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A2.1 SERVICE DESCRIPTION

A2.1.1 Scope of Clinical Services

This section A2 sets out the requirements for the centralized facilities for the Facility's Emergency department serving both adult and paediatric patients to be achieved or accommodated by Project Co in providing the Works and the Services. The range of services to be provided within this component includes:

- The Abbotsford Hospital and Cancer Centre will continue to work with the Royal Columbian Hospital (RCH), as one of the provincial hospitals, to develop an appropriate range of services to support the care of major trauma patients. In pursuing this goal, the Abbotsford Hospital will serve as a major emergency unit and will ensure that it can provide appropriate services locally and establish linkages with RCH and other trauma providers for services that are beyond its capabilities.

- In addition to the traditional functions associated with the role of an emergency centre, Abbotsford Hospital will also be the regional disaster centre, with appropriate facilities for dealing with natural or man-made catastrophes (e.g., earthquake) generating mass casualties, as well as other accidents associated with severe chemical contamination.

- Emergency services provided include:

  - Resuscitation: conditions that are threats to life or limb (or imminent risk of deterioration) requiring immediate aggressive interventions. Time to physician and RN – immediate. After resuscitation and stabilization, facilitation of transfer may occur.

  - Emergent: conditions that are a potential threat to life, limb or function, requiring rapid medical intervention or delegated acts. Time to physician – $\leq$ 15 minutes. Time to RN assessment – immediate. Stabilization and facilitation of transfer may occur.

  - Urgent: conditions that could potentially progress to a serious problem requiring emergency intervention may be associated with significant discomfort or affecting ability to function at work or activities of daily living. Time to physician – $\leq$ 30 minutes. Time to RN assessment – 30 minutes.

  - Urgent care: diagnosis, treatment (with physiological monitoring) and initial management of patients with serious physical problems whose conditions are not considered potentially life-threatening but do require immediate medical attention to alleviate pain or to avoid further problems, including a separate sub-area for pediatric patients and the initial assessment of psychiatric patients.

    The majority of all acute hospital cardiac admissions are related to the management of acute coronary syndrome (ACS). The ACS group includes the diagnostic constellation of chest pain, unstable angina and acute myocardial infarction. Strategies to reduce admission of this group of patients will have significant impact on inpatient bed resources.

    This includes a separate sub-area for the pediatric patients.

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- Less-urgent: conditions that related to patient age, distress, or potential for deterioration or complications would benefit from intervention or reassurance within 1-2 hours. Time to physician – ≤ 60 minutes. Time to RN assessment – 60 minutes.

  Most of these patients will be provided with a "fast-track" service. Some patients will stay longer for tests (e.g., ongoing abdominal pain).

- Non-urgent: conditions that may be acute but non-urgent as well as conditions which may be part of a chronic problem with or without evidence of deterioration. The investigation or interventions for some of these illnesses or injuries could be delayed or even referred to other areas of the hospital or health care system. Time to physician – ≤ 120 minutes. Time to RN assessment – 120 minutes.

  Most of these patients will be provided with a "fast-track" service. Some patients will stay longer for tests if necessary.

- Clinical decision: short term assessment (up to a maximum of 23 hours) of urgent care medical and psychiatric patients in order to avoid unnecessary inpatient admissions. Patients leaving this area will either be discharged or be admitted to an inpatient bed.

- Poison control functions will continue to be based at St. Paul's Hospital, Vancouver, but access to current manuals and microfiles will be maintained in-house.

- The main hospital 24-hour protection services pursuant to the E9 Service Category will operate out of this component. Police will occasionally accompany patients (especially psychiatric patients).

- The psychiatric response (after hours) team and the quick response team (social worker) will operate out of the Emergency component.

- The Emergency component will specifically address the unique requirements of pediatrics.

- Facilities will be provided to support the Fraser Valley sexual assault program.

- The Emergency component will continue to provide services to prisoners of surrounding corrections facilities with guards in attendance.

