Day Surgery/ Procedure Unit

1 Introduction

The Day Surgery/ Procedure Unit provides a safe and controlled environment for the operative care of patients undergoing diagnostic/ surgical procedures under local or general anaesthesia and peri-operative care including post procedure recovery within a stand-alone facility. Such a facility may be on a hospital campus or independent of hospital care.

Day Surgery is sometimes referred to as Outpatient Surgery, Day Care or Minor Surgery, depending on the context of discussion.

Description

A Day Surgery/ Procedure Unit is where operative or endoscopic procedures are performed; and admission, preparation and procedure occur within the same day with recovery/ discharge is completed in a period less than 24-hours. Therefore, the name “Day” Surgery does not necessarily imply that the unit only functions during daylight hours.

The Unit will include one or more Operating Rooms, with provision to deliver anaesthesia and accommodation for the immediate post-operative recovery of day patients.

Many components of a Day Surgery Unit including the Operating Rooms, Recovery Rooms and Staff Change Rooms may be fully integrated with an Operating Unit.

A Day Surgery Unit may be collocated with an Endoscopy Unit, sharing some of the patient management facilities such as Reception, Waiting, Pre-Op holding and Recovery.

The range of procedures that may be undertaken in a Day Surgery/ Procedures Unit may include:

- Surgical procedures, particularly ENT, Dental, Plastic Surgery, Ophthalmology
- Endoscopy - gastrointestinal, respiratory, urology
- Electroconvulsive Therapy (ECT) for mental health inpatients
- Day Medical Procedures including intravenous infusions and minor treatments.
- Interventional imaging includes angiography, cardiac catheter procedures undertaken in imaging Units.
- Ortho, Hand, and Gynecology

The full list of surgeries which may be carried out in a Day Surgery/ Procedure Unit will depend on the facility’s operational policy, availability of the necessary skilled staff. It will also depend on the ability to safely perform the surgery within the Unit without immediate support of a full Hospital’s resources.

In the context of this Functional Planning Unit, the term Surgery has the same meaning as Procedure.

For specific details on provisions for Endoscopy, refer to Endoscopy Unit, in these Guidelines.

2 Functional & Planning Considerations

Hours of Operation

In a Day Surgery/ Procedure Unit the hours of operation will depend on the model of care adopted. For pure Day Surgery (or same-day surgery), the typical hours of operation will be from early morning to evening (6 AM to 8 PM) on working days excluding weekends.

However, by adopting the 23-hour surgery model (described below), surgery may take place through late afternoon with recovery overnight and discharge in early morning. By the time overnight patients are discharged, a new group of patients will arrive. Therefore, under the 23-hour surgery model, the facility itself will never close and effectively have a 24-hour operation.

Similarly, there is no barrier to restricting the operation working days. The operation may continue through the weekend.
**Operational Models**

The range of options for a Day Surgery/Procedure Unit may include:

- A standalone center, fully self-contained
- A dedicated fully self-contained unit within a hospital
- A Unit collocated with a specialist clinical service such as Gastroenterology or Respiratory Medicine, within an acute hospital.
- A Unit collocated with the Operating Unit with shared facilities.
- A Unit collocated with the Endoscopy Unit with shared facilities.

If the facility is part of an Acute Care Hospital or other Medical Facility, services can be shared, as appropriate to minimise duplication.

**Model of Care**

Up to 70% of all surgery may be performed as Day Surgery as opposed to Inpatient Surgery. Every surgical case performed as Day Surgery will save between 1 to 3 bed-days as inpatient unit (IPU) beds will not be occupied by the patient. This will save costs whilst preserving valuable IPU beds for major inpatient surgery.

Models of care will affect the service plan and operational policies of a facility. Therefore, it is important to determine the model of care as one of the following:

- Day Surgery for same day patients who are discharged home before midnight.
- 23-Hour Surgery, as above but recovery overnight and discharge home in the morning
- DOSA (Day of Surgery Admission), as above followed by transfer to an inpatient unit or short stay unit for extended recovery. The DOSA unit can only exist as a unit on a hospital campus, located within, or connected to the hospital.

The above models of care are described in greater detail below.

**Day Surgery**

In conventional Day Surgery, (or One-day Surgery) patients will generally undergo a pre-admission assessment to streamline admission procedures. Day Surgery patients should be organized to arrive very early (e.g. 6-7 am) with the aim of starting surgery as soon as possible (e.g. at 7-8 am). Day Surgery patients will recover in the unit and go home before the evening. This means sufficient time should be set aside for the last patient’s recovery. The last surgery may be around 4 pm or earlier. In a typical stand-alone Day Surgery Centre, all patients are discharged; and the facility is closed before midnight.

As in a full Operating Unit, Day Surgery/Procedure Units which performs surgery under general anaesthesia will require both Stage 1 and Stage 2 recovery facilities.

However, for some very minor procedures, the patient may not undergo general anaesthesia or may wake up immediately after surgery. These patients do not require Stage 1 Recovery and following the procedure they can be taken directly to Stage 2 Recovery.

Endoscopy procedures may be integrated with Day Surgery. Patient may follow the same patient flows as Day Surgery. It is anticipated that over time many types of surgery will require a form of endoscopy. Therefore, surgical facilities need to regard every operating room as an endoscopy theater. With careful design it is not necessary to perform endoscopy in a separate unit. As long as the endoscopy rooms are discretely located at one end of the surgical unit, there should be no need to duplicate other facilities. For dedicated, stand-alone Endoscopy, refer to the separate Endoscopy Unit Functional Planning Unit (FPU) within Part B of these Guidelines.

Similarly, a Catheter Lab may be integrated with a Day Surgery Unit as it can utilize many of the same patient management facilities but with a separate procedure room and control room.

The typical Day Surgery patient flow diagram is shown below:
Part B: Health Facility Briefing & Design
Day Surgery / Procedure Unit

Figure 1: Day (or Outpatient) Surgery patient flow diagram

23-Hour Surgery

Under the above Day Surgery models, the Stage 2 Recovery facilities will be unused overnight. This is seen as a waste of resources and valuable investment, resulting in the introduction of 23 Hour Surgery. 23-Hour Surgery is very similar to Day Surgery with the exception that procedures can be scheduled at any time of the day as there is no operational time limit imposed on procedures.

The patient may be admitted at any time including in the late afternoon with a scheduled surgery at any time including late afternoon or evening. Therefore, the patient may recover in the Stage 1 Recovery then stay overnight (may consider a Private room as an optional for a Private sector) in the Stage 2 recovery which has been enhanced for overnight stay. The patient is then discharged the next morning prior to the arrival of other patients requiring day surgery. Additional overnight nursing personnel and suitable facilities for the patient’s overnight stay (e.g., toilets, showers with reasonable privacy) must be provided.

Patient admission and discharge in this model must occur in a period of no more than 24 hours regardless of the starting and finishing time. The staffing and services attending to the patients must be equal to the daytime with no compromises.

