

## Part B – Health Facility Briefing & Design

### 130 Intensive Care Unit - General



iHFG

## International Health Facility Guidelines

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## 20 Intensive Care Unit - General

### 1 Introduction

#### *Description*

Intensive Care is a dedicated unit for critically ill patients who require invasive life support, high levels of medical and nursing care and complex treatment. The intensive care unit provides a concentration of clinical expertise, technological and therapeutic resources which are coordinated to care for the critically ill patient.

### 2 Planning

#### *Operational Models*

The level of Intensive Care available should support the delineated role of the particular hospital. The role of a particular ICU will vary, depending on staffing, facilities and support services as well as the type and number of patients it has to manage.

There are a number of operational models applicable to intensive care units including:

#### Combined Critical Care

The Combined Critical Care may include a High Dependency Unit, Intensive Care and/or Coronary Care, often located in a rural or regional hospital where flexibility of bed utilisation is important. This will allow short and medium term intensive care patients to be managed appropriately when required, and at other times, the Unit may be used for the more common cardiology or high dependency patients. These Units have lower medical and nursing demands, and will usually be staffed on a nurse/patient ratio of significantly less than 'one to one'.

#### Combined General Intensive Care

In this model the Intensive Care consists of all patient specialties such as cardiothoracic surgery, orthopaedics, neurosurgery, and general medical patients. These Units will usually have a combination of intensive care and high dependency beds.

This model may be adopted where there are limited numbers of sub-specialty critical patients. The disadvantage of this model is that if the general intensive care is fully occupied, critical sub specialty cases may need to remain in standard inpatient units for treatment.

#### Hot Floor

The 'Hot Floor' model of Intensive Care can be collocated with specialty Intensive Care Units such as cardiothoracic, neurosurgical and general intensive care and may include a high dependency unit.

A comprehensive 'Hot Floor' model may include collocation of ICU with Operating Unit, Emergency, CCU and parts or all of Medical Imaging. The Hot Floor model has the principal advantage of collocating services, avoiding duplication and with a single management structure, allows a more efficient medical and nursing overview.

Advantages of the Hot Floor model include:

- enables standardisation of equipment across the Hot Floor avoiding duplication and minimises service costs
- assists practitioners particularly medical and nursing to develop expertise in the specialties
- prevents access blockage to general ICU beds optimising patient throughput

The disadvantages of a Hot Floor involve:

- the management of a large group of nurses and doctors
- infection control risks including cross infection of patients in co-located units

## Separate Intensive Care Units

This model covers a range of specialty Intensive Care Units provided as disconnected units in separate locations, with an independent management structure for each unit.

Advantages of this model include:

- may help to avoid bed blockages by allowing different groups to control the Intensive Care resources
- encourages the development of sub-specialty medical and nursing skills

Disadvantages include duplication of management, policies and procedures and physical isolation of units that may make staffing more difficult.

## Planning Models

The ICU should be in a location that eliminates the need for through traffic and avoids or minimises:

- disturbing sounds (ambulances, traffic, sirens)
- disturbing sights (morgue, cemeteries etc.)
- problems associated with prevailing weather conditions (excessive wind, sun exposure etc.).

The location and design should enable expansion if additional beds are required in the future.

In the ideal configuration of an ICU, all beds should be visible from the Staff Station. In larger units where this cannot be achieved, consideration may be given to providing decentralised staff / work stations with computer support.

## Functional Areas

The Intensive Care Unit will consist of the following Functional Areas:

- Entry/ Reception/ Waiting Areas
- Patient/ Treatment Areas including patient Bed Bays and Rooms, Ensuites and Procedures rooms
- Support Areas including Biomedical workshop areas, Cleaner's Room , Clean and Dirty Utility Rooms, Disposal Room, Store Rooms, Laboratory facilities, Linen bays, Overnight accommodation, Staff Station, write-up and handover areas, Pantry
- Administrative / Office Areas, with Offices, Workstations for a range of clinical staff, Meeting and Interview rooms
- Staff Amenities areas, including Staff Room, Toilets, Shower and Lockers.

### Entry/ Reception/ Waiting Areas

As determined by the size of the ICU and hospital operating policy, a Reception and visitor's / relatives' Waiting Areas shall be provided immediately outside the entry to the ICU, but away from patient and staff traffic areas. It is desirable that this room has provision for a drink dispenser, radio, television and comfortable seating. An Interview Room and a separate area for distressed relatives should be available.