A2.1.1.1 *Current Trends*

In providing the Works and Services, Project Co shall take into account the following trends:

- *With the increasing use of the Canadian Triage Acuity Scale, 5-level triage system, Level 5 patients (non-urgent) may be designated as deferrable in the future.*

- *The development of urgi-care centres or physician group practices offering extended hours of operation will have an impact on Emergency department workloads in the future.*

- *Increased acuity of patients due to the increasing older population.*

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- *Increased requirement for evaluation of patients with artificial organs (e.g., IV membrane oxygenerators, monitoring of implanted devices, renal assist devices, artificial pancreas, ventricular assist device-related complications).*
- *Increased new drug delivery interventions (e.g., inhalable insulin, implantable pumps, nasal and time release analgesics, closed-loop implantable devices).*
- *Increased effectiveness of cancer pharmaceuticals and biologics (improvement in supportive agents).*
- *Use of hand held ultrasound and ECG machines.*
- *Increased use of remote monitoring.*
- *New tissue and fluid bioengineering advances [e.g., hemoglobin oxygen carriers, bone cement, bioactive synthetic and allogenic dermal matrices (burn care)].*
- *Impact of HIPPA on room enclosures.*

A2.1.2 Scope of Education Services

Emergency will provide clinical resources in support of teaching programs for the following types and numbers of students:

- Medical/surgical residents, 4 at a time
- Medical undergraduates, up to 4 at a time
- Nursing (diploma, undergraduate and graduate) students, up to 8 at a time (on one shift)
- Pharmacy undergraduates/residents, 1 at a time
- Respiratory therapy students, up to 2 at a time
- Dietetic intern, 1 at a time
- Social work students, up to 3 at a time

Other students may come from other areas of the Abbotsford Hospital & Cancer Centre for practical experience in this component.

Inservice education and patient teaching programs will also occur in the component.

A2.1.3 Scope of Research Services

Emergency staff participate in research on an intermittent basis when requested. Space will be provided in the multipurpose conference room for this purpose.

A2.1.4 Specific Exclusions

This specification excludes emergency services/requirements provided elsewhere, including:

- Level 1 trauma services provided at Royal Columbian Hospital or other Lower Mainland trauma centres

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- Burn care, which is provided at the Vancouver Hospital and Health Sciences Centre or Children's and Women's Health Centre of British Columbia
- Obstetrical patients at 20 weeks gestation or greater will be sent directly to Maternal Child Program (see section B5 Maternal Child Program)

A2.2 OPERATIONAL DESCRIPTION

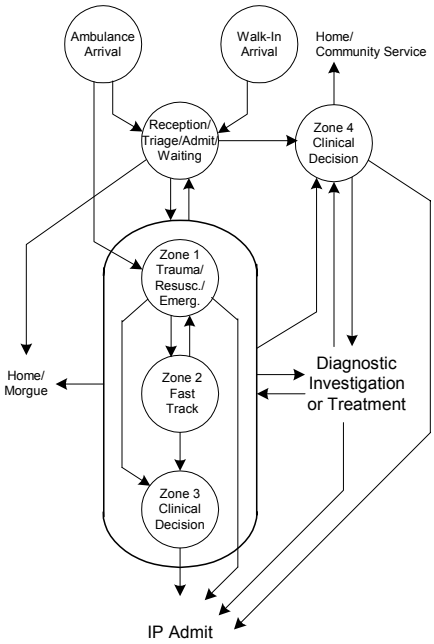
A2.2.1 Minimum Hours of Operation

Emergency services will be available 24 hours a day, 7 days a week.

A2.2.2 Patient Management Processes

A2.2.2.1 Reception/Triage

Two entrances will be provided, one for ambulances/ stretcher patients and one for private vehicle/walk-in patients both adequate in size for bed access. Unloading of ambulance vehicles (and some private vehicles) will occur under a separate covered exterior ambulance shelter. This separation will ensure that critically ill patients can be transferred, without hindrance, directly from an ambulance or a private vehicle to a trauma/resuscitation room. Also it provides a visual barrier between the distressing aspects of certain ambulance arrivals and the non-critical patients' walk-in entry. Traffic flow from these two entries should not cross one another. However, while providing the above degree of separation, both entrances will be visible/easily accessible from/to the reception/triage desk.



