1 x 40 | | |
| OFFICE - SINGLE PERSON 9M2 | yes | | 1 x 9 | 1 x 9 | 1 x 9 | | |
| OFFICE - SHARED | similar | 1 x 12 | 1 x 15/20 | 1 x 15/20 | 1 x 15/20 | | 2 - 4 people sharing |
| STAFF OVERNIGHT ACCOMMODATION | | | 1 x 25 | 1 x 25 | 1 x 25 | | |
| STORE - GENERAL | yes | | 1 x 15 | 1 x 15 | 1 x 15 | | |
| STORE - DRUG | | | 1 x 5 | 1 x 5 | 1 x 5 | | |
| STAFF ROOM | yes | Shared | Shared | Shared | Shared | | |
| CHANGE - STAFF | yes | Shared | Shared | Shared | Shared | | |
| DISCOUNTED CIRCULATION | | 15% | 15% | 15% | 15% | 15% | |

## Functional Relationships

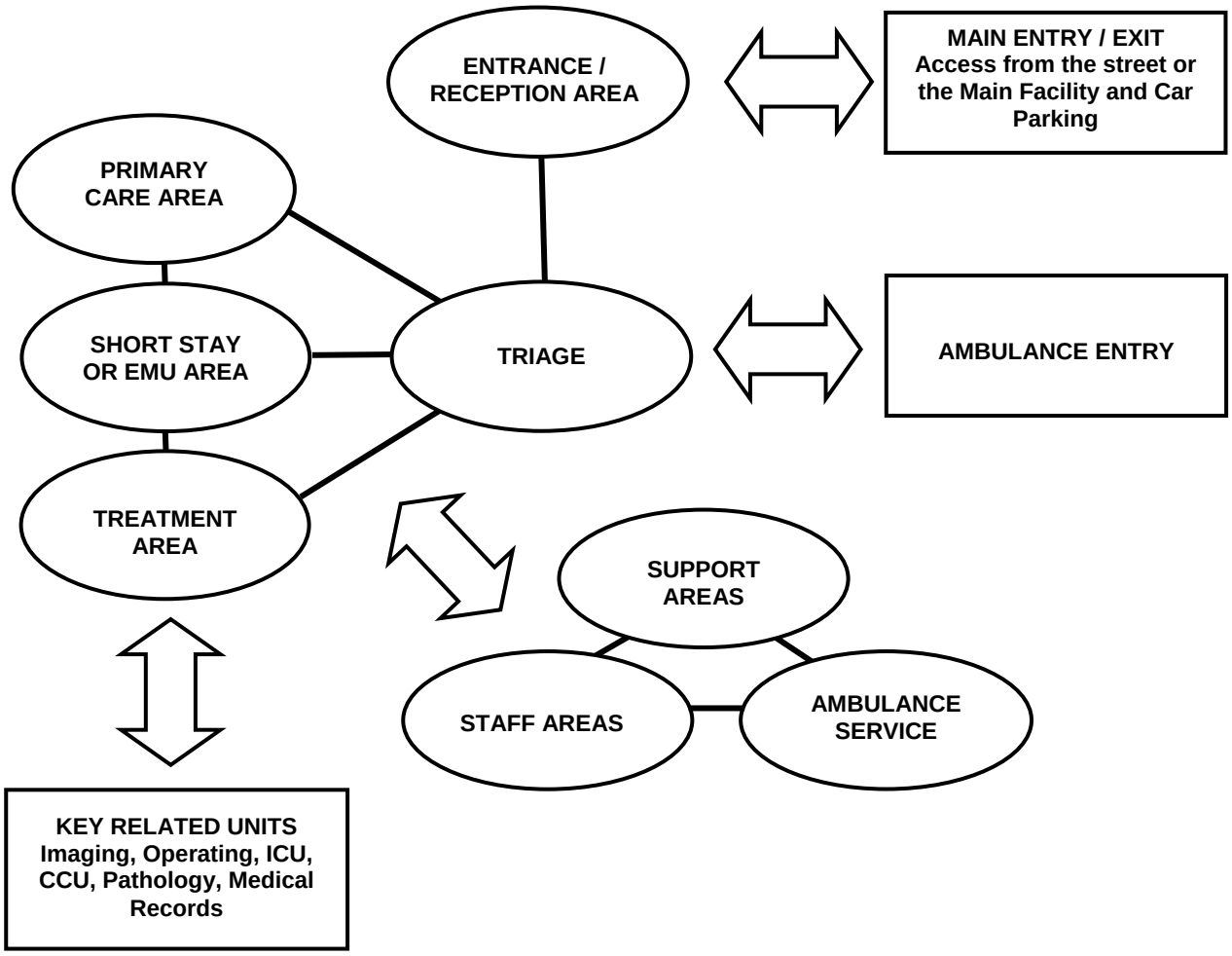
300 .86.00 A diagram showing key functional relationships is attached.

## Checklists

300 .87.00 A checklist of issues to be addressed in the design of EDs is attached to this document. Refer also to Part C of these Guidelines.

## FUNCTIONAL RELATIONSHIP DIAGRAM – EMERGENCY UNIT

The following diagram sets out the relationships between zones in an Emergency Department:



## SECURITY CHECKLIST – EMERGENCY UNIT

| FACILITY: | DEPARTMENT: EMERGENCY UNIT |
|---|---|
| **RISK ISSUE** | **DESIGN RESPONSE** |
| 1. Has a CCTV System been considered to monitor the waiting area and/or access to the public access points in the waiting area? | |
| 2. How is 'after hours' access provided for patients and how is this access point monitored? | |
| 3. Has a secure 'barrier' been installed between staff and the waiting area to:<br>(a) monitor the waiting area;<br>(b) provide staff contact with patients;<br>(c) provide adequate visual and audible communication; and<br>(d) allow for document and item transfer. | |
| 4. Do staff have access to both fixed and mobile duress systems? | |
| 5. Is access to patient records restricted to staff entitled to that access? | |
| 6. Is a system implemented to prevent theft of equipment, files, personal possessions, etc? | |
| 7. How does the ED address assessment / treatment of potential Mental Health patients in the ED? | |
| 8. Is a gun safe required and is it incorporated in the design? | |
| 9. Are drug safes installed in accordance with current regulations? | |
| 10. Is the waiting area furniture incapable of being utilised as a 'weapon'? | |
| 11. How is unauthorised access prevented from Ambulance entrance? | |
| 12. Is there a means of access/egress for staff other than through the Waiting Area? | |
| 13. How is after hours access provided for staff? | |
| 14. How is this area secured during and after hours, and is access prevented to other areas of the facility after hours? | |
| 15. Are there lockable storage areas available for specialised equipment? | |
| 16. Is lockable furniture provided for storage of staff personal effects? | |
| 17. Is appropriate bench seating provided for patients/visitors/relatives? | |
| 18. If a TV is provided in Waiting Area, is it securely fixed and out of reach of visitors, etc? | |

| DESIGN COMMENTARY/NOTES | DESIGN SIGN-OFF |
|---|---|
| | Name: ……..……..<br>Position: ……..……..<br>Signature: ……..……..<br>Date: ……..……..<br><br>Name: ……..……..<br>Position: ……..……..<br>Signature: ……..……..<br>Date: ……..…….. |