### Patient Areas

Patient Bed Bays, Enclosed Bays, Isolation rooms, Ensuites and Bathrooms will be provided according to the Service Plan. All patient areas are to comply with Standard Components. It is recommended that ensuites be provided in a ratio of 1:6 beds and 1 for each isolation room.

### Procedures Room

A Procedures Room shall be provided if required by the Operational Policy.

If a special Procedures Room is provided, it should be located within, or immediately adjacent to, the ICU. One special Procedures Room may serve several ICUs in close proximity. Consideration should be given to ease of access for patients transported from areas outside the ICU.

Room size should be sufficient to accommodate the necessary equipment and personnel. Monitoring capabilities, equipment, support services, and safety considerations must be consistent with those services provided in the ICU proper. Work surfaces and storage areas must be adequate enough to maintain all necessary supplies and permit the performance of all desired procedures without the need for staff to leave the room.

Procedures Rooms are to comply with Standard Components – Procedures Room.

## Support Areas

### Biomedical Workshop

Dependent upon the size and intended use of the ICU, a dedicated electronic and pneumatic equipment maintenance service may have to be accommodated within the hospital or a 24 hour on-call emergency service made available. This same service would cover the Operating, Emergency and Medical Imaging Units.

If a dedicated workshop is provided, its location should be in an area that is equally accessible to all of the above mentioned departments. The facility should have a degree of sound-proofing and be accessible from a non-sterile area.

### Laboratory Facilities

The ICU must have available 24-hour clinical laboratory services. When this service cannot be provided by the central hospital Laboratory, a satellite laboratory within or immediately adjacent to the ICU must serve this function. Satellite facilities must be able to provide minimum chemistry and haematology testing, including arterial blood gas analysis.

### Overnight Accommodation

Depending upon the availability of nearby commercial accommodation, consideration should be given to the provision of overnight accommodation for relatives and staff, preferably near the unit. This will be dependent upon the size and intended function of the ICU. A motel type bed-sitter level of provision is recommended.

### Storage Areas

Mobile equipment such as cardiopulmonary resuscitation trolleys and mobile X-ray, that are used and located within the ICU, shall have storage areas that are out of traffic paths but conveniently located for easy access by staff. Consideration should be given to the ever increasing amount of equipment used in the unit.

### Staff Facilities

Offices / workstations will be required for senior staff in full time administrative roles according to the approved positions in the Unit. Offices / workstations for medical staff and some nursing staff (manager/ specialists/ registrars/ educators) may be located as part of the Intensive Care Unit where required for clinical functions or adjacent in an administrative area, to facilitate unit co-ordination, educational and research activities

A Staff Lounge shall be provided within the unit for staff to relax and prepare beverages. Inclusion of a window to the outside is desirable. A Library/ Reference area with an appropriate range of bench manuals, textbooks and journals for rapid access 24 hours a day should be available within the Intensive Care Unit.

Staff will need close access to the following:

- Toilets and Shower
- Lockers
- Meeting room/s.

### *Functional Relationships*

#### External

It is desirable that the Intensive Care Unit has ready access to:

- Emergency Unit, for urgent admissions
- Operating Unit, for urgent patient transfers
- Medical Imaging particularly for chest x-rays and CT scanning
- Pathology Services (also via pneumatic tube)
- Pharmacy
- Biomedical Engineering to ensure availability and functioning of monitoring and life support equipment