The patient flow diagram for this model is shown below:

Figure 2: 23-Hour Surgery patient flow diagram

DOSA (Day of Surgery Admissions)

This model is only applicable to a Day Surgery/Procedure Unit located within a hospital campus. Patients are not expected to be discharged on the same day or even overnight but will be admitted to the hospital on the ‘day of surgery’, not earlier.

Patients may undergo more complex surgeries requiring a length of stay between 1 to 4 days in an Inpatient Unit post-surgery. Unlike the Day Surgery and 23 hours surgery, Day of Surgery (DOSA) patients are formally admitted to an Inpatient bed after Recovery Stage 1. Similar to 23-hour Surgery, operations scheduled under the DOSA model can take place in late hours of the day. The advantage of this model is that for each DOSA patient, one bed-day will be saved resulting in more reduced costs for the healthcare operator and ultimately the patient.

As this model depends on availability and accessibility to an Inpatient Unit, it will only suit stand-alone facilities which are located within a hospital campus with direct link from the DOSA Unit to an Inpatient Unit. The common patient flow in this model is demonstrated below:
Part B: Health Facility Briefing & Design
Day Surgery / Procedure Unit

Figure 3: Same-day Surgery/ DOSA patient flow diagram

3 Unit Planning Models

There are numbers of basic and acceptable planning geometries for Day Surgery Units.

The surgical areas of the unit are very similar to the Operating Unit FPU, which may well have an integrated Day Surgery Function. The main difference is that facilities for receiving Inpatients are not required. However, additional facilities for receiving ambulant patients such as reception and waiting are required.

It is typically assumed that a Day Surgery Centre is smaller than a hospital based Operating Unit. This may be true for most facilities at the current time. However, the trend is to have larger Day Surgery facilities performing increasingly complex procedures. Therefore, over time any differences based on size will diminish.

Planning models include:

- Combined operating and procedure rooms with appropriate numbers of pre-op (pre-operative) holding and post-op (post-operative) recovery areas
- Linked but separate peri-operative unit (combined pre-op and post-op), for admission and recovery of day surgery and DOSA patients
- The use of an Inpatient Unit, set aside to act as pre-op and post-op recovery stage 2 and typically referred to as a Day Care Ward
- Co-located pre-admission outpatient unit for sharing of administrative support and waiting areas.

Functional Areas

The Day Surgery/ Procedure Unit may consist of a number of Functional Areas/ Zones:

- Entry/ Reception including:
  - Reception and Waiting
  - Consulting and Interview rooms
  - Storage for files, photocopier, and printers
  - Public amenities, toilets for waiting patients and relatives unless available nearby.
- Patient Holding and Preparation including:
  - Pre-op holding bed bays.
  - Staff Station
  - Change rooms and changed waiting areas (separate for males and females), optional if pre-op holding bays are provided
  - Patient toilets and lockers
- Operating/ Procedures area with:
  - Operating rooms, appropriate to the procedures to be undertaken in the unit.
  - Anesthetic induction rooms (optional)
  - Scrub bays
  - Clean-up rooms shared between operating rooms
  - Sterile stock
  - Consumables storage
- Recovery Areas that may also be used for extended recovery where patients are discharged
within 23 hours:
- Stage 1 recovery bed bays for immediate post-operative/ recovery
- Stage 2 recovery bed and recliner chair spaces for continued recovery and staff supervision
- Discharge lounge for patients recovered, changed and ready to be discharged (optional)
- Support areas including utilities, storage for linen stock
- Patient Toilets
- Patient Showers if recovery areas are used for overnight accommodation under 23-hour model.

- Support Areas including:
  - Storage for mobile equipment and consumable stock used in the unit
  - Cleaner’s room

- Staff Areas incorporating:
  - Change rooms with showers, toilets and lockers
  - Offices
  - Meeting Room (optional)

Some of the above zones and components are described and guidance is provided below:

Entry
A covered Entrance for dropping off and collection of patients after surgery shall be provided. The Entry may be a shared facility and shall include:
- Reception and information counter or desk
- Waiting areas that allow for the separation of paediatric and adult patients, if organized Paediatric Services are provided.
- Convenient access to wheelchair storage
- Convenient access to public toilet facilities

In stand-alone Day Surgery buildings, it is desirable to separate the external building entry from the Day Surgery Reception area with a public lobby.

Ambulance Access
A discreet pick-up point, preferably under cover, shall be provided for the transfer of patients to and from the Day Surgery/ Procedure Unit.

Car Parking
Adequate car parking facilities with convenient access needs to be provided.

Reception
The Reception is the receiving hub of the Day Surgery/ Procedures Unit for patients and accompanying relatives. The reception also serves as the main access control point for the unit to ensure the security of the unit. Patients must announce their presence and register at the reception. This may be accomplished manually or electronically.

Waiting Areas
Waiting areas should provide suitable seating for a range of occupants including those with limited mobility with convenient access to amenities. Waiting areas should be sized to accommodate the maximum number of visitors and waiting relatives. Waiting areas should allow for the discrete separation of females and males.

Clinical Records
A secure room or cupboard shall be provided with provision for storage, recording and retrieval of clinical records. If geographically appropriate, and if the Day Surgery/ Procedures Unit is part of,
or attached to, an acute care hospital, the general clinical records facility might be used in lieu of a dedicated and separate room.

**Pre-operative Examination/ Preparation Areas**

- **Consult/ Examination Rooms**

  A number of rooms will be required for patient consultation and interview prior to procedures. The number of rooms will be determined by the Service Plan and Operational Policy of the Unit.

- **Patient Change Areas**

  Separate areas shall be provided where outpatients can change from street clothing into hospital gowns and be prepared for surgery, convenient to the waiting area. The patient change areas shall include waiting rooms and lockers. Design of change areas is to facilitate management of patient lockers, patient property, and keys. There are two models which can be adopted.

  **Option 1** - Separate change rooms are provided for male and female patients. The change rooms typically incorporate toilets, hand wash basins, and lockers. After changing, patients need a space to temporarily wait in a separate area outside the change rooms until their turn for surgery. Depending on the operational model, they may be allowed to walk to the designated nearest operating room, use a wheelchair, or lie on a trolley bed for immediate transfer to the operating room. Under this option a minimum number of patient holding bed bays are required. In this model, patient privacy should be protected, and they should be able to walk to the holding bays quickly and directly.

  **Option 2** - It is possible to replace change rooms with relatively private bed bays, grouped for use by men or women. The patients may change within the bed bays, then lie on the trolley bed, ready to be transferred to the operating room. If this model is adopted, separate toilets and lockers will be required. Patient’s street clothes and other belongings are typically put in the patient’s own gym bag or zipped plastic bag supplied by the unit. As this option relies entirely on bed bays for both changing and waiting, a larger number of patient holding bed bays will be required. A minimum of 1 per operating room is necessary. However, a larger number is recommended for maximum flexibility. Option 2 is increasingly the default and preferred model for day surgery as it provides maximum privacy and enhanced patient experience.