Patient Flow Diagram

The main security office will be located adjacent to these entrances.

Patients will arrive at Emergency by two principal means; either by ambulance or by self-direction. Those that arrive by ambulance will be escorted into the facility via the ambulance shelter, whereas, those arriving by means other than ambulance will access the department through the separate walk-in entry. Both entries must arrive at the reception/control/triage area for initial assessment. All arrivals will be triaged by a health professional, streamed, asked to wait or immediately directed to the appropriate area for treatment.

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Critically injured or ill patients arriving by ambulance will typically be taken directly to a trauma/resuscitation room. A team, including a surgeon, emergency physician and an anesthetist on 24-hour call, will be available for resuscitation, assessment and treatment of severe trauma victims. Patients treated in a trauma/resuscitation room may be transferred to the nearest appropriate trauma centre, admitted to the Intensive Care/Stepdown Units, Comprehensive Cardiology Care Unit, or to a General Inpatient Unit, sent to the Surgical Suite for an operative procedure, or Morgue.

Walk-in patients will, immediately upon entry, be assessed at the reception/triage area by an Emergency department nurse, for the establishment of the urgency and type of treatment required. All patients will then be registered by admitting staff based in this component. There will be a linkage across emergency rooms at a regional level. Those walk-in patients not requiring emergent/urgent attention/or psychiatric attention will be directed to the "non-urgent" care/fast-track area or to the public waiting area until further attention and treatment can be given.

Patients requiring immediate treatment will be taken directly to the "emergent care area". Registration or admitting procedures of emergent care patients may be completed after patient care is initiated, with the admitting clerk going to the patient, or obtaining information from others present. If immediate care is not required, the patient, or other persons accompanying the patient will carry out documentation before patient care services are provided.

Visibility of the patient reception/triage area directly from the staff work area/communications centre is highly desirable to facilitate prompt “patient symptom recognition” by nurses/doctors.

Two grieving/quiet rooms will be provided for family members of critically ill or deceased patients, and these must be acoustically and visually private. The function of the grieving rooms is to provide a temporary refuge for distressed family/friends, not for prolonged use. The rooms should not be located directly adjacent to each other in order to maximize the privacy of the users.

A2.2.2.2 Waiting

Separate waiting areas are required for ambulant emergency patients and those on stretchers. Following arrival in the department and registration at reception, stretcher patients will be taken to a holding area, suitable for stretchers or beds. Ambulant patients, together with their escorts and carers, will be directed to the main waiting area. Provision for up to 6 wheelchairs is required in this area. Most patients attend with at least 1 relative and the average number of emergency visits is anticipated to be up to 200 per day. The entire waiting/holding area is to be kept under visual observation by nursing staff in case assistance or clinical intervention is required.

Patients will be called from the waiting area by a nurse and escorted to an examination cubicle/room. Toilet facilities will be provided to serve each treatment zone.

A2.2.2.3 Investigation

The assisted movement of patients to/from Emergency for diagnostic investigations or therapeutic interventions will be managed at all times by porters.

Most patients will have some sort of diagnostic investigation performed. Imaging will be the most common, but many will also need to have blood drawn and other body fluid tests, or require some electrodiagnostic studies. Other than imaging, many investigations will be carried out by Emergency department staff. Near-patient testing will also be necessary.

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Imaging will be done in the main Medical Imaging component (see section C3).

After initial assessment and/or treatment, patients may be sent to other areas of the Health Centre (e.g., Medical Imaging) for examination before returning to Emergency.

A social worker, dedicated to the Emergency component, will perform screening, address issues of sudden death, family violence (e.g., child abuse, elder abuse, spousal assault), elderly at risk, etc., and arrange community and/or outpatient follow-up.

A2.2.2.4 Diagnosis

It can take between 10 minutes and 2 hours for a working diagnosis to be made. The fluidity of patient movement is essential in the department to allow for anomalies in deciding diagnoses. Those patients who have unclear diagnoses but are stable will be sent to the clinical decision unit (CDU). Once a working diagnosis is made, the patient could be admitted and moved to an inpatient unit or discharged home.

Lengths of stay in Emergency are expected to change frequently to meet demands on the service and to reflect current issues, so definitive guidelines are difficult to issue at this point. Developers are recommended to work closely with clinical advisors regarding this point.

A2.2.2.5 Treatment

Workloads will vary greatly at different times of the day. Organization of patient care areas should allow concentration of patient care activity in one area, at times of low workload, and allow the zone of activity to expand as workload increases.

A large number of patients have minor ailments/injuries and will have had a diagnosis made within an hour of booking in at reception.

All cubicles will be curtained on three sides with a 1.5m length of the side walls of each cubicle, adjacent to the patient's head, provided solid from floor to ceiling to ensure some visual screening between cubicles. A bulkhead over the open end of the cubicle, adjacent to the corridor will also enhance acoustic control. These provisions should provide an appropriate degree of visual and acoustic privacy for the patient together with nursing observation from cubicle to cubicle. Selected patient care spaces will be provided as rooms (i.e., for pediatrics, obstetrics/gynecology, suture, EENT and isolation).

Simple treatments may be carried out in the area in which the patient is examined.

The application of plasters will be done in the cast room specifically designed for this purpose and wound closures will be performed in the suture room. Overhead operating lighting that can be manoeuvred to suit difficult angles needs to be provided in all patient cubicles as standard.

The use of ultraviolet light diagnostic equipment requires blackout in the obstetrics/gynecology rooms.

As well as ample storage space for general supplies, stores and equipment, staff require ‘quick grab’ shelves in all patient areas, for things such as suture packs and dressings. This is particularly essential in the minor treatment areas to avoid over-crowding of the patient bays.

Provide a special contained/controlled waiting area for children, visually and acoustically segregated from the main adult waiting area. Provide exam rooms designated for use by children which are designed as child-friendly.

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A2.2.2.6 Admission

If there has been a decision to admit, patients will be transferred to the appropriate Inpatient Unit by a porter/nurse. This will be done for the most part on an Emergency stretcher, but some patients will be taken in wheelchairs, hospital beds and some may choose to walk. Up to 10 relatives may be with the patient, although the average is 2.

A2.2.2.7 Discharge

Patient who no longer need to be in the acute treatment areas of the department will be taken to the central waiting room which will be within easy access. Patients who do not need to be admitted to hospital will be treated as necessary and discharged by a health professional. While most are expected to find their own transport home, a significant number will need to be transported by taxi or ambulance.

A2.2.3 Patient Information Management

A key resource of the future emergency facility will be an Emergency Information System providing computerized triage control (bed/treatment status/waiting numbers etc.), controlled/generated by triage and accessible as part of the computerized information system at any terminal, including information from BCCA (CAIS). This system will be provided by the FHA and integrated with the IM and other emergency departments in the FHA.

Direct communication links will be provided between Emergency and the FHA switchboard/call centre, Surgical Suite, Intensive/Stepdown Care Units, Comprehensive Cardiology Care Unit, security, police and ambulance service.

Facilities will be provided to access the “telehealth” service (i.e., a teleconference room for remote conferencing) and selected examination areas for teleconsultation with oncologists or others on call.

Dedicated, secure access to outside systems like BCBedline and PharmaNet must be provided.

Also refer to Output Specifications, Section 3: Non-Clinical Services, subsection D1 Information Management; Section 5: Design and Technical, subsection 5.3.17 Technology and Communication Systems; and Section 6: IT/Tel Services.