#### Internal

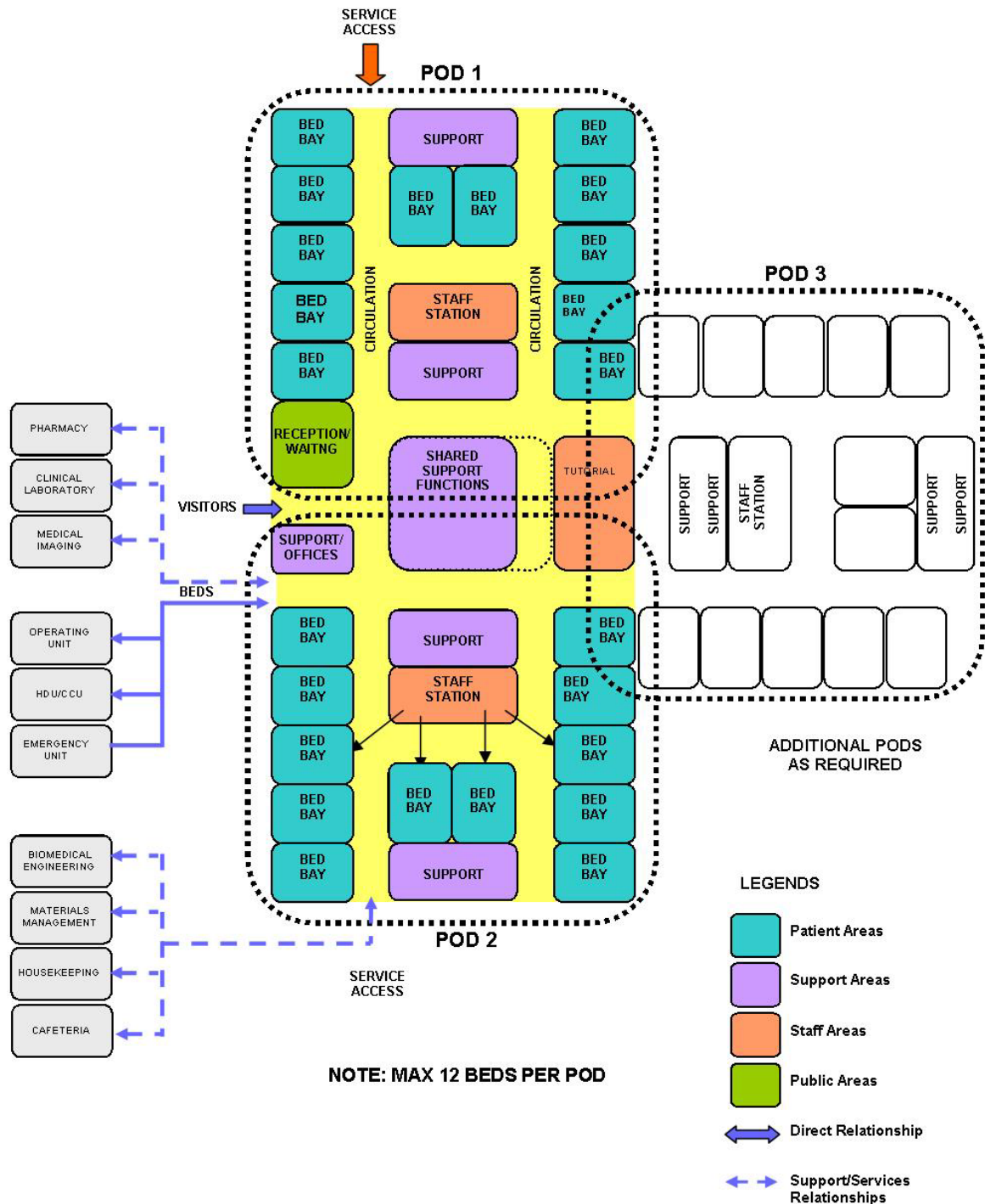
Optimal internal relationships to be achieved include those between:

- Patient occupied areas, forming the core of the unit, which require direct access and observation by staff
- Staff station(s) and associated areas that need direct access and observation of patient areas and ready access to administration areas
- Clinical Support Areas such as Utility and storage areas that need to be readily accessible to both patient and staff work areas
- Public areas located on the perimeter of the unit with access to lifts and circulation corridors
- Shared support areas that should be easily accessible from the units served.

The Optimum functional relationships are demonstrated in the diagram below.

### Functional Relationships Diagram

The internal and external functional relationships are demonstrated in the diagram below.



External functional relationships outlined in the diagram include:

- Entry for visitors directly from dedicated lifts and public corridor
- Bed access to / from key clinical units associated with patient arrivals and transfers via service corridor
- Ready access to Medical Imaging and Pharmacy Units
- Entry for staff via public or service corridor
- Separate service access for biomedical engineering, materials, catering and housekeeping.

Internal relationships outlined in the diagram include:

- Bed Room(s) on the perimeter arranged in a linear model, although other models are also suitable
- Staff Station(s) located close to the Unit entry with supervision and control over the entry corridor and the patient areas
- Clinical support areas located close to Staff Station(s) and centralised for ease of staff access
- Administrative areas located at the Unit entry and in staff accessible corridors
- Good visibility and access from Staff Station to Patient Bedrooms.