- **Pre-op Holding Area**

  A holding area may be provided where gowned patients enter after changing and wait for their procedure under Option 1 or 2 above. Such an area must have access to nurse call services. The pre-operative holding area shall be provided with the following minimum requirements as appropriate to the proposed service:

  - A patient trolley or patient seating
  - Privacy screening
  - Handbasins with liquid soap and paper towel fittings
  - Patient nurse call/ emergency call buttons with pendant handsets and indicators
  - Medical gases including oxygen and suction and power outlets to each bed

- **Preparation Room**

  A preparation room may be required for patients undergoing certain procedures such as Endoscopy or Ophthalmology. If included, the preparation room should include:

  - Handbasin - Clinical
  - Bench, and cupboards for setting up of procedures
  - Adequate space for procedures equipment trolleys
  - Examination couch
  - Patient privacy screening
Procedural Areas

Operating/ Procedures Rooms

The design of the Operating/ Procedure Rooms must allow for adequate space, ready access, free movement and demarcation of sterile and non-sterile zones. Standard Components are provided for a range of different type of Operating Rooms. Minimum operating rooms sizes, suitable for most procedures including the use of general anaesthesia is 42m². Operating rooms used exclusively for minor operations/ procedures without the use of general anaesthesia may be as small as 36m², however, 42m² is recommended for greater flexibility. Minimum dimension shall be no less than 5m².

Modular operating rooms may be used, whilst complying with all the requirements of these Guidelines including the minimum size. However, Modular operating rooms are not mandatory or preferred by these Guidelines.

Endoscopy Procedures Rooms

This Unit may also incorporate Endoscopy rooms. The number and function of Endoscopy rooms will be determined by the Service Plan or Feasibility Study. Room sizes for Endoscopy may vary, dependent upon:
- The use of video equipment
- Electrosurgical laser treatment
- Fluoroscopy equipment installed
- Multiple endoscope activity
- Multiple observers
- The use of mobile X-Ray units

Refer to separate FPU - Endoscopy Unit for requirements.

Scrub Bay

Scrub facilities shall be located adjacent to the Operating Rooms. Scrub Bays require sufficient enclosure to ensure the mechanical ventilation system can extract the air and create a relative negative pressure. This is to contain the floating micro-droplets of water and minimise the spread of contaminants potentially floating in the air.

Scrub bays do not require a door to the corridor and can be arranged in a semi-enclosed bay. However, there must be a door access to the operating room. Scrub bays created directly inside the operating rooms are strictly prohibited. Open scrub troughs along the main Operating Unit corridors are not considered desirable in case of dedicated Endoscopy Rooms, an additional hand wash facility may be provided inside the room.

The door from the scrub bay to the operating room may be dedicated and direct. It should incorporate features so that opening the door in either direction does not require touching the door or door handle. Alternatively, surgeons and nurses can use the main doors to the operating room as long as electric doors are provided with knee, elbow, gesture or similar activation pads.

Direct doors from scrub rooms to the operating rooms should ideally be light doors, opening both ways by light pressure either with the elbow or the hip. This allows the surgeons and nurses to enter the operating rooms backwards without touching the door or door handle.

Optionally, a window may be provided between the scrub bay and the operating room. This allows the surgeons to observe the way the room is being set up for the next case.

Recovery Areas

Recovery areas shall be separated into male and female zones with sufficient privacy screening.

There are two types of Recovery space, which are used in according to the operational models explained earlier.
Recovery Stage 1 – After the procedure which require General Anaesthesia, patient is taken to Recovery Stage 1 and kept there until the effect of anaesthesia dissipates, patient is conscious and gag reflex is present. During stage 1 recovery, close monitoring of the patient is essential.

Following Recover Stage 1, patients who undergo “Day Surgery” are moved to Recovery Stage 2, vacating the bed for new patients.

Patients who stay overnight under the “23-hour surgery” model, stay in Stage 2 Recovery, planned and equipped with sufficient privacy and access to toilets and showers.

If Paediatric Surgery is part of the function, the Recovery Room shall provide for the needs of parents/attendants.

Stage 1 Recovery

The number of bed-bays in the Stage 1 Recovery Area will be dependent upon the nature of surgery or procedures performed as outlined in the Operational Policy and the proposed throughput. Considering the nature and fast throughput of Day Surgery facilities, it is considered that as a minimum, 1.5 (but ideally 2) Stage 1 Recovery bed bays per Operating Room shall be provided (and rounded up).

The Stage 1 Recovery area will require the following support facilities:

- Staff station/s with a centrally located resuscitation trolley.
- Bays for linen and mobile equipment
- Clean Utility/ Medication Room
- Dirty Utility
- Storeroom
- Patient toilets
- Showers if used for overnight stay under the “23-hour surgery” model.

Stage 2 Recovery

Room may be provided as required to accommodate:

- Patients who have undergone local anaesthesia but require a period of observation.
- Patient who regained consciousness immediately after the procedure but require further observation.
- Patients who have undergone general anaesthesia, who must first spend some time in the Recovery Stage 1, then move to Recovery Stage 2 on foot or wheelchair.

Stage 2 Recovery requires, as a minimum, a number of comfortable recliners. However, a percentage of bed bays may also be incorporated for patients who may feel uncomfortable on recliners.

Patients who undergo local anaesthesia or are already awake upon leaving the operating room may be taken directly to the Recovery Stage 2, by-passing Recovery Stage 1.

The number of recliner/bed bays in the Stage 2 Recovery Area will be dependent upon the following:

- Nature of surgery or procedures typically performed as outlined in the Operational Policy
- The expected throughput based on the surgery time + changeover
- The expected recovery times.

For fast throughput operations more Stage 2 recovery bays are required. All of the above factors may change on a daily basis and over time. Therefore, on balance it is considered that as a minimum 2 (but ideally 3) Stage 2 recovery bays per Operating Room shall be provided.

Within Recovery Stage 2 patients may remain in surgical gowns or change back to street clothes. Whilst in Recovery Stage 2 patients may want to drink or eat, therefore access to facilities for serving drinks and light meals such as sandwiches should be provided.
Depending on the operational model, Recovery Stage 2 may be combined back-to-back with the Pre-Operative holding areas, but management should ensure in-coming and out-going patients are not mixed or confused.

In facilities which mainly cater for Day Surgery (not inpatient surgery), Recovery Stage 2 may be placed back-to-back with Recovery Stage 1.

All Recovery bed bays recliner bays and support areas shall comply with the details identified in Standard Components Room Data Sheets and Room Layout Sheets.