A2.2.4 Staff Work Processes

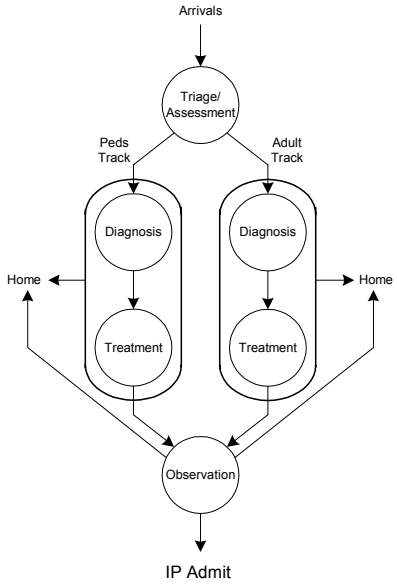
A2.2.4.1 Reception/Triage

The reception desk/triage/assessment/admit cubicles are to be integrated to better facilitate patient handling and flow. Staff will be based here 24/7 and will be responsible for initial patient management.

A2.2.4.2 Care Stations

A central care station/physicians "communications centre" will be central to all patient examination and treatment areas in Zone 1 in order to facilitate nursing, physician and clerical interaction. Planning should strive to provide nurses in this station with visual contact with as many patients as possible and with direct access and visibility to the reception/triage to facilitate observation of incoming new patients by doctors (at a distance).

This main “communications centre” will be equipped with central cardiac/physiological monitoring equipment and a computerized order entry/patient care system. This will be the central care station, with room for students and the expanded multidisciplinary team, charting, and physicians’ dictation areas.



Process Flow Diagram

Care substations will be provided for each of the other designated zone areas (e.g., fast-track, medical observation, psychiatric observation).

A2.2.4.3 Treatment

The component will be organized into 4 major patient care zones. Each zone may/will have a care sub-station integral with that zone.

Although “zoning” is desirable for the organization of different patient requirements and levels of care, a general concept of openness and “elasticity” will be achieved in the overall layout, which maximizes flexibility in use, nurse/patient visibility of all patient care zones and minimizes inappropriate isolation of patients from nurse contact. A plan that emphasizes the importance of a single patient care space (with some physical segregation) would be ideal.

The 4 zones will be generally organized as follows:

Zone 1 – trauma/resuscitation/emergent care area is for the treatment of "emergent" patients with life-threatening or potentially life-threatening conditions. This will be the most easily accessible area from the ambulance entrance and will include enclosed rooms only. This zone will also treat "urgent" patients who will be located in a variety of accommodation, including enclosed rooms and curtained cubicles suited to a range of needs. These address the unique requirements of substance misuse /psychiatric patients, pediatric and obstetrical/gynecological patients.

This area will also assess and treat lower priority non-urgent pediatric patients, usually walk-ins who can be processed in a more structured and orderly fashion.

Zone 2 – fast-track area – adults is for the assessment and treatment of lower priority non-urgent adult patients, usually walk-ins who can be processed in a more structured

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and orderly fashion. Zone 2 will be planned as a physically separate area that can be operated independently of Zones 1 and closed down for part of the night.

Zone 3 – clinical decision unit – medical is for the holding/ observation of medical patients for up to 23 hours, who are being assessed for admittance as inpatients or for discharge.

Zone 4 – clinical decision unit – psychiatry is for the holding/observation of psychiatric patients for up to 23 hours, who are being assessed for admittance as inpatients or for discharge to community services or home.

A2.2.4.4 Staff Services

Outer clothing will be stored in coat closets located in a lockable coat hanging area. Students and volunteers will also have space for coat storage in the coat closets. Half lockers will be provided for personal valuables and will be shared across shifts. A small staff break room will be provided for beverage making, staff debriefing, grieving and rest.

A2.2.5 Materiel Services

Storage of patients clothing for use by patients who arrive in states of undress will also be provided in the unit's equipment storage description with lock up capabilities.

Also refer to Output Specifications, Section 4: Facility Management Services, subsection E7 Materiel Services, and Section 2: Clinical Services, subsection C8 Sterile Processing Services.

A2.2.6 Linen/Housekeeping Services

Refer to Output Specifications, Section 4: Facility Management Services, subsections E5 Housekeeping Services and E6 Laundry/Linen Services.

A2.2.7 Equipment Asset Management

Biomedical Engineering staff will provide a full service to provide equipment support/maintenance services.

Equipment storage space will be provided within Emergency for frequent use (up to once a month) items (e.g., stretcher, wheelchairs, IV carts and poles). More bulky items (e.g., balkan frames) and less frequent use items will be stored in the Abbotsford Hospital's central equipment storage area located in Materiel Services (see E7).

Also refer to Output Specifications, Section 4: Facility Management Services, subsection E2 Biomedical Engineering; and Section 7: Equipment.

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A2.3 ACTIVITY INDICATORS

The table below summarized the projected activity for emergency services which must be addressed by Project Co in performing the Works and the Services.

A2.3.1 Hospital Activity

Unit	Minimum Projected Yearly Activity
Emergency Visits	
Emergent	6,000
Urgent	24,000
Non-Urgent/Fast Track	30,000
Total	60,000

Notes & Assumptions

1 Future workload distribution based on Emergent @ 10% of total, Urgent @ 40% of total and Non-Urgent/Fast Track @ 50% of total.

A2.3.2 Cancer Centre Activity *(Incl. in Hospital Activity above)*

A2.4 PEOPLE REQUIREMENTS

This component will have a total staff complement in the range of 119 FTE, consisting of 98 nurses, 1 clinician, 3 social workers, 6 physicians, and 11 clerical/ administrative personnel.

It is anticipated that the key functional areas in the component will need to accommodate the following maximum number of people.

Functional Areas	Patients	Staff	Visitors	Others	Total
Reception/Control/Triage Area	20-25	5	20	4-6	49-56
Zone 1 – Trauma/Resuscitation/Emergent Care Area	26	6-8	10	4-6	46-50
Zone 2 – Fast-Track Area – Adult	30-35	4-6	20	4-6	58-67
Zone 3 – Clinical Decision Unit - Medical	10	2-3	10	2-3	24-26
Zone 4 – Clinical Decision Unit - Psychiatry	4	1-2	4	1-2	10-12
Shared Support Area	0	2-3	0	1-2	3-5
Administrative Area	0	16-20	0	1-2	17-22
Staff Support Area	0	12-15	0	1-2	13-17

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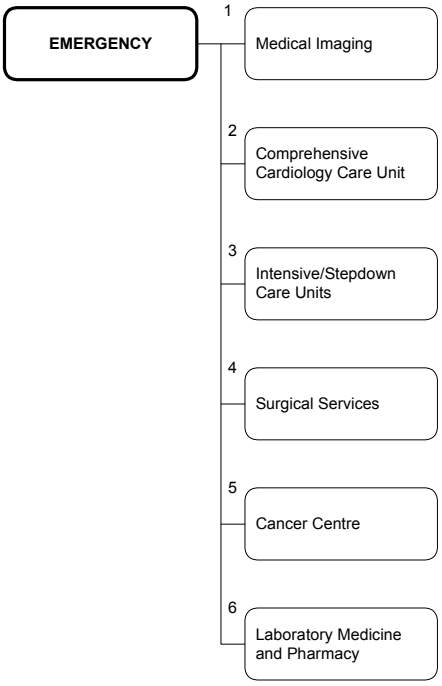
A2.5 DESIGN CRITERIA

A2.5.1 Key External Relationships

The following key relationships will be achieved in the priority order as numbered for the purposes stated:



1 Provide <u>direct</u> access by <u>internal</u> circulation to Medical Imaging for the movement of patients and staff. (In particular, the trauma/resuscitation room(s) will be adjacent to the trauma X-ray room and the CT scanner.)

2 Provide <u>direct</u> access by <u>internal</u> circulation to the Comprehensive Cardiology Care Unit for the immediate transfer of cardiology patients.

3,4 Provide <u>direct</u> access by <u>general</u> circulation to the Intensive/Stepdown Care Units and the Surgical Services for the movement of patients in critical condition. A "restricted" non-public dedicated access is highly desirable.

5 Provide <u>direct</u> access by <u>general</u> circulation to the Cancer Centre for after-hours access by cancer patients requiring emergency radiation therapy treatment.

6 Provide <u>convenient</u> access by <u>general</u> circulation from the Laboratory and Pharmacy for the movement of staff, specimens and medications. (These connections may be augmented by pneumatic tube connections.)

<u>Note</u>: Provide <u>direct</u>, <u>external</u> access to the site helipad for the movement of patients on stretchers.

A2.5.2 Key Internal Relationships/ Environmental Considerations

The following will be achieved:

A2.5.2.1 <u>After Hours Hospital Entry</u>

After hours (2100h to 0630h), the main entry to the Abbotsford Hospital will be locked and a secondary entrance adjacent to the Emergency entrance will act as the general access to the Abbotsford Hospital. The security officer will monitor access and screen traffic.

The layout of circulation corridors will need to allow for ambulance deliveries to the Abbotsford Hospital, other then those destined for Emergency, and other after hours access to discreetly

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bypass the Emergency component and in particular the Emergency reception/triage area, which will not perform an Abbotsford Hospital information service at any time.

A2.5.2.2 Direct Access to CT Scan and Trauma Radiology Room(s)
Direct, quick and easy access from the Emergency entrance/trauma rooms to the CT scan and trauma radiology room(s) is essential.

A2.5.2.3 Planning for Disaster Management
In addition to being planned for normal day-to-day provision of Emergency services, the examination/treatment areas will be planned to allow for increased numbers of casualties generated by a major disaster. This could be achieved by means of the following:

- Highly flexible space, with a minimum of solid partitions within the component to allow for maximum open space to accommodate increased numbers of stretchers
- Protected and alternative access routes from the exterior to the exam/treatment areas to enhance and guarantee accessibility during a disaster
- Adjacency to, and ease of use of other open spaces (e.g., hospital corridors, waiting areas, "soft" examination/treatment areas in other Ambulatory Care Centre; and the main lobby spaces) that could be also used for accommodating additional stretchers

A2.5.2.4 Decontamination Suite
The decontamination suite will be located peripheral to the component, connected to it for direct access but able to be sealed off when contaminated. The degree of connection and the risks attached to contamination of adjacent Abbotsford Hospital areas requires careful consideration. A one-way patient flow is envisaged, with an entry vestibule, located with access from the ambulance shelter, where a contaminated patient will be undressed, leading to a decontamination room/stretcher-shower area, and finally to an exit vestibule.

All parts of the suite will be designed to be lined with a disposable polythene liner. Exit from the suite will be possible either directly to the resuscitation/trauma area or to the outside (if the patient is still considered a contamination risk). A separate, isolated exhaust air system will be provided.

It is assumed that radiation containment is not required. However, the need for a catchment sump under the shower drainage and ambulance bay wash down area will be reviewed at the design stage.

It must be noted that although the decontamination suite has a primary purpose, it should, if possible, be located and equipped for general exam/treatment use, since it will be used for its primary purpose very infrequently. The stretcher shower will be easily accessible for frequent general patient use.

A2.5.2.5 Room Isolation Capability
Refer to Output Specifications, Section 1: Key Site and Building Design Criteria, subsection 1.2.4.5 Infection Control; and Section 5: Design and Technical, Division 15 Mechanical.

A2.5.2.6 Noise Control/Privacy
Ensure that noise transference generally is kept to a minimum, and that adjacent spaces are sound attenuated and/or visually screened to achieve the required degree of privacy. This applies especially to staff work spaces, triage admitting cubicles, and nurse stations, physician dictation areas, staff phones and computer monitors (protected from patient view).

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A2.5.2.7 Containment of Ambulance Exhaust Fumes
Ensure that exhaust fumes from ambulances parked in the covered drop-off area are not transferred into the building.

A2.5.2.8 Environment
Refer to Output Specifications, Section 1: Key Site and Building Design Criteria, subsection 1.2.5 Indoor Environmental Quality.

A2.5.2.9 Flexibility in Use of Space
Refer to Output Specifications, Section 1: Key Site and Building Design Criteria, subsection 1.2.3.3 Flexibility and Expandability.

A2.5.2.10 Prevention of Drafts Adjacent to Entrance
Ensure that functional spaces adjacent to external entrances are draft free, by means of appropriate lobby design.

A2.5.2.11 Disabled/Elderly Patient Accessibility
Refer to Output Specifications, Section 1: Key Site and Building Design Criteria, subsection 1.2.4.7 Design Standards for the Disabled.

A2.5.2.12 Security and Personal Safety
Access to the component for emergency patients and visitors will be through the main emergency entrance only. Planning and design should provide the means to minimize theft. Closed circuit television may be incorporated.

The layout and design of the component must address the dangers to staff inherent in the services provided (e.g., from violent patients). A staff “escape route” from the triage area must be provided to protect staff from such patients.

In the event that a significant incident occurs outside of the hospital (i.e., Emergency department parking lot) which involves aggressive behaviour, weapons, multiple assailants and/or large hostile crowds, an emergency lockdown is authorized. The lockdown is intended to prevent the aggression from spreading or affecting the rest of the Emergency department or Abbotsford Hospital. Once the lockdown is activated, the main doors that exit into the Emergency parking lot will lock and the doors cannot be accessed from the outside of the building.

Design of isolated staff workstations, especially those used by staff at night, should ensure the maximum safety of staff by means of glass walls for visibility and/or staff emergency call system access.

All glass walls or windows will be designed for maximum security.

A locked cupboard will be used to store patients clothing for patients that are transferred from one space to another (e.g., operating room or psychiatry).

Also refer to Output Specifications, Section 1: Key Site and Building Design Criteria, subsection 1.2.2.3 Security and Personal Safety.

A2.5.2.13 Access and Parking
Provide suitable patient and ambulance parking immediately adjacent to the component and convenient, quick access to the reception triage area.

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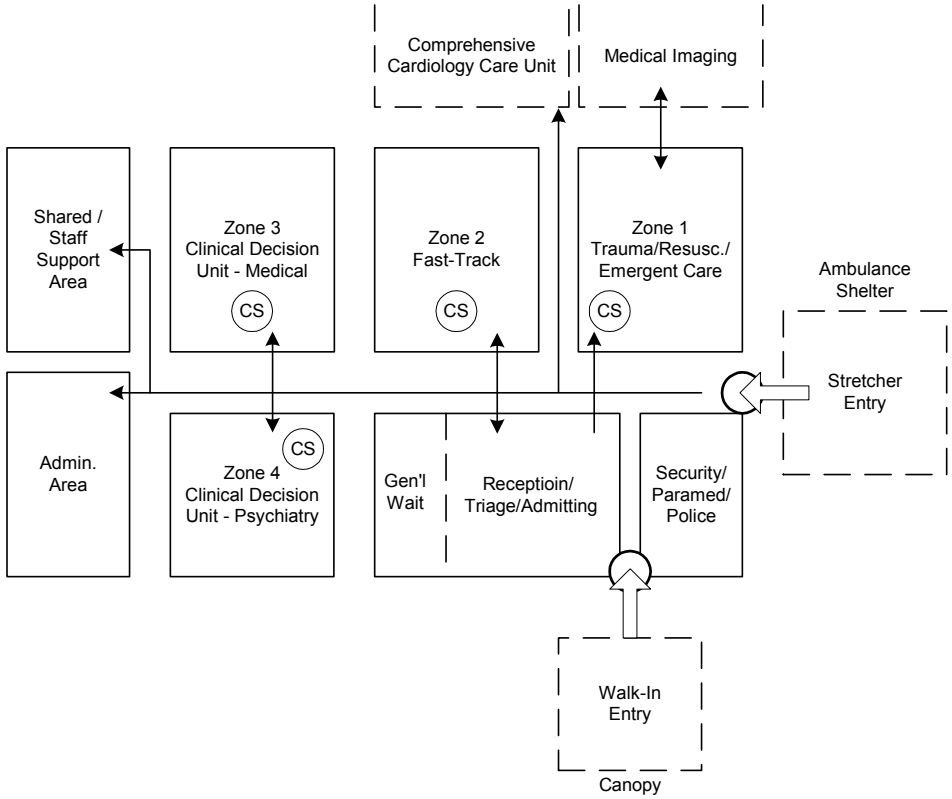