### 3 Design

#### *Access*

##### External

Ideally there should be a separate and discrete entry or entries for staff, goods and supplies with swipe card or similar electronic access to authorised personnel. Discrete entry for patients on beds or trolleys may also be considered and this should provide:

- Ready access from Emergency Unit, and Operating Unit that may involve transfers via lifts
- Ready access to and from Diagnostic Imaging areas.

##### Internal

There should be one only point of public entry overseen by a ward clerk / receptionist during extended daytime hours to:

- monitor and / or prevent access by visitors depending on the patients' condition
- advise visitors if patients have been moved or are out of the unit for any reason
- monitor visiting staff and direct them to the appropriate staff member or patient
- monitor patient movements in and out of the unit.

#### *Patient Treatment Areas*

Patients must be situated so that healthcare providers have direct or indirect visualization, such as by video monitoring, at all times. This approach permits the monitoring of patient status under both routine and emergency circumstances. The preferred design is to allow a direct line of vision between the patient and the central Staff Station. In ICUs with a modular design, patients should be visible from their respective nursing substations.

Sliding glass doors and partitions facilitate this arrangement and increase access to the room in emergency situations

#### *Renal Dialysis Facilities*

Dialysis facilities including water and drainage should be provided to patient treatment areas according to the Unit's Operational Policy. As a minimum, dialysis facilities should be provided in the Isolation Room/s.

#### *Environmental Considerations*

##### Acoustics

Signals from patient call systems, alarms from monitoring equipment, and telephones add to the sensory overload in critical care units. Without reducing their importance or sense of urgency, such signals should be modulated to a level that will alert staff members, yet be rendered less intrusive.

For these reasons, floor coverings that absorb sound should be used while keeping infection control, maintenance, and equipment movement needs under consideration. Walls and ceilings



should be constructed of materials with high sound absorption capabilities. Ceiling soffits and baffles help reduce echoed sounds. Doorways should be offset, rather than being placed in symmetrically opposed positions, to reduce sound transmission. Counters, partitions, and glass doors are also effective in reducing noise levels.

### Natural Light

Natural light and views should be available from the Unit for the benefit of staff and patients. Windows are an important aspect of sensory orientation, and as many rooms as possible should have windows to reinforce day/ night orientation. If windows cannot be provided in each room, an alternate option is to allow a remote view of an outside window or skylight.

### *Space Standards and Components*

Where an open plan arrangement is provided, bed spaces shall be arranged so that there is a clearance of at least 1200 mm from the side of the bed to the nearest fixed obstruction (including bed screens) or wall. At the head of the bed, at least 900 mm clearance shall be allowed between the bed and any fixed obstruction or wall.

When an open plan arrangement is provided, a circulation space of 2200 mm minimum clear width shall be provided beyond dedicated cubicle space.

Separate cubicles and Single Patient Bedrooms including Isolation Rooms, shall have minimum dimensions of 3900 mm x 3900 mm.

### *Finishes*

The aesthetics of the Unit should be warm, relaxing and non-clinical as far as possible. The following additional factors should be considered in the selection of finishes:

- acoustic properties
- durability
- ease of cleaning
- infection control
- fire safety
- movement of equipment, floor finishes should be resistant to marring and shearing by wheeled equipment.

In all areas where patient observation is critical, colours shall be chosen that do not alter the observer's perception of skin colour.

Wall protection should be provided where bed or trolley movement occurs such as corridors, patients' bedrooms, equipment and linen storage and treatment areas.

### *Equipment*

Bedside monitoring equipment should be located to permit easy access and viewing, and should not interfere with the visualisation of, or access to the patient. The bedside nurse and/or monitor technician must be able to observe the monitored status of each patient at a glance. This goal can be achieved either by a central monitoring station, or by bedside monitors that permit the observation of more than one patient simultaneously. Neither of these methods are intended to replace bedside observation.

Weight-bearing surfaces that support the monitoring equipment should be sturdy enough to withstand high levels of strain over time. It should be assumed that monitoring equipment will increase in volume over time. Therefore, space and electrical facilities should be designed accordingly.

### *Fixtures & Fittings*

#### Clocks

An analogue clock/s with a second sweep hand shall be provided and conveniently located for easy reference from all bed positions and the Staff Station.

#### Bedside Storage

Each patient bed space shall include storage and writing provision for staff use.