Discharge Lounge

Following Recovery Stage 2, patients may be discharged via the reception/waiting area. Optionally, in larger facilities (e.g. more than 6 operating rooms) a dedicated Discharge Lounge (also referred to as Departure Lounge or Recovery Stage 3) may be provided for a formal handover of the patient to family members carers or transport staff.

Peri-Operative Area

Where Day Surgery/Procedures (day only surgical service) are provided within the same area as Inpatient Acute Surgery (shared facility), the design shall consider the need to separate the two distinct functions at the incoming side.

This means the operating theatres, staff change rooms and recovery stage 1 may be shared between Inpatient Surgery and Day Surgery.

Inpatient Surgery will have its own separate entrance for access by the Inpatients. However, Day Surgery will have its own Peri-Operative facilities including pre-op holding and stage 2 recovery, separated from Inpatient Surgery.

Staff Areas

Administration Areas

General and individual offices shall be provided as required for business transactions, records, administrative and professional staff. These shall be separate from public and patient areas with provision for confidentiality of records.

Enclosed office spaces shall be provided for:

- Administration and consultation
- Manager/ Nurse Unit Manager as required.

Staff Amenities

Appropriate change rooms, toilet and showers shall be provided separately for male and female personnel (nurses, doctors, and technicians) working within the Day Surgery/Procedure Unit. The Change Rooms shall contain adequate lockers, showers, toilets, hand basins and space for donning surgical attire and booting. Staff Change Rooms shall be arranged to encourage a one-way traffic pattern so that personnel entering from outside the surgical suite can change and move directly into the Day Surgery/Procedure Unit.

Alternatively, the entrance to the Change Rooms may be planned in direct view of a Staff Station at the entrance to the Day Surgery/Procedure Unit. The Change Room entrance door shall be provided with locks or electronic access devices to prevent the entry of unauthorised persons into the Day Surgery/Procedure Unit.

Staff Change rooms may not be shared with Patient Change rooms.
4 Functional Relationships

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

External Relationships

The Day Surgery/Procedure Unit will have functional relationships with the following units:

- Pre-Admission Clinic (part of Outpatient Clinics)
- Main Entrance Unit
- Medical Imaging Unit
- Laboratory Unit
- Inpatient Unit (if used as part of a DOSA operational model—refer to Operating Unit for details)
- Clinical Records Unit
- Administration Unit
- Sterile Supply Unit
- Catering Unit

Internal Relationships

Within the Unit, key functional relationships will include:

- Unidirectional patient flow from arrival at Reception, through Changing, Holding, Procedure Rooms, Recovery rooms, then discharge to home or transfer to an Inpatient Unit (under DOSA)
- Separation of clean and dirty traffic flows
- Staff access to the Unit via dedicated change rooms
- Staff visibility of patient areas for patient supervision and safety
- Transfer of sterile instruments from SSU to the operating room/s
- Transfer of sterile supplies and consumables to the operating room/s

The Internal Relationships are best demonstrated by Functional Relationship Diagrams below.

Functional Relationship Diagrams

The requirements for infection control and patient management result in a number of planning 'models' that have proved successful through numerous built examples and many years of practice. For a detailed discussion of the various 'models' and their permutations refer to separate FPU - Operating Unit, Functional Relationship Diagrams and the air pressurization regimes required. The same requirements apply to Day Surgery Units.

Here, for convenience the Single Corridor model of surgery has been provided as it applies to a large majority of medium sized stand-alone Day Surgery Centers. For larger facilities, readers are referred to the Double Corridor model provided as part of the Operating Unit Functional Relationship Diagrams.
Note: Blue dotted lines and arrows refer to external relationships where the unit is located on a hospital campus as a stand-alone unit. These are not required when the unit is independent of a hospital.

In a Unit that integrates Inpatient Surgery and Day Surgery, the Pre-Operative area has a similar status as an Inpatient Unit. Patients within the Pre-operative area are regarded as outside the Operating Unit until the door access to the inside corridor of the Operating Unit (from blue area to yellow corridor).
5 Design Considerations

Patient Treatment Areas

The Day Surgery/Procedure Unit should be designed to accommodate all types of patients using the Unit as determined by the operator’s clinical service plan. This may include paediatric, bariatric or disabled patients.

The design should also be able to accommodate changes in equipment technology as well as changing workload and variability to throughputs. Use of modular components and standard rooms sizes are recommended to provide flexibility of design.

Pre-operative and post-operative patient facilities can be co-located to share resources such as staff stations, utilities and storage, if required. Patient areas may require gender separation, according to local customs.

Environmental Considerations

Acoustics

Design should consider reduction of the ambient noise level within the unit, particularly waiting areas.

Acoustic privacy treatment will be required to:

- Consulting / interview rooms
- Preparation rooms where patient pre-treatments may be undertaken
- Operating/Procedure Rooms

The transfer of sound between clinical spaces should be minimized to reduce the potential of staff error from disruptions and miscommunication and to increase patient safety and privacy. Noisy areas such as Staff rooms should be located away from procedural areas.

It should be noted that it is common to have sound systems to provide piped music in operating rooms. Therefore, the acoustic design should take this into consideration.

Natural Light

The need for an external view from the Operating Room is an important consideration. Provision of windows need to consider the following:

- Vision from the Operating Room could be through a corridor, set up area or directly to the external environment.
- Many procedures require black-out, so any windows should incorporate black-out features.
- There are heating, cooling, and shading implications for windows in the Unit located on the outside of the building that may have an impact on the recurrent costs for maintenance and cleaning.
- Viewing windows from a corridor to the Operating Unit can be useful for supervision and training purposes.
- Any window to the operating room must be fixed, double glazed with internal louvers for light control.
- Windows to Recovery areas are desirable, but not mandatory.
- Windows to Staff Lounge where staff spend a considerable amount of their time should be given a high priority in design. However, this is not a mandatory requirement.

Privacy

The design of the patient areas within the Day Surgery Unit needs to consider the contradictory requirement for staff visibility of patients while maintaining patient privacy.

Unit design and location of staff stations will offer varying degrees of visibility and privacy. The expected patient acuity, age, gender, and level of dependency should be considered.
Each bed bay or recliner bay in pre-op and post-op areas shall be provided with bed screens (curtains) to ensure privacy of patients when needed. Refer to the Standard Components Room Data Sheets and Room Layout Sheets for examples.

The following features shall be integrated to the design of the Unit:

- Doors and windows to be located appropriately to ensure patient privacy and not comprise staff security.
- Discreet spaces to enable confidentiality of discussions related to a patient and storage of patient’s medical records.
- Privacy screening to bed and recliner bays for patients.
- Consultation, Interview and Preparation rooms should not be visible from the public or waiting areas; examination couches should not face the door.
- Location of patient change areas to provide direct access to waiting areas to prevent patients in gowns travelling through public areas when changed before and after procedures.
- Separation of male, female, and paediatric changing rooms.
- Separation of male, female and family waiting areas as required and preferred by local customs.

**Accessibility**

**External**

In a stand-alone Day Surgery facility or for a Unit located within a hospital but with its own direct entry, a weatherproof vehicle drop-off area for patients with limited mobility or wheelchair-bound should be provided.

**Internal**

Patient areas within the Unit must provide sufficient clearance for wheelchair-bound patients and comply to the local accessibility requirements. Reception counters and Staff Station counters are to include a low section suitable for wheelchair users.

**Curtains and Blinds**

Windows that require screening within the entire Operating Unit shall be double glazed with internal blinds. Surface mounted blinds or window curtains are not permitted in Day Surgery/Procedure Unit due to difficulty in cleaning and maintaining a dust-free environment.

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

Privacy bed screens must be provided to each bed bay in Holding and Recovery areas. Privacy bed screens must be washable, fireproof and cleanly maintained at all times. Disposable bed screens may also be considered.

**Add-on Modules**

A number of compatible modules may be integrated with a typical Day Surgery/Procedure Unit. The modules include Catheter Labs and Endoscopy.

In doing so, the procedural areas (e.g., Cath Lab or Endoscopy Room) may be grouped together with the Day Surgery Operating Rooms or slightly separated.

Refer to separate FPU’s for the requirements of these facilities and ensure all items are provided or shared within an integrated unit.

**Doors**

Specific door clearances can be found in the Room Layout Sheets available in the Standard Components of these guidelines. In general, where bed/trolley access is required, an unobstructed width of a clear 1400mm minimum should be considered. Clearances should be larger if manoeuvring of larger equipment will take place and as determined by the Operational Policy.
Refer to Part C – Access, Mobility and OH&S of these Guidelines for further details.

**Drug Storage**

The storage for controlled or dangerous drugs is commonly regulated by a local Authority. In addition to this, each facility will have its own operational and drug storage policy.

A lockable refrigerator or a refrigerator located within a lockable room is required to store restricted substances.

**Ergonomics/ OH&S**

Design of clinical spaces including Operating and Procedure rooms must consider Ergonomics and OH&S issues for patient and staff safety and welfare. Particular attention should be given to storage of stock and equipment, to minimise manual handling and provide minimum distances between shelving aisles.

Refer to Part C – Access, Mobility and OH&S of these Guidelines for further details.

**Finishes**

The aesthetics of the Unit should be warm, relaxing and non-clinical as far as possible. Finishes including fabrics, floor, wall and ceiling finishes, should be appropriate to the highly clinical nature of this unit including the following considerations:

- Easy of cleaning
- Infection control
- Acoustic properties
- Durability
- Fire safety
- Movement of equipment floor finishes should be resistant to marring and shearing by wheeled equipment.

Day Surgery/ Procedure Units shall have the following finishes:

- Floors that are smooth, non-slip, impervious, continuous, and cleanable with aggressive chemical agents
- Wall finishes which are seamless, impervious, and washable
- Ceilings which are smooth and impervious and cleanable
- Floors and ceiling finishes should be anti-bacterial and anti-fungal.
- Intersections of walls and ceilings to be smooth without any gaps or joints

In areas where clinical observation is critical such as Operating/ Procedure rooms, Recovery and bed bays, lighting and color selected must not impede the accurate assessment of skin tones.

Refer to Part C – Access, Mobility and OH&S of these Guidelines for further details.

**Restricted Staff Access**

Hospital staff may not enter the Unit without first changing in the change rooms provided. Change rooms must therefore be located on the perimeter of the unit with a linear flow (only in one direction). The same applies to staff delivering patients on beds and trolleys, those delivering food for the staff rooms and those delivering boxes to the non-sterile store. A typical and practical solution is to consider a “transfer” or “hand-over” zone where items are passed outside to the inside, across a table, through a hatch or across a red line.

**Safety and Security**

The Day Surgery/ Procedure Unit shall provide a safe and secure environment for patients, staff and visitors, while maintaining a non-threatening and supportive atmosphere conducive to recovery.
Internal spaces and zones should offer a high standard of security through grouping functions, controlling access and egress from the Unit and providing optimum observation for staff. Patient holding, procedural and recovery areas will require restricted and controlled access to prevent unauthorised entry by visitors or others.

The arrangement of spaces and zones shall offer a high standard of security through the grouping of like functions, control over access and egress from the Unit and the provision of optimum observation for staff. The level of observation and visibility has security implications.

**Building Services Requirements**

**Information Technology (IT) and Communications**

The Day Surgery/ Procedure Unit will require special consideration of the following IT/ Communication system:

- Electronic Health Records (EHR) which may form part of the Health Information System (HIS), incorporating Patient Administration System (PAS)
- Hand-held tablets and other smart devices
- Picture archiving communications systems (PACS) and location of monitors
- Paging and personal telephones replacing some aspects of call systems.
- Voice and data cabling for telephones and computers/ DECT
- Bar coding systems for supplies, x-rays and records
- Wireless network requirements
- Videoconferencing requirements for meeting rooms
- Digital operating room requirements particularly linkages to seminar and education facilities for teaching purposes
- Communications rooms and server requirements
- Scheduling systems to manage Procedure or operating room sessions.
- Management and statistical information required for administration and quality assurance.

**Heating, Ventilation and Air conditioning (HVAC)**

The Operating Rooms will require special air-conditioning with positive pressure, HEPA filtration. Temperature, humidity and air changes per hour are to comply with relevant standards and guidelines established in these guidelines as well as other standards and guidelines referenced. Individual Operating Room temperatures should be controllable by staff from within the room.

Refer to Part E – Engineering Services in these Guidelines for specific details.

**Hydraulics**

Warm water supplied to all areas accessed by patients within the Unit must not exceed 43 degrees Celsius. This requirement includes all staff handwash basins and sinks located within patient accessible areas.

**Medical Gases**

The Day Surgery Unit shall provide medical gases and quantities of outlets identified in Standard Components Room Data Sheets and Room Layout Sheets to Operating/ Procedures rooms and various Pre-op and Post-op bed bays.

Each space routinely used for administration of inhalation anaesthesia or analgesia shall include a gas scavenging system to vent waste.

Medical Gases must be dedicated to each patient. Gas outlets may not be shared between two patients in bed/chair bays.
Staff Call
Patient, Staff Assist and Emergency Call facilities must be provided in all patient areas (e.g., Anaesthetic Induction Room, Holding bays, Recovery bay, Lounges, Change Rooms and toilets) in order for patients and staff to request an urgent assistance.

The individual call buttons will alert to a central module situated at or adjacent to the Staff Station. Calls must be audible in Utilities, Staff Room and Meeting Rooms within the Unit. The alert to staff members should be done in a discreet manner at all times. Calls left unanswered should have be escalated by the system automatically. In modern facilities, individual hand-held devices may be used and carried by clinical staff.

Radiation Shielding
If the Unit is undertaking procedures involving imaging, plans and specifications will require assessment for radiation protection by a certified physicist or other qualified expert as required by the MOH. The radiation protection assessment will specify the type, location and amount of radiation protection required according to the final equipment selections and layout. Radiation protection requirements must be incorporated into the final specifications and building plans.
Incorporate all radiation protection requirements into the final specifications and building plans and re-evaluate radiation protection if the intended use of a room changes, equipment is upgraded, or surrounding room occupancy is altered. Consideration should be given to the provision of floor and ceiling shielding when rooms immediately above and below are occupied.

Infection Control
Consideration of Infection Control is important in the design of this Unit. Separation of clean and dirty workflows in treatment and clean-up areas and separation of patient care areas and contaminated spaces and equipment is critical to the function of the Unit and to prevent cross infection. Procedure/ Operating rooms will be used for a variety of clients whose infection status may be unknown. Standard precautions must be taken for all clients regardless of their diagnosis or presumed infectious status. Staff hand washing facilities, including disposable paper towels, must be readily available and highly visible.

Standard precautions apply to the Day Surgery Unit areas to prevent cross infection between patients, staff and visitors.

Hand Wash Basins
Clinical hand-washing facilities shall be provided within all patient holding and recovery areas and convenient to the Staff Stations. The ratio of provision shall be a minimum of one clinical hand-washing facility for every four patient bays in open-plan areas.
Refer to Part D – Infection Control of these Guidelines for the requirements of hand wash basins.

Antiseptic Hand Rubs
Antiseptic hand rubs should be located so they are readily available for use at points of care, at the end of patient beds and in high traffic areas. The placement of antiseptic hand rubs should be consistent and reliable throughout facilities. Antiseptic hand rubs are to comply with Part D – Infection Control, in these guidelines.

Antiseptic Hand Rubs, although very useful and welcome, cannot fully replace Hand Wash Bays. Both are required.
Refer to Part D – Infection Control of these Guidelines for further information.

Isolation Rooms
By default, Operating Rooms will require Positive Pressure. The need for Negative Pressure Operating Rooms shall be determined by the Service Plan and Operational Policy of the Unit. Such a provision must be restricted to certain patient types.
The need for Isolation rooms (Positive and Negative Pressure) in Holding and Recovery areas is to be evaluated by an infection control risk assessment and will reflect the requirements of the Service Plan.
Any Endoscopy rooms integrated within the Day Surgery Unit may be designed with Positive Pressure or Negative Pressure. However, considering the range of usage of Endoscopy Rooms, it is recommended that all endoscopy rooms be designed with Negative Pressure. Switchable Negative/Positive pressure rooms must be avoided.

6 Components of the Unit

Standard Components

Standard Components are typical rooms within a health facility, each represented by a Room Data Sheet (RDS) and Room Layout Sheet (RLS). Sometimes, there are more than one configuration possible and therefore, more than one room layout sheet can be found in the Standard Components for a room with same function. They may differ in room size and/or the requirement of FF&FE items.

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

- Primary Room Information - includes Briefed Areas, Occupancy, Room Description, relationships and special room requirements.
- Building Fabric and Finishes - required fabric and finishes for the room’s ceiling, floor, walls, doors and glazing requirements.
- Furniture and Fittings - a list of fittings and furniture typically located in the rooms; furniture and fittings are identified with a group number indicating who is responsible for providing the item and/or installation. Their definitions are shown below:

<table>
<thead>
<tr>
<th>Group</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Provided and installed by the Builder/Contractor</td>
</tr>
<tr>
<td>2</td>
<td>Provided by the Client and installed by the Builder/Contractor</td>
</tr>
<tr>
<td>3</td>
<td>Provided and installed by the Client</td>
</tr>
</tbody>
</table>

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

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

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

The Operating Unit will consist of Standard Components to comply with details described in these Guidelines. Each FPU should be designed in compliance with Standard Components - Room Data Sheets and Room Layout Sheets, nominated in the Schedules of Accommodation below.
**Non-Standard Rooms**

Non-standard rooms are those which have not yet been standardized within these guidelines. As such there are very few Non-standard rooms. These are identified in the SOA as NS and are separately covered below.

**Exit Bay**

The Exit Bay is an area adjacent to the Operating/Procedure rooms which is designed to hold the patient bed/trolley during the procedure. The Exit Bed Bat should consider and include the following:

- 1 Exit Bay must be provided per Operating/Procedure Room
- Adequate space to accommodate patient bed without encroaching on circulation corridor.
- Adequate power should be provided to recharge the bed and any equipment attached.

### 7 Schedule of Equipment & Furniture

The Schedule of Equipment and Furniture below lists the major equipment required for the key rooms in this FPU.

<table>
<thead>
<tr>
<th>Room Name</th>
<th>Operating Room - General, room code (or-gn-i)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Air flowmeter</td>
<td>Endoscopy tower: laparoscopy</td>
</tr>
<tr>
<td>Anaesthesia unit: standard</td>
<td>Headlight: surgical</td>
</tr>
<tr>
<td>Bowl stand: single</td>
<td>Hypo-hyperthermia unit: general</td>
</tr>
<tr>
<td>Cabinet: server, OR integration</td>
<td>IV pole: mobile</td>
</tr>
<tr>
<td>Cabinet: storage, instrument, OR, double door,</td>
<td>Infusion pump: rapid, blood/solution warming, on stand</td>
</tr>
<tr>
<td>recessed</td>
<td>Oxygen flowmeter</td>
</tr>
<tr>
<td>Camera: in room</td>
<td>Infusion pump: single channel</td>
</tr>
<tr>
<td>Carrier stand, suction canisters</td>
<td>Pump: suction/ aspirator, portable</td>
</tr>
<tr>
<td>Control panel: surgical, recessed</td>
<td>Light: surgical, single, ceiling, with monitor arm</td>
</tr>
<tr>
<td>Defibrillator: with monitor</td>
<td>Stool: adjustable, OR, with backrest</td>
</tr>
<tr>
<td>Services pendant: ceiling</td>
<td>Suction adapter</td>
</tr>
<tr>
<td>Table: mayo</td>
<td>Light: surgical, single, ceiling, with two monitor arms &amp; camera</td>
</tr>
<tr>
<td>Warming cabinet: dual compartment, freestanding,</td>
<td>Medication dispensing system: automated, anaesthesia</td>
</tr>
<tr>
<td>500L</td>
<td>Monitor: cardiac</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Room Name</th>
<th>Patient Bay-Recovery Stage 1, room code (pbtr-rs1-12-i similar)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Air flowmeter</td>
<td>Oxygen flowmeter</td>
</tr>
<tr>
<td>IV pole: mobile</td>
<td>Light: procedure, single, ceiling mounted</td>
</tr>
<tr>
<td>Infusion pump: single channel</td>
<td>Monitor: cardiac</td>
</tr>
<tr>
<td></td>
<td>Suction adapter</td>
</tr>
</tbody>
</table>
8 Schedule of Accommodation

The Schedule of Accommodation (SOA) provided below represents generic requirements for this Unit. It identifies the rooms required along with the room quantities and the recommended room areas. The sum of the room areas is shown as the Sub Total as the Net Area. The total area comprises of the sub-total areas of these rooms plus an additional percentage of the sub-total applied as the circulation (corridors within the Unit). Circulation is represented as a percentage is the minimum recommended target area. Any external areas and optional rooms/ spaces are not included in the total areas in the SOA.

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

The Schedule of Accommodations are developed for particular levels of services known as Role Delineation Level (RDL) and numbered from 1 to 6. The table below shows three alternative SOAs for 3 sizes, 2 OR’s 4 OR’s and 12 OR’s. Due to the nature of a Day Surgery Centre, it may apply to all Role Delineation Levels (RDL’s) from 2 to 6. RDL’s. Role Delineation Levels 1, being Primary Care does not apply.

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

For stand-alone facilities, designers may add any other FPU’s required such as Main Entrance Unit, Medical Imaging Unit etc based on the business model.

Note: For Dedicated Endoscopy units SOA refer to Endoscopy FPU provided in these Guidelines.

The following should be considered in conjunction with the SOA/s provided below:

- Areas noted in Schedules of Accommodation take precedence over all other areas noted in the Standard Components.
- Rooms indicated in the schedule reflect the typical arrangement according to the Role Delineation and/ or capacity required for the clinical service.
- Exact requirements for room quantities and sizes reflect Key Planning Units (KPU) identified in the Service Plan and the Operational Policies of the Unit.
- All areas shown in the SOA follow the No-Gap system described elsewhere in these Guidelines. Refer to Part B Preliminaries.
- Room sizes indicated should be viewed as a minimum requirement; variations are acceptable to reflect the needs of individual Unit.
- Staff and support rooms may be shared between Functional Planning Units dependent on location and accessibility to each unit and may provide scope to reduce duplication of facilities.
- Offices to be provided according to the number of approved full-time positions within the Unit.
## Stand-alone Day Surgery/ Procedures Unit

<table>
<thead>
<tr>
<th>ROOM/ SPACE</th>
<th>Standard Component Room Codes</th>
<th>RDL 2-6 Qty x m²</th>
<th>RDL 2-6 Qty x m²</th>
<th>RDL 2-6 Qty x m²</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entry/ Reception</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reception/ Clerical</td>
<td>recl-10-i similar recl-15-i similar</td>
<td>1 x 12</td>
<td>1 x 15</td>
<td>1 x 15</td>
<td>2, 3 &amp; 4 staff respectively</td>
</tr>
<tr>
<td>Waiting Male</td>
<td>wait-10-i wait-15-i wait-30-i</td>
<td>1 x 10</td>
<td>1 x 15</td>
<td>1 x 30</td>
<td></td>
</tr>
<tr>
<td>Waiting Female</td>
<td>wait-15-i wait-20-i wait-30-i</td>
<td>1 x 15</td>
<td>1 x 20</td>
<td>1 x 30</td>
<td></td>
</tr>
<tr>
<td>Store - Files</td>
<td>stfs-10-i similar</td>
<td>1 x 8</td>
<td>1 x 10</td>
<td>1 x 10</td>
<td>Optional if electronic records in use</td>
</tr>
<tr>
<td>Store - Photocopy / Stationery</td>
<td>stps-8-i similar</td>
<td>1 x 8</td>
<td>1 x 8</td>
<td>1 x 8</td>
<td>Include secure paper/ recycling bin as required</td>
</tr>
<tr>
<td>Toilet - Accessible</td>
<td>wcac-i</td>
<td>1 x 6</td>
<td>1 x 6</td>
<td>1 x 6</td>
<td>Include baby change facilities as necessary;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>May share with common areas if close</td>
</tr>
<tr>
<td>Toilet - Public</td>
<td>wcpu-3-i</td>
<td>1 x 3</td>
<td>2 x 3</td>
<td>2 x 3</td>
<td>May share toilets in common areas if close</td>
</tr>
<tr>
<td>Consult/ Exam Room</td>
<td>cons-i</td>
<td>1 x 14</td>
<td>1 x 14</td>
<td>2 x 14</td>
<td></td>
</tr>
<tr>
<td>Interview Room</td>
<td>intf-i similar</td>
<td>1 x 9</td>
<td>1 x 12</td>
<td>2 x 12</td>
<td></td>
</tr>
<tr>
<td>Patient Holding/ Preparation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bay - Handwashing, Type B</td>
<td>bhws-b-i</td>
<td>1 x 1</td>
<td>1 x 1</td>
<td>3 x 1</td>
<td></td>
</tr>
<tr>
<td>Bay - Linen</td>
<td>bln-i</td>
<td>1 x 2</td>
<td>1 x 2</td>
<td>1 x 2</td>
<td></td>
</tr>
<tr>
<td>Change Cubicle - Accessible</td>
<td>chpt-d-i</td>
<td>2 x 4</td>
<td>4 x 4</td>
<td>8 x 4</td>
<td>Optional if holding bays provided, Male/ Female</td>
</tr>
<tr>
<td>Patient Bay - Holding</td>
<td>pbtr-h-10-i</td>
<td>2 x 10</td>
<td>4 x 10</td>
<td>1 x 10</td>
<td>1 per OR; may also be used for recovery</td>
</tr>
<tr>
<td>Property Bay</td>
<td>prop-3-i similar</td>
<td>1 x 2</td>
<td>1 x 3</td>
<td>2 x 3</td>
<td>Patient lockers</td>
</tr>
<tr>
<td>Staff Station</td>
<td>sstr-5-i similar</td>
<td>1 x 5</td>
<td>1 x 14</td>
<td>1 x 14</td>
<td></td>
</tr>
<tr>
<td></td>
<td>sstr-14-i similar</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toilet - Accessible</td>
<td>wcac-i</td>
<td>1 x 6</td>
<td>1 x 6</td>
<td>1 x 6</td>
<td>For Patient</td>
</tr>
<tr>
<td>Toilet - Patient</td>
<td>wcpt-i</td>
<td>1 x 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shower - Patient</td>
<td>shpt-i</td>
<td>1 x 4</td>
<td>1 x 4</td>
<td>1 x 4</td>
<td>Optional</td>
</tr>
</tbody>
</table>
### Day Surgery / Procedure Unit

<table>
<thead>
<tr>
<th>Waiting - Sub</th>
<th>wait-sub-i similar</th>
<th>2 x 5</th>
<th>2 x 7</th>
<th>2 x 10</th>
<th>Optional, Changed waiting space</th>
</tr>
</thead>
</table>

### Operating/Procedure Area

<table>
<thead>
<tr>
<th>Operating Room - Minor</th>
<th>or-ms-i</th>
<th>2 x 36</th>
<th>6 x 36</th>
<th>For minor operations including general anaesthetic, 42m² is recommended for greater flexibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure Room</td>
<td>proc-25-i</td>
<td>1 x 25</td>
<td>1 x 25</td>
<td>For local anaesthetic</td>
</tr>
<tr>
<td>Operating Room - General</td>
<td>or-gn-i</td>
<td>2 x 42</td>
<td>2 x 42</td>
<td>6 x 42</td>
</tr>
<tr>
<td>Anaesthetic Induction Room</td>
<td>anin-i</td>
<td>2 x 15</td>
<td>4 x 15</td>
<td>1 x 15</td>
</tr>
<tr>
<td>Scrub Bay</td>
<td>scrb-6-i</td>
<td>2 x 6</td>
<td>4 x 6</td>
<td>1 x 6</td>
</tr>
<tr>
<td>Exit Bay</td>
<td>NS</td>
<td>2 x 8</td>
<td>4 x 8</td>
<td>1 x 8</td>
</tr>
<tr>
<td>Clean-up Room</td>
<td>clup-7-i</td>
<td>1 x 7</td>
<td>2 x 7</td>
<td>2 x 7</td>
</tr>
<tr>
<td>Store - Sterile Stock</td>
<td>stss-20-i similar</td>
<td>1 x 20</td>
<td>1 x 40</td>
<td>2 x 60</td>
</tr>
</tbody>
</table>

### Recovery Areas

| Patient Bay-Recovery Stage 1 | pbtr-rs1-12-i similar | 4 x 12 | 8 x 12 | 2 x 12 | 2 bays per OR in Stage 1; separate M / F |
| Patient Bay-Enclosed Recovery Stage 1 | pbtr-rs1-12-i similar | 2 x 12 | As required for Class S isolation, paediatrics etc |
| Patient Bed Bay - Recovery Stage 2 | pbtr-h-10-i similar | 4 x 10 | 8 x 10 | 2 x 10 | 2 Bed Bays per OR in Stage 2, may separate M / F. A minimum of 2 bed bays is required. Note 1 |
| Patient Chair Bay - Recovery Stage 2 | lnpt-rs-2-i similar | 2 x 2 | 4 x 2 | 1 x 2 | 6 | 1 chair Bay per OR, may separate M / F. Minimum acceptable is multi-movement recliners at 70% of overall total. Note 1 |
| Bay - Blanket/ Fluid Warmer | bbw-1-i | 1 x 1 | 1 x 1 | 1 x 1 | Optional |
| Bay - Handwashing, Type A | bhws-a-i | 4 x 1 | 8 x 1 | 2 x 1 | 1 per 4 bed/ chair bays |
| Bay - Linen              | blin-i | 1 x 2 | 1 x 2 | 2 x 2 | |
| Bay - Resuscitation Trolley | bres-i | 1 x 1.5 | 1 x 1.5 | 2 x 1.5 | |
| Clean Utility/ Medication | clum-14-i similar | 1 x 12 | 1 x 14 | 2 x 14 | Includes Waste Disposal |
| Dirty Utility            | dtur-12-i  dtur-14-i | 1 x 12 | 1 x 14 | 2 x 14 | |
| Staff Station | sstn-14+ similar | 1 x 10 | 1 x 14 | 2 x 14 | To oversee all recovery spaces |
| Toilet - Accessible | wcac-i | 1 x 6 | 1 x 6 | 2 x 6 | For Patient |
| Toilet - Patient | wcpt-i | 1 x 4 | 2 x 4 | 6 x 4 |

**Support Areas**

| Bay - Mobile Equipment | bmeq-4-i | 1 x 4 | 2 x 4 | 4 x 4 |
| Cleaner's Room | clrm-6-i | 1 x 6 | 1 x 6 | 2 x 6 |
| Gown Up | gw-up | 1 x 36 | 1 x 36 | 1 x 36 | varies according to operation policy |
| Gown Down | gw-dn | 1 x 36 | 1 x 36 | 1 x 36 | optional |
| Store – Equipment/General | steq-14+ similar | 1 x 14 | 1 x 20 | 2 x 20 | With access for Recovery |
| | stgn-14+ similar | 1 x 14 | 1 x 20 | 2 x 20 |
| | steq-20+ similar | 1 x 14 | 1 x 20 | 2 x 20 |
| | stgn-20+ similar | 1 x 14 | 1 x 20 | 2 x 20 |

**Staff Areas**

| Change - Staff, Male/ Female | chst-12+ similar | 2 x 12 | 2 x 12 | 2 x 20 |
| | chst-20+ similar | 2 x 12 | 2 x 12 | 2 x 20 |
| Office - 2 person | off-2p-i | 1 x 12 | 1 x 12 | Clerical/ administrative support |
| Office - Clinical/ Handover | off-cln-i similar | 1 x 12 | 1 x 15 | 1 x 20 | Medical/ Nursing workstations |
| Office - Single Person | off-s9-i | 1 x 9 | 1 x 9 | 1 x 9 | Unit Manager |
| Meeting Room | meet-9+ similar | 1 x 9 | 1 x 15 | 1 x 15 | May share with an adjacent unit |
| | meet-l-15+ similar | 1 x 9 | 1 x 15 | 1 x 15 |
| Staff Lounge | smr-15+ | 2 x 15 | 2 x 20 | 2 x 25 | May be shared with the Operating Unit |
| | smr-25+ similar | 2 x 15 | 2 x 20 | 2 x 25 |

| Sub Total | 503.5 | 853.5 | 2112 |
| Circulation % | 40 | 40 | 40 |
| Area Total | 704.9 | 1194.9 | 2956.8 |

Note 1: Stage 2 Recovery 3 Bays per OR may be all in recliners or a mix of chairs and beds. The recommended percentage of each is 70% multi-movement comfortable recliners and 30% bed bays. The minimum acceptable is just multi-movement recliners.

Note 2: Offices to be provided according to the number of approved full-time positions within the Unit.

Note 3: This sample SOA does not include Endoscopy. If Endoscopy is to be integrated, check and include the special requirements of Endoscopy Unit within these Guidelines and incorporated in the SOA.

Please also note the following:

- Areas noted in Schedules of Accommodation take precedence over all other areas noted in the Standard Components.
▪ All the areas shown in the SOA follow the No-Gap system described elsewhere in these Guidelines.
▪ Exact requirements for room quantities and sizes will reflect Key Planning Units identified in the service plan and the policies of the Unit.
▪ Room sizes indicated should be viewed as a minimum requirement; variations are acceptable to reflect the needs of individual Unit.
9 References and Further Reading

This FPU should be read in conjunction of other parts of the Guidelines in particular Part C - Access, Mobility, OH&S; Part D - Infection Control and Part E - Engineering Services.

In addition, the following may be found useful by the readers: