

Australasian Health Facility Guidelines

Part B - Health Facility Briefing and Planning 0270 - Day Surgery Procedure Unit

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01 INTRODUCTION

01.01 Preamble

This Health Planning Unit (HPU) has been developed by the Australasian Health Infrastructure Alliance (AHIA) following extensive consultation during 2015. This HPU is intended to assist in the planning and design process for the design team, project managers and end users.

01.02 Introduction

This HPU outlines the specific requirements for planning and designing a Day Surgery/ Procedure Unit.

A Day Surgery / Procedure Unit may be integrated within a hospital complex, be a separate facility on a hospital campus or a stand-alone facility. This HPU may be used to develop facilities for day only or extended stay services (greater than 72 hours).

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

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

Additional HPUs which should be read in conjunction with this HPU include:

- 170 Cardiac Investigations Unit for information relating to cardiac catheter services;
- 190 Sterilizing Services Unit, which contains details of scope reprocessing requirements;
- 440 Medical Imaging Unit for information relating to angiography services; and
- 520 Operating Unit; and
- 155 Ambulatory Care Unit for information relating to preadmission clinics.

01.03 Policy Framework

Before undertaking a project, planners and project personnel should familiarise themselves with individual jurisdictional plans, regulations, policies, service specific guidelines and reports.

Jurisdictional policy information, where available, is contained in the Further Reading section of this HPU.

Some key reference documents will include:

- ACORN Standards for Perioperative Nursing (current versions); including Nursing Roles, Guidelines and Position Statements, The Australian College of Operating Room Nurses Ltd;
- Australian and New Zealand College of Anaesthetics Professional Standards;
- Best practice guidelines for ambulatory surgery and procedures, Australian Day Surgery Nurses Association, 2013;

- Standards for Endoscopic Facilities and Services, Gastroenterological Society of Australia and Gastroenterological Nurses Society of Australia, 3rd Edition 2006;
- NHMRC, 2010, Australian Guidelines for the Prevention and Control of Infection in Healthcare (2010); and
- AS/NZS 4187:2014 Reprocessing of reusable medical devices in health service organisations.

01.04 Description of Unit

DESCRIPTION AND MODEL OF CARE

The components of a Day Surgery/ Procedure Unit may vary to provide only operating theatres, operating theatres and endoscopy rooms or a dedicated endoscopy service.

A Day Surgery/ Procedure Unit will include facilities to support the care of patients undergoing a range of surgical and/or endoscopic procedures with provision to deliver inhalational and other anaesthetic agents.

Patients referred to Day Surgery/ Procedure Units will usually undergo preadmission screening to ensure they are adequately prepared for the procedure. This screening may range from a telephone interview or review in a preadmission clinic.

Models and service configurations for day surgery/ procedure services will vary and reflect local requirements. Many health services are seeking to 'stream' elective procedural activity so the number of hospital initiated postponement rates are reduced. These streams may include day only, extended day only (23 to 72 hours) and extended stay (greater than 72 hours). This streaming can also impact positively on length of stay as efficiency is improved (Lowthian JA et.al., 2011)

Changes and improvements in surgical/ procedural and anaesthetic techniques have resulted in an increase in the number of patients who can now be managed in a day only or extended day only environments (e.g. minimally invasive surgery). In addition, improvements in technology, such as the use of digital operating room environments, can also improve patient throughput.

Increasing links with community based services, such as hospital-in-the-home has also increased number of patients who can be treated in a Day Surgery/ Procedure Unit. Some services report that integrated home-based follow-up has reduced the need for medihotel beds.

Operating and procedure room requirements will be based on expected casemix and number of procedures. While the document focuses on operating and endoscopy rooms, selected services may also include other procedure rooms such as cardiac catheter or angiography rooms used for interventional radiology.

RANGE OF SERVICES/PROCEDURES

The range of procedures that may be undertaken in a Day Surgery/Procedures Unit and the clinical services that may access the Unit may include:

- a range of surgical procedures such as ENT, dental, general surgery, gynaecology, gastrointestinal, ophthalmology, urology, vascular, oncology, endocrine, plastics and orthopaedics;
- ECT (where there is no dedicated ECT suite within in a mental health unit);
- endoscopy – gastrointestinal and respiratory;
- cardiac procedures (e.g. cardiac angiography);
- interventional radiology (e.g. interventional angiography); and

other procedures such as:

- biopsies including 'lumps and bumps';
- aspirations (joints, pleural cavity, abdominal); and
- insertion of peripherally inserted catheter (PIC) lines, PEG tubes and venous access catheters for dialysis under radiological or ultrasound control.

02 PLANNING

02.01 Operational Models

OPERATIONAL MODELS

The Day Surgery/ Procedure Unit may be:

- a free-standing centre;
- a discrete fully self-contained unit within a hospital;
- collocated with a specialist clinical service within a hospital such as gastroenterology Unit; and
- incorporated into an Operating Unit complex sharing selected facilities such as reception, holding, recovery and staff amenities.

If free-standing, the Day Surgery / Procedure Unit should be located with an acute hospital within a reasonable distance for transfer of patients in case of an emergency.

The most efficient hospital-based day surgery/ procedure services may be achieved by nominated dedicated operating and procedure rooms or scheduling of activity.

02.01 Operational Policies

GENERAL

The following issues should be considered in identifying the models of care to be implemented and developing the operational model for the Centre, as they will all impact the configuration of the Centre and overall space requirements.

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

HOURS OF OPERATION

The Day Surgery/Procedures Unit will routinely operate Monday to Friday and will typically open at 6.30am to admit and prepare patients. Theatre and procedure lists will generally be conducted between 8.00am and 5.00pm. Patient recovery services may extend to 9.00pm at night. These hours are indicative only and may vary between services.

PRE-ADMISSION SCREENING

All patients referred for a procedure should be assessed to ensure they are fit and all of the necessary pre-admission assessment has been undertaken by the medical specialist, GP or hospital pre-admission screening team. Many patients will be considered fit and will not need to visit a pre-admission clinic.

Preadmission clinics may be provided as part of a Day Surgery/ Procedure Unit or collocated with other outpatient clinics in an ambulatory care centre.

ADMISSION AND PREPARATION

A patient will present to the Day Surgery/ Procedure Unit reception where admission details are checked and finalised. Patients will wait in an adjacent waiting room and will then be collected by a nurse and taken to be prepared for the procedure. This will usually involve checking information, taking a set of observations etc. Patients then change from street clothes into a hospital gown and are prepared for surgery/ procedure.

The patient may need to be assessed by an anaesthetist. This assessment is usually undertaken in an interview room or holding bay. Gowned patients will usually wait in a dedicated waiting area, separate to the main waiting area.

As approaches to patient fasting are changing, and many patients are now able to consume clear fluids up to two hours prior to their procedure, access to a beverage bay may need to be considered.

Patients will either walk into the operating/ procedure room, or be transferred on a trolley from a holding bay. The anaesthetic will routinely be administered in the operating/ procedure room.

Refer to PS15: Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery, 2010, Section 4.5.2 for further details.

ANAESTHESIA AND RECOVERY

Anaesthesia may be local, regional, conscious sedation or general anaesthesia (GA). All procedure and operating rooms should be capable of supporting patients having a range of anaesthesia including local anaesthetic and GA.

The recovery stages used in a Day Surgery/ Procedure Units will routinely include:

- Stage 1 recovery is a dedicated area where post-procedure patients are recovered under supervision. Transfer from Stage 1 recovery will be based on patients meeting established clinical criteria;
- Stage 2 recovery is used to manage day surgery patients who are transferred from Stage 1 or those patients who have had little or no sedation. Most patients will be nursed in a recliner although some access to trolleys may be needed. Patients will receive a light meal post-discharge instructions and be supplied with discharge medications or a script; and
- Stage 3 recovery may be collocated with stage 2 in a single area to improve staffing efficiencies and patient flow. Alternatively, a small lounge may be provided and patients wait until they are ready to be collected by a carer.

Patients who require a longer length of stay may be transferred from Stage 1 recovery to an extended day only unit. The location of this Unit is ideally located near the Day Surgery/ Procedure. However, where patient stays exceed 23 hours, the level of amenity needed to support the patient and their family changes and typically, an inpatient unit environment is needed (refer to HPU 340 Inpatient Accommodation Unit).

The Australian and New Zealand College of Anaesthetists recommends that at least 1.5 spaces are available per operating room (PS04: Recommendations for the Post-Anaesthesia Recovery Room, 2006).

Typical numbers per operating/ procedure room include:

- Stage 1 recovery: at least 1.5 spaces (PS04: Recommendations for the Post-Anaesthesia Recovery Room, 2006);
- Stage 2 recovery: three trolley/ chair spaces; and
- Stage 3 recovery/ discharge: two to three chairs.

ENDOSCOPE REPROCESSING

Larger endoscopy services will usually be collocated with a scope reprocessing unit. This arrangement is generally preferred as instruments are delicate, expensive and a fast turn-around is needed.

Refer to:

- AusHFG Health Planning Unit 190 Sterilizing Services Unit (2016) for information to functional and design requirements;
- Standards for Endoscopic Facilities and Services, Gastroenterological Society of Australia and Gastroenterological Nurses Society of Australia, 3rd Edition 2006; and
- Infection Control in Endoscopy, Gastroenterological Society of Australia and Gastroenterological Nurses Society of Australia, 3rd Edition 2010.

ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY

Where these services are required, project staff will need to determine whether Endoscopic Retrograde Cholangiopancreatography (ERCP) will be undertaken in the Day Surgery Unit or in the Imaging Unit as the procedure requires radiology facilities and appropriate room screening etc.

MANAGEMENT OF BRONCHOSCOPIES

Patients having bronchoscopy for sputum induction to determine their tuberculosis status should be managed both pre and post-procedure in a single isolation room with appropriate negative pressure air-conditioning. The Gastroenterological Society of Australia recommends not performing bronchoscopy on patients with active tuberculosis unless the risk of tuberculosis transmission is outweighed by not performing the procedure. These patients will typically be managed at a specialist centre.

It is preferred that the Procedure Room itself have negative pressure exhaust ventilation or high efficiency particulate air (HEPA) filtration.

Refer to:

- Fibre-optic bronchoscopy in adults: a position paper, The Thoracic Society of Australia and New Zealand, R Wood-Baker, J Burdon, A McGregor, P Robinson and P Seal, Internal Medicine Journal 2001; 31: 479-487; and
- Infection Control in Endoscopy, Gastroenterological Society of Australia and Gastroenterological Nurses Society of Australia, 3rd Edition 2010.

MANAGEMENT OF THOSE WITH SPECIAL NEEDS

Where children / adolescents are managed in a Day Surgery/ Procedure Unit, some separation between children and adults is ideal. This can be managed in several ways including child-friendly waiting areas, scheduling, single rooms, or identifying a cohort of beds. The environment must be child-friendly. Suitable equipment, toys, games and a play area should be provided to reduce anxiety and speed recovery. It is usual for parents/ carers to accompany their child through the procedure (excluding the operating room). Parents / carers should have access to amenities to support the care of their child.

Transfer to the procedure / operating room will depend on the age but may be carried, walking or trolley.

Other patients, such as those with intellectual disability may also need to be considered. A calm environment with space for a carer may be needed.

Those travelling from remote locations may require special consideration (e.g. access to a space to undertake bowel preparations and showers).

Refer to:

- Royal Australasian College of Physicians, Association for the Wellbeing of Children in Healthcare and Children's Hospitals of Australasia, Standards for the Care of Children and Adolescents in Health Services, 2008;
- Standards for Endoscopic Facilities and Services, Gastroenterological Society of Australia and Gastroenterological Nurses Society of Australia, 3rd Edition 2006 (Chapter 13); and
- PS29: Statement on Anaesthesia Care of Children in Healthcare Facilities Without Dedicated Paediatric Facilities, 2008

MANAGEMENT OF EMERGENCIES

Procedures need to be in place to manage medical emergencies.

Medical emergencies occurring to patient while in the Unit requiring access to resuscitation equipment and ongoing care and possible admission to an inpatient bed or transfer to an acute hospital facility.

Stand-alone Day Surgery/ Procedure Units will transfer patients to a nearby hospital should the patient condition deteriorate.

PATIENT PROPERTY

The method of holding and return of patient's clothing and effects must be determined to understand facility impacts. Usual methods are to provide lockers for patient property or for patient's property to remain with them.

RADIOLOGY REQUIREMENTS

Either fixed or mobile units that are suitable for fluoroscopy should be available in a radiation protected procedure room. Storage of lead apparel will be needed

Where ERCP and associated pancreatico-biliary therapeutic procedures are to be undertaken, the x-ray equipment will be able to support high definition images. 'X-ray in use' signs should be in place to alert staff outside of rooms of radiation danger.

02.02 Planning Models

In a combined Day Surgery / Procedure Unit most zones will be shared to manage both surgical and procedural cases (e.g. holding and recovery spaces). However, Operating Rooms and Procedure Rooms should be separated to:

- promote patient throughput for endoscopy and other high turnover cases; and
- avoid the need for procedural services to comply with all aseptic technique standards as outlined in ACORN Standard 2. Where procedure rooms are collocated with operating rooms, surgical standards must be maintained.

In selected services, the use of rooms may be shared with surgical and procedural activity scheduled at different times. In this case, it makes sense for these rooms to be collocated to promote flexibility and efficient use of resources.

In some cases, a service may collocate preadmission clinics with the Day Surgery / Procedure Unit rather than with other outpatient services. In this case, these rooms may share the space such as waiting and reception.

02.03 Functional Areas

FUNCTIONAL ZONES

The Day Surgery / Procedure Unit comprises the following functional zones:

- entry/ reception / waiting;
- pre-procedure preparation and holding;
- operating/ procedure rooms area;
- recovery, stages 1 to 3
- clinical support area; and
- staff offices and amenities.

ENTRY / RECEPTION / WAITING

Provides for reception and admission of patients to the Unit, with general oversight of day-to-day operations, control of entry and exit from the Unit and completion of general administrative tasks (e.g. files management, clerical admissions/discharges, statistics compilation, typing). Areas may include:

- reception;

- office space for selected staff;
- public waiting; and
- public amenities.

PATIENT PREPARATION AND HOLDING AREA

This area will be used to check administrative paperwork, enable patients to change and toilet prior to undergoing procedures and wait in a suitably discreet location under supervision of staff.

Facilities comprise:

- an interview/ consult room to check paperwork etc;
- patient amenities such as toilets, showers, lockers and change rooms;
- changed waiting with access to chairs and/or trolleys, depending on the local model. The number of spaces per operating/ procedure room will depend on the patient turnover as it is assumed that at least one patient per room will be changed and ready; and
- access to a staff base and utilities (clean and dirty). Depending on the size of the service, this is usually shared across holding and recovery areas.

To reduce duplication, it may be possible to reuse holding as stage 2/3 recovery bays.

OPERATING/ PROCEDURE ROOMS

The number and mix of procedure / operating rooms should be as determined through clinical services planning and the number and range of procedures to be undertaken.

Room configuration will vary dependent upon:

- use (i.e. endoscopy or surgery);
- the use of video equipment;
- electrosurgical laser treatment;
- multiple scope activity; and
- the use of x-ray (image intensifying).

Operating rooms may include a holding bay that is used by anaesthetists to prepare the patient for theatre (e.g. insertion of lines, blocks). Alternatively, a dedicated anaesthetic bay/room may be needed.

An endoscopy procedure room will be fitted out as an operating room – minor (refer to Standard Components).

Direct access to the scope cleaning room is recommended from nominated endoscopy room/s.

The arrangement of operating and procedure rooms is described in Planning Models.

CLINICAL SUPPORT AREAS

Refer to the schedule of accommodation for suggested requirements.

Dedicated and separate storage should be provided for a range of sterile stock, consumables and equipment. The amount will vary and depend on the size and complexity of the service. The location of the storage may vary depending on how frequently it is accessed. An audit of existing and planned equipment should be undertaken to assess storage needed. The complexity of procedures being undertaken in a Day Surgery/ Procedure Unit is increasing and with it comes additional equipment.

RECOVERY AREAS

In larger facilities it is preferable to have a three recovery areas - Stage 1, Stage 2 and Stage 3 (Discharge Lounge). Smaller units may combine Stages 2 and 3. Depending on the Unit size, a staff station and other clinical support will be shared.

Services that treat paediatric patients may provide a separate zone in the discharge area designed specifically for the recovery of children. Alternatively, paediatric cases could be scheduled or cohorted.

Recovery Stage 1

Stage 1 Recovery accommodates unconscious patients who require constant observation and monitoring with, ideally one-to-one patient nurse ratio. Open planned bays will be provided that can be observed from a staff station.

Recovery Stage 2

Recovery stage 2 accommodates:

- patients who have regained consciousness after anaesthesia but require further observation; and
- patients who have undergone procedures with local anaesthetic who may 'bypass' recovery stage 1.

Depending on the size and complexity of the service, these spaces may also be used to hold patients prior to their procedure as the peaks in activity change across the day.

Bay will be arranged in an open-planned arrangement with direct access to Stage 1 and Stage 3 areas. Depending on the patient, access to recliner chairs or a trolley bay is needed.

Access is required to toilets and a beverage bay.

Recovery Stage 3 (Discharge Lounge)

The recovery Stage 3/ discharge lounge will accommodate comfortable chairs with adequate space between them for small tables. Centres which have a high volume of more rapid turnover patients with shorter first stage recovery (e.g. endoscopy, cystoscopy, ophthalmology, plastic surgery) may require larger discharge lounges with more chairs to avoid overcrowding.

Access is required to toilets, lockers and a beverage bay.

Access to a small interview room for confidential follow-up discussions and instructions. Depending on configuration, this room may be shared with holding.

The exit from the discharge area may be separate from the admission entrance.

The covered ambulance bay for transfer of patients to hospital in cases of emergency should be easily accessible from the recovery areas.

EXTENDED DAY ONLY UNIT

Selected services may choose to collocate an extended hours inpatient unit to accommodate a greater range of cases (i.e. those with a length of stay of between 24 and 72 hours). Alternatively, patients may be transferred to a dedicated inpatient unit.

Where beds are collocated with a Day Surgery/ Procedure Unit, planners will need to consider access for visitors and additional patient amenities such as toilets and showers.

STAFF AREAS

Facilities include:

- male/female change rooms which will include toilets, showers and lockers;
- staff room;
- meeting / tutorial room; and
- office space to support the service.

02.04 Functional Relationships

EXTERNAL

- sterilizing services unit;
- operating suite, if not collocated;
- extended day Unit and other inpatient units; and
- pre-admission clinic.

INTERNAL

Key issues to be managed include:

- separation of clean and dirty flows;
- logical orderly patient flow from arrival at reception, through Holding, procedural areas and recovery stages 1 to 3;
- the ability of staff to monitor the condition and safety of patients at all times; and
- the efficient management of the Unit, in particular ensuring the design does not result in additional staffing costs.

03 DESIGN

03.01 Access

INTERNAL

Other hospital staff and visitors should only be able to access the Unit as far as the reception / entry area. Selected visited may be escorted to other areas (e.g. recovery)

Discreet access is required for inpatients on beds or trolleys, where services are provided to inpatients.

EXTERNAL

To facilitate easy access to the Unit by the patients and carers, consideration should be given to the following:

- provision of a covered pick-up area adjacent to the main entrance to the facility;
- clearly signposted directions to the area; and
- provision of car parking for visitors to the area within easy access of the main entrance to the facility.

Discreet ambulance access also needs to be considered.

03.01 Parking

For staff parking, refer to AusHFG Part C Section 6.0 Safety and Security Precautions.

03.03 Disaster Planning

In case of a disaster, elective cases may be cancelled and these facilities used to provide additional unplanned capacity.

Refer to AusHFG Part B Section 80 General Requirements for further information.

03.02 Infection Prevention and Control

The design should support the implementation of the following policies, standards and guidelines:

- ACORN Standards for Perioperative Nursing (current versions) including Nursing Roles, Guidelines and Position Statements, The Australian College of Operating Room Nurses Ltd;
- AS/NZS 4187:2014 Reprocessing of reusable medical devices in health service organisations; and
- AusHFG Part D Infection Prevention and Control;
- Infection Control in Endoscopy, Gastroenterological Society of Australia and Gastroenterological Nurses Society of Australia, 3rd Edition 2010;
- NHMRC, 2010, Australian Guidelines for the Prevention and Control of Infection in Healthcare (2010); and
- PS28: Guidelines on Infection Control in Anaesthesia, 2015.

03.03 Environmental Considerations

NATURAL LIGHT AND EXTERNAL VIEWS

Where possible the design of the unit should incorporate external views and natural light to such areas as waiting areas, holding and recovery, and the staff lounge. The use of natural light can enhance wellbeing and make the environment feel less like a hospital and support the high throughput model.

When external views and natural light are introduced into patient areas, care must be taken to minimise glare, heat gain/ loss and ensure privacy is not compromised.

INTERIOR DECOR

Interior decor should be calming and offer positive distractions to reduce stress. Features that distract patients (e.g. artwork) may also be helpful.

03.04 Space Standards and Components

HUMAN ENGINEERING

Human Engineering covers aspects of design that permit effective, appropriate, safe and dignified use by all people, including those with disabilities. It includes occupational ergonomics, which aims to fit the work practices, FF&E and work environment to the physical and cognitive capabilities of all people e.g. access to a range of seating options in waiting areas to accommodate younger people as well as frail / aged.

Refer Part C Section 730 of these Guidelines for information.

ACCESS AND MOBILITY

Refer to:

- AS1428 - Design for Access and Mobility (set); and
- AusHFG Part C Section 4.0 Human Engineering.

BUILDING ELEMENTS

Refer AusHFG Part C Section 3.0 Space Standards and Dimensions for details.

03.05 Safety and Security

SAFETY

The design of the Unit should seek to prevent injury and reduce the number of potential hazards that may include:

- exposure to infectious substances through consideration of clean and dirty flows and provision of clean-up areas;
- exposure to anaesthetic gases through the provision of scavenging;
- injury from equipment such as lasers; and
- injuries related to manual handling.

SECURITY

Access control systems will be needed to ensure that only those authorised will have access to restricted areas of the Unit. Duress points may also be needed at staff stations and receptions. Patient/ visitor escorted access only beyond waiting area.

03.08 Finishes

GENERAL

As with most Units, the selection of finishes for the Day Surgery / Procedure Unit is influenced by both durability and infection control issues.

The finishes should be easy to clean to facilitate infection control. At the same time, they should be hard wearing and impervious to moisture.

See AusHFG Part D Infection Prevention and Control and relevant Standard Components for further information.

WALL FINISHES AND PROTECTION

Wall surfaces are subject to the cleaning protocols. Full height wall vinyl is used in operating/ procedure rooms.

Due to the high number of trolley and equipment movements in the Unit, wall and corner protection is required wherever there is the potential for damage from trolleys.

Refer to AusHFG Part C Section 3.0 Space Standards and Dimensions for details.

FLOOR FINISHES

Floor finishes should be of a type that are impervious to moisture, easily cleaned, stain resistant, comfortable for long periods of standing and suitable for wheeled traffic.

In the procedure/ operating rooms, the colour should be such that there is sufficient contrast to find small dropped items.

Slip resistant sheet vinyl with welded joints and coved skirtings is considered appropriate throughout the Unit.

Carpet may be used in the non-clinical areas of the Unit such as offices and public waiting areas.

CEILING FINISHES

Ceilings will be subjected to the cleaning protocols. Refer to AusHFG Part D Infection Control and Prevention for further information.

03.06 Fixtures, Fittings & Equipment

DEFINITION

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

Refer to the Room Data Sheets (RDS) and Room Layout Sheets (RLS) and:

- AusHFG Part C Section 3.0, Space Standards and Dimensions; and
- AusHFG Part F Section 680 Furniture Fittings and Equipment.

03.10 Building Service Requirements

GENERAL

The provision of appropriate building services to the Unit, and easy access to these from the unit, is essential for efficient and safe operation.

These are described in more detail in both Room Data and Room Layout Sheets.

NURSE CALL SYSTEMS

Nurse call system requirements are detailed on room data sheets including operating rooms, anaesthetic induction room, patient bay – holding/ recovery and patient amenities such as toilets.

MEDICAL GASES

Medical gas requirements are detailed on room data sheets for procedure rooms, operating rooms, anaesthetic induction spaces and recovery bays. Consideration may be given to sharing medical gases between patient bays in Stage 2 recovery.

RADIATION SAFETY

Radiation shielding will be required in all operating/ procedure rooms where imaging routinely occurs. Specialist advice from a qualified consultant will be needed.

Where imaging equipment is used within operating and procedure rooms, staff will need access to lead gowns. These will be stored on a mobile unit or on a wall mounted rack.

LASER SAFETY

AS/NZS 4173:2004 Guide to the safe use of lasers in health care describes the requirements that will need to be met where lasers are used in an operating theatre. Staff will require access to suitable PPE when lasers are being used.

Major facility implications include:

- signage is located at the entry and egress point of each room where laser is used; and
- glass is treated to comply with laser use or covered with suitable covering such as a laser blind.

Refer also to:

- ACORN Standards for Perioperative Nursing S8 Laser Safety, 2012-13; and
- jurisdictional policies.

SURGICAL PLUME

During surgical procedures energy-based surgical devices intentionally vaporise tissue creating a potentially hazardous, visible and invisible by-product or plume. Plume extraction systems will be needed.

For additional information refer to:

- NSW Health Guideline GL2015_002 Work Health and Safety - Controlling Exposure to Surgical Plume, 2015; and
- ACORN Standard Surgical Plume.

04 COMPONENTS OF THE UNIT

04.01 Standard Components

Rooms / spaces are defined as:

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

The standard component types are listed in the attached Schedule of Accommodation.

The current Standard Components can be found at:

<https://healthfacilityguidelines.com.au/standard-components>

Non-Standard Components for this HPU are described below.

04.02 Non-Standard Components

ENDOSCOPE REPROCESSING ROOM

Refer to information contained in HPU 190 Sterilizing Services Unit for details.

AX APPENDICES

AX.01 Schedule of Accommodation

A Schedule of Accommodation follows and assumes a 2 room and a 4 room suite that may incorporate day surgery. The 2 room scenario shows one operating room and one procedure room. The 4 room scenario shows two operating rooms and two procedure rooms. These room numbers will need to be amended in accordance with the requirements of the Service Plan and the planned procedural and surgical caseload.

All other rooms are non-standard and will need to be briefed using relevant functional and operational information provided in this HPU. In some cases, Room/ Spaces are described as 'Optional' or 'o'. Inclusion of this Room/ Space will be dependent on a range of factors such as operational policies or clinical services planning.

ENTRY/ RECEPTION/ WAITING

ROOM CODE	ROOM/SPACE	SC/ SC-D	Qty x m2	Qty x m2	REMARKS
			2 Rooms	4 Rooms	
WAIT-10	Waiting	Yes	1 x 10	1 x 15	8 and 12 seats respectively
WCPU-3	Toilet – Public, 3m2	Yes	1 x 3	1 x 3	
WCAC	Toilet – Accessible, 6m2	Yes	1 x 6	1 x 6	
RECL-10	Reception/ Clerical, 10m2	Yes	1 x 10	1 x 10	1 - 2 staff
OFF-2P	Office – 2 Person, Shared, 12m2	Yes	-	1 x 12	Clerical workroom, dependent on staffing profile.
STPS-8	Store - Photocopy/ Stationery, 8m2	Yes	1 x 8	1 x 8	
STFS-10	Store - Files	Yes	1 x 4	1 x 6	Optional. Depends if hard copy files are used and/ or retained.
OFF-S9	Office - Single Person, 9m2	Yes	1 x 9	1 x 9	Unit Manager
	Office – Workstation, 5.5m2		1 x 5.5 (o)	1 x 5.5	CNS

OFF-CLN	Office - Clinical Workroom	Yes	1 x 12	1 x 15	Workstations for nursing and visiting staff
	Discounted circulation		25%	25%	

PATIENT PREPARATION AND HOLDING AREA

ROOM CODE	ROOM/SPACE	SC/ SC-D	Qty x m2	Qty x m2	REMARKS
			2 Rooms	4 Rooms	
INTF	Interview Room	Yes	1 x 9	2 x 9	
CHPT	Change Cubicle, Patient, 2m2	Yes	1 x 2	2 x 2	
CHPT-D	Change Cubicle – Accessible, 4m2	Yes	1 x 4	1 x 4	
WCPT	Toilet – Patient, 4m2	Yes	1 x 4	1 x 4	
ENS-ACC	Ensuite – Accessible, 6m2	Yes	1 x 7	1 x 7	
	Property Bay - Patient		1 x 2 (o)	1 x 3 (o)	Assumes lockers. Property may instead travel with the patient.
WAIT-SUB	Waiting	Yes	1 x 5	1 x 10	'Changed' Waiting - Chairs
PBTR-H-6	Patient Bay – Holding, 6m2	Yes	1 x 6	2 x 6	'Changed' Waiting - Trolley Bay. May need to be 9m2 should access be required at each side.
	Staff Base		1 x 6	1 x 8	To oversight changed waiting and can be shared to support pre and post-operative areas
BHWS-B	Bay – Handwashing, Type B	Yes	1 x 1	1 x 1	

	Discounted circulation	35%	35%	
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OPERATING/ PROCEDURE ROOMS

Note 1: The operating and procedure rooms reflected below are to reflect an indicative scenario only. The number and type of rooms provided for each project will be identified during the development of the clinical services plan.

Note 2: Smaller services may multipurpose operating/ procedure rooms so in this case, rooms may be located side by side. As the size of the service increases, it is preferable to separate procedure rooms and operating rooms, so that procedural work can be done without impacting surgical activity.

ROOM CODE	ROOM/ SPACE	SC/ SC-D	Qty x m2	Qty x m2	REMARKS
			2 Rooms	4 Rooms	
PROCEDURE ROOMS					
ORGN	Operating Room, General, 42m2	Yes	1 x 42	2 x 42	Able to rotate bed through 360 degrees
	Scope Reprocessing		1 x 17	1 x 24	Refer to HPU 190 Sterilizing Services Unit for details regarding space allocations for dirty and clean zones.
	Endoscope Store		1 x 2	1 x 2	
SCRB-6	Scrub-up/ Gowning, 6m2	Yes	1 x 6	1 x 6	Shared between rooms
OPERATING ROOMS					
ORLA	Operating Room, Large	Yes	1 x 55	2 x 55	Selected services may opt for a 42m2 room.
ANIN	Anaesthetic Induction Room	Yes	1 x 15	2 x 15	Optional or bay as some services may not use owing to operational requirements.
SCRB-6	Scrub-up/ Gowning, 6m2	Yes	1 x 6	1 x 6	Shared between rooms
CLUP-7	Clean-Up Room	Yes	1 x 6	1 x 8	Optional for surgical instruments processing

	Discounted circulation	35%	35%	
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RECOVERY AREAS

ROOM CODE	ROOM/ SPACE	SC/ SC-D	Qty x m2	Qty x m2	REMARKS
			15 Chair/ Bay	30 Chair/ Bay	
SSTN-10	Staff Station	Yes	1 x 9	1 x 14	
IBR-H-12	1 Bed Room – Holding, 12m2	Yes	1 x 12	2 x 12	Used for children, special needs or isolation
PBTR-RS1	Patient Bay - Recovery Stage 1, 9m2	Yes	3 x 9	6 x 9	
PBTR-H-9	Patient Bay – Holding, 9m2	Yes	6 x 9	12 x 9	Stage 2 Recovery. If chairs, a smaller space allocation may be considered (i.e. 6m2)
BHWS-B	Bay – Handwashing, Type B	Yes	4 x 1	8 x 1	
BBEV-OP	Bay- Beverage, Open Plan	Yes	1 x 4	1 x 4	Include ice machine if needed
	Recovery Stage 3 / Discharge Lounge		6 x 4	12 x 4	Each chair planned at 4m2. In some smaller units, patients may be discharged from Stage 2 recovery
INTF	Interview Room	Yes	1 x 9 (o)	1 x 9	In smaller services, interview room may be shared between zones.
	Discounted circulation		35%	35%	

CLINICAL SUPPORT

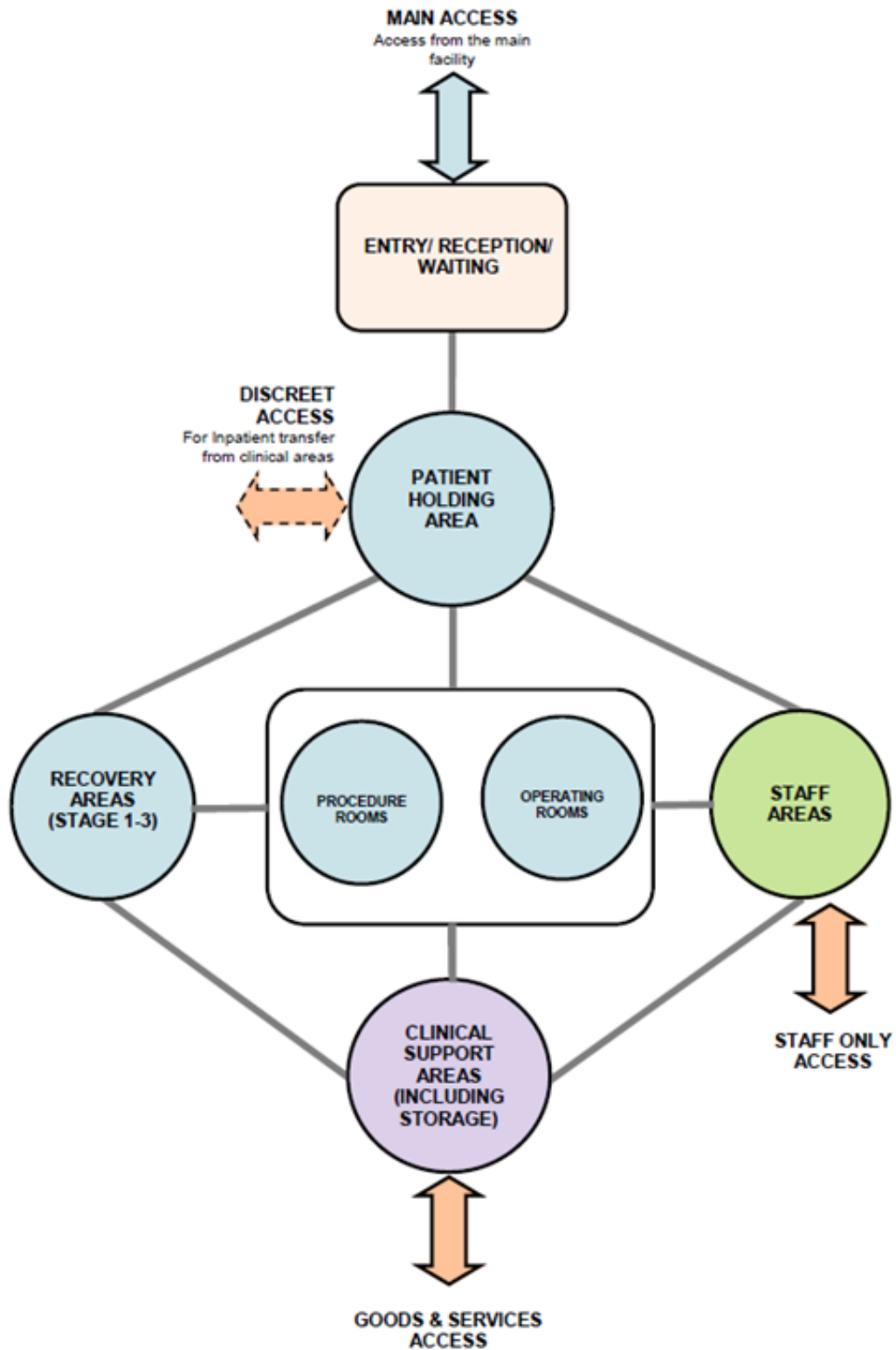
ROOM CODE	ROOM/SPACE	SC/ SC-D	Qty x m2	Qty x m2	REMARKS
			2 Rooms	4 Rooms	
BLIN	Bay – Linen	Yes	1 x 2	2 x 2	Assumes 1 bay: 2 rooms
STSS-12	Store – Sterile Stock	Yes	1 x 18	1 x 30	
STEQ-14	Store - Equipment	Yes	1 x 12	1 x 16	With power points for recharging pumps etc
BMEQ-4	Bay - Mobile Equipment	Yes	2 x 2	4 x 2	Image intensifiers, lead gowns, blanket warmers and trolleys etc
CLUR-10	Clean Utility/ Medication Room	Yes	1 x 10	1 x 12	
	Dirty Utility / Disposal Room		1 x 12	1 x 14	
BRES	Bay - Resuscitation	Yes	1 x 1.5	1 x 1.5	
CLRM-5	Cleaner's Room, 5m2	Yes	1 x 5	1 x 5	
	Discounted circulation		35%	35%	

STAFF AREAS

ROOM CODE	ROOM/SPACE	SC/ SC-D	Qty x m2	Qty x m2	REMARKS
			2 Rooms	4 Rooms	
	Staff Room	Yes	1 x 12	1 x 15	
CHST-10	Change - Staff Male / Female, 10m2	Yes	1 x 10	1 x 10	Full lockers - adjust mix as required. Toilet and showers included
CHST-10	Change - Staff Male / Female, 10m2	Yes	1 x 10	1 x 14	Full lockers - adjust mix as required. Toilet and showers included
	Discounted circulation		15%	15%	

AX.02 Functional Relationships / Diagrams

A functional relationships diagram is shown below.



AX.03 Checklists

For planning checklists, refer to Parts A, B, C and D of these Guidelines.

AX.04 References

- ACORN Standards for Perioperative Nursing (current versions), The Australian College of Operating Room Nurses Ltd including:
 - S2 Aseptic Technique
 - S8 Laser Safety
 - G3 Planning and Design of the Perioperative Environment
 - G4 Management of the Post anaesthesia Recovery (PAR) Unit
- Australian Institute of Health and Welfare 2014: Australia's hospitals 2013-2014 at a glance. Cat. no. HSE 157. Canberra: AIHW
- Australian/ New Zealand Standards, Standards Australia, 2000 including:
 - AS/NZS 4187:2014 Reprocessing of reusable medical devices in health service organisations
 - AS/NZS 4187:2014 Reprocessing of reusable medical devices in health service organisations
 - AS/NZS 4173:2004 Guide to the safe use of lasers in health care
 - AS1428 - Design for Access and Mobility (set)
- Australian and New Zealand College of Anaesthetics Professional Standards including:
 - PS04: Recommendations for the Post-Anaesthesia Recovery Room, 2006
 - PS09: Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures, 2014
 - PS15: Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery, 2010
 - PS28: Guidelines on Infection Control in Anaesthesia, 2015
 - PS29: Statement on Anaesthesia Care of Children in Healthcare Facilities Without Dedicated Paediatric Facilities, 2008
 - PS55 Recommendations on Minimum Facilities for Safe Administration of Anaesthetic in operating Suites and Other Anaesthetising Locations, 2012.
- Australian Day Surgery Nurses Association, Best practice guidelines for ambulatory surgery and procedures, 2013;
- Gastroenterological Society of Australia and Gastroenterological Nurses Society of Australia Standards for Endoscopic Facilities and Services, 3rd Edition 2006
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- Lowthian JA, Curtis AJ, Comitti BL, Cameron PA, Keogh MJ, Johnson WR, Tomlinson J, Stripp AM, 2011, Streamlining elective surgery care in a public hospital: the Alfred experience, Medical Journal of Australia, Volume 194, Number 9, pp.448-452
- NHMRC, Australian Guidelines for the Prevention and Control of Infection in Healthcare, 2010

- NSW Health Guideline GL2015_002 Work Health and Safety - Controlling Exposure to Surgical Plume, 2015
- Royal Australasian College of Physicians, Association for the Wellbeing of Children in Healthcare and Children's Hospitals of Australasia, Standards for the Care of Children and Adolescents in Health Services, 2008
- Wood-Baker R, Burdon J, McGregor A, Robinson P and Seal P, Fibre-optic bronchoscopy in adults: a position paper, Internal Medicine Journal 2001; 31: 479-487.

FURTHER READING

- Day Surgery in Australia, Report and Recommendations of the Australian Day Surgery Council of Royal Australian College of Surgeons, Australian and New Zealand College of Anaesthetists and The Australian Society of Anaesthetists, Revised Edition, 2004.
- Day Surgery Centres In Australia Planning And Design, Lindsay Roberts FRCS FRACS - Chairman, Australian Day Surgery Council, 1990 - 2000, March 2005.
- MacLellan DG, Cregan PC, McCaughan BC, O'Connell TJ and McGrath KM. Applying clinical process redesign methods to planned arrivals in NSW hospitals, Medical Journal of Australia 2009: 188
- NSW Health GL2007_018 Pre-Procedure Preparation Toolkit, November 2007
- NSW Health PD2011_045 Extended Day Only Admission Policy, July 2011
- NSW Health GL2012_001 High Volume Short Stay Surgical Model Toolkit, January 2012
- NSW Health Surgery Futures: A Plan for Greater Sydney, NSW Surgical Services Taskforce, January 2011
- Queensland Government Department of Health 23 Hour Ward Admission Criteria, Document no. QH-GDL-412-2001, March 2014
- Surgery in Australian Hospitals 2010-11, Australian Institute of Health and Welfare, website <http://www.aihw.gov.au/hospitals/surgery-2010-11>