#### Window Treatments

Window treatments should be durable and easy to clean. Consideration may be given to use of double glazing with integral blinds, tinted glass, reflective glass, exterior overhangs or louvers to control the level of lighting.

### *Infection Control*

#### Handbasins

Clinical Hand-washing Facilities shall be provided convenient to the Staff Station and patient bed areas. The ratio of provision shall be one clinical hand-washing facility for every two patient beds in open-plan areas and one in each patient Bedroom or cubicle.

#### Isolation Rooms

At least one negative pressure Isolation Room per ICU shall be provided in Level 5 and 6 facilities. Entry shall be through an airlock. Clinical hand-washing, gown and mask storage, and waste disposal shall be provided within the airlock. An Ensuite - Special, directly accessible from the Isolation Room, shall also be provided.

All entry points, doors or openings, shall be a minimum of 1200 mm wide, unobstructed. Larger openings may be required for special equipment, as determined by the Operational Policy.

### *Building Service Requirements*

#### Mechanical Services

The unit shall have appropriate air conditioning that allows control of temperature, humidity and air change.

Refer to Part E of these Guidelines for the specific requirements for Mechanical and Electrical provision.

#### Communications

It is vital to provide reliable and effective IT/ Communications service for efficient operation of the Unit. The following items relating to IT/ Communication shall be addressed in the design of the Unit:

- electronic patient records – patient information systems
- electronic forms and requests (e.g. scripts and investigative requests)
- picture archiving communications systems (PACS)
- telephones including cordless and mobile phones;
- computers and hand-held computers
- paging for staff and emergencies
- duress systems
- bar coding for supplies, x-rays and records
- wireless network requirements
- videoconferencing requirements
- communications rooms and server requirements.

Nurse and Emergency Call facilities shall be provided in all patient and treatment areas in order for patients and staff to request for urgent assistance.

The individual call buttons shall alert to an annunciator system. Annunciator panels should be located in strategic points within the circulation area, particularly Staff Stations, Staff Rooms, and Meeting Rooms and should be of the “non-scrolling” type, allowing all calls to be displayed at the same time. The audible signal of these call systems should be controllable to ensure minimal disturbance to patients at night. The alert to staff members shall be done in a discreet manner at all times.

### Security

Entrance doors need to be secured to prevent unauthorised access. A video intercom with speech should be provided from entrance and exit door to main staff reception complete with door release button for staff access control. Security surveillance of the Unit may include CCTV cameras and monitors.

## 4 Components of the Unit

### *Standard Components*

The Intensive Care Unit will consist of Standard Components to comply with details described in these Guidelines. Refer also to Standard Components Room Data Sheets and Room Layout Sheets.

## 5 Schedule of Accommodation

### Intensive Care Unit – General at Role Delineation Levels 4 to 6

Note: Units at RDL 2/3 will be a High Dependency Unit and may be separate or collocated with an Intensive Care Unit or Inpatient Unit

ROOM/ SPACE	Standard Component Room Codes	RDL 2/3 Qty x m <sup>2</sup>			RDL 4 Qty x m <sup>2</sup>			RDL 5 Qty x m <sup>2</sup>			RDL 6 Qty x m <sup>2</sup>			Remarks
		4 Bed HDU			8 Beds			12 Beds			24 Beds			
<b>Entry / Reception</b>														
Reception/ Clerical	RECL-10-I RECL-12-I				1	x	10	1	x	12	1	x	12	
Waiting	WAIT-15-I WAIT-20-I WAIT-30-I	1	x	15	1	x	20	1	x	20	1	x	30	1.2 m <sup>2</sup> per person; 1.5 m <sup>2</sup> per wheelchair
Waiting - Family	WAIT-20-I WAIT-25-I WAIT-50-I	1	x	20	1	x	20	1	x	25	1	x	50	
Meeting Room	MEET-12-I MEET-L-15-I				1	x	12	1	x	15	1	x	15	
Toilet - Public	WCPU-3-I	2	x	3	2	x	3	2	x	3	2	x	3	May share public amenities if located close
<b>Patient Areas</b>														
Patient Bay - Critical	PBC-16-I	1	x	16										16m <sup>2</sup> bed bays may be used for lower acuity units
Patient Bay - Critical	PBC-24-I	1	x	24	4	x	24	5	x	24	10	x	24	Group of not more than 12, within observation of Staff Station
Patient Bay - Critical (Enclosed); Class S Isolation	PBCE-25-I	1	x	25	3	x	25	6	x	25	12	x	25	Group of not more than 12, within observation of Staff Station
Patient Bay - Critical (Enclosed); Class N Isolation	PBCE-25-I	1	x	25	1	x	25	1	x	25	2	x	25	Clustered, located away from Unit entrance
Anteroom	ANRM-I	1	x	5	1	x	5	2	x	5	2	x	5	For Class N Isolation Rooms
Ensuite - Super	ENS-SP-I	2	x	6	3	x	6	4	x	6	7	x	6	Size for 'full assistance', i.e. 2 staff plus equipment
<b>Support Areas</b>														
Bathroom	BATH-I	1	x	16	1	x	16	1	x	16	1	x	16	Inclusion depends on operational policy of unit
Bay - Beverage	BBEV-OP-I BBEV-ENC-I	1	x	4	1	x	4	1	x	5	1	x	5	
Bay - Blanket Warmer	BBW-I	1	x	1	1	x	1	1	x	1	1	x	1	Optional
Bay - Handwashing, Type A	BHWS-A-I	1	x	1	2	x	1	3	x	1	4	x	1	At entry to the Unit and in Corridors
Bay - Linen	BLIN-I	1	x	2	1	x	2	2	x	2	2	x	2	
Bay - Mobile Equipment	BMEQ-4-I	1	x	4	1	x	4	2	x	4	2	x	4	
Bay - Pathology	BPATH-I (similar)	1	x	1	1	x	2	1	x	4	1	x	4	
Bay - PPE	BPPE-I	1	x	1.5	1	x	1.5	1	x	1.5	4	x	1.5	As required, may be combined with Bay-Handwashing
Bay - Resuscitation Trolley	BRES-I	1	x	1.5	1	x	1.5	1	x	1.5	1	x	1.5	
Cleaners Room	CLRM-5-I	1	x	5	1	x	5	1	x	5	1	x	5	
Clean Utility/ Medication	CLUR-12-I CLUM-14-I	1	x	12	1	x	12	1	x	14	2	x	14	Medication room may be separate
Dirty Utility	DTUR-12-I DTUR-12-I DTUR-14-I	1	x	10	1	x	12	1	x	14	2	x	14	

ROOM/ SPACE	Standard Component Room Codes	RDL 2/3 Qty x m <sup>2</sup>		RDL 4 Qty x m <sup>2</sup>		RDL 5 Qty x m <sup>2</sup>		RDL 6 Qty x m <sup>2</sup>		Remarks
		4 Bed HDU	8 Beds	12 Beds	24 Beds					
Disposal Room	DISP-8-I DISP-10-I	1 x 8	1 x 8	1 x 10	1 x 10					Inclusion depends on unit size & waste operational policies
Equipment Clean-up	ECL-8-I	1 x 8	1 x 8	1 x 8	1 x 8					Room size according to service requirements
Office - Clinical Workroom	OFF-CLW-I (similar)	1 x 10	1 x 15	1 x 15	1 x 20					Locate near staff station
Office - Write-up Bay	OFF-WI-1-U	2 x 1	4 x 1	7 x 1	14 x 1					1 per each enclosed bed room
Respiratory/ Biomedical Workroom	REWM-I (similar)			1 x 20	1 x 20					Inclusion depends on operational policy of unit
Staff Station	SSTN-12-I SSTN-18-I SSTN-20-I	1 x 12	1 x 18	1 x 20	2 x 20					
Store - Drugs	STDR-5-I STDR-10-I	1 x 5	1 x 10	1 x 10	1 x 10					Optional
Store - Equipment	STEQ-10-I STEQ-15-I STEQ-30-I	1 x 10	1 x 15	1 x 15	1 x 30					May be subdivided and located near Birthing rooms as required
Store - General	STGN-12-I STGN-16-I STGN-30-I	1 x 12	1 x 16	1 x 16	1 x 30					
Store - Respiratory	STEQ-20-I				1 x 20					Inclusion depends on operational policy of unit
Store - Sterile Stock	STSS-12-I (sim) STSS-24-I	1 x 6	1 x 12	1 x 24	2 x 24					
<b>Staff Areas</b>										
Bay - Beverage	BBEV-OP-I BBEV-ENC-I		1 x 4	1 x 5	1 x 5					Optional, near Meeting Room/s
Change - Staff (Male/Female)	CHST-10-I CHST-20-I CHST-25-I	2 x 10	2 x 14	2 x 20	2 x 25					Toilets, Shower and Lockers; size dependent on staffing numbers
Meeting Room	MEET-L-15-I MEET-L-25-I	shared		1 x 15	1 x 25	2 x 25				Quantity and size dependent on Service Plan
Office - Single Person, 12 m <sup>2</sup>	OFF-S12-I			1 x 12	1 x 12					Note 1; Director/ Service Manager
Office - Single Person, 9 m <sup>2</sup>	OFF-S9-I	1 x 9	1 x 9	1 x 9	2 x 9					Note 1; Unit Manager
Office - Single Person, 9 m <sup>2</sup>	OFF-S9-I	1 x 9	1 x 9							Note 1; Staff Specialists
Office - 2 Person, Shared	OFF-2P-I		x	1 x 12	1 x 12					Note 1; Nurse Educators, Staff Specialists, Clinicians
Office - Workstation/s	OFF-WS-I	1 x 5.5	2 x 5.5	4 x 5.5	8 x 5.5					Note 1; Registrars, Nursing, Secretarial
Overnight Stay - Bedroom	OVBR-I			1 x 10	1 x 10					Optional
Overnight Stay - Ensuite	OVES-I			1 x 4	1 x 4					Optional
Staff Room	SRM-15-I SRM-20-I SRM-35-I	1 x 15	1 x 15	1 x 20	1 x 35					May be shared
Store - Files	STFS-10-I				1 x 10					Optional, depends on record storage operational policy
Store - Photocopy/ Stationery	STPS-8-I STPS-10-I	1 x 8	1 x 8	1 x 10	1 x 10					
<b>Sub Total</b>		<b>346.5</b>	<b>555.0</b>	<b>798.0</b>	<b>1375.5</b>					
<b>Circulation %</b>		<b>40</b>	<b>40</b>	<b>40</b>	<b>40</b>					
<b>Area Total</b>		<b>485.1</b>	<b>777.0</b>	<b>1117.2</b>	<b>1925.7</b>					

Note 1: Offices to be provided according to the number of approved full time positions within the Unit

Please note the following:

- Areas noted in Schedules of Accommodation take precedence over all other areas noted in the FPU.
- Rooms indicated in the schedule reflect the typical arrangement according to the Role Delineation.
- Exact requirements for room quantities and sizes will reflect Key Planning Units identified in the Service Plan and the Operational Policies of the Unit.
- Room sizes indicated should be viewed as a minimum requirement; variations are acceptable to reflect the needs of individual Unit.
- Office areas are to be provided according to the Unit role delineation and the number of endorsed full time positions within the Unit
- Staff and support rooms may be shared between Functional Planning Units dependant on location and accessibility to each unit and may provide scope to reduce duplication of facilities.

## 6 References and Further Reading

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

- AHIA, Australasian Health Facility Guidelines, Part B Health Facility Briefing and Planning, Intensive Care - General, Rev 6, 2016; refer to website: <https://healthfacilityguidelines.com.au/health-planning-units>
- Guidelines for Design and Construction of Hospitals and Outpatient Facilities; The Facility Guidelines Institute, 2014, refer to website [www.fgiguideines.org](http://www.fgiguideines.org)
- DH (Department of Health) (UK) Health Building Note 57: Facilities for critical care, 2003, refer to [www.estatesknowledge.dh.gov.uk](http://www.estatesknowledge.dh.gov.uk)



The International Health Facility Guidelines recommends the use of HFBS “Health Facility Briefing System” to edit all room data sheet information for your project.

HFBS provides edit access to all iHFG standard rooms, and departments, and more than 100 custom report templates.

## HFBS Health Facility Briefing System



### Briefing Module

The Health Facility Briefing System (HFBS) has numerous modules available via annual subscription. It suits healthcare Architects, Medical Planners, Equipment Planners Project Managers and Health Authorities.

Use the HFBS Briefing Module to quickly drag in health facility departments or pre-configured room templates from the iHFG standard, edit the room features such as finishes, furniture, fittings, fixtures, medical equipment, engineering services. The system can print or download as PDF more than 100 custom reports including room data sheets, schedules, and more...

To learn more about the HFBS web-based Healthcare Briefing and Design Software and to obtain editable versions of the “Standard Components” including Room Data Sheets (RDS) and Room Layout Sheets (RLS) offered on the iHFG website, signup for HFBS using the link below.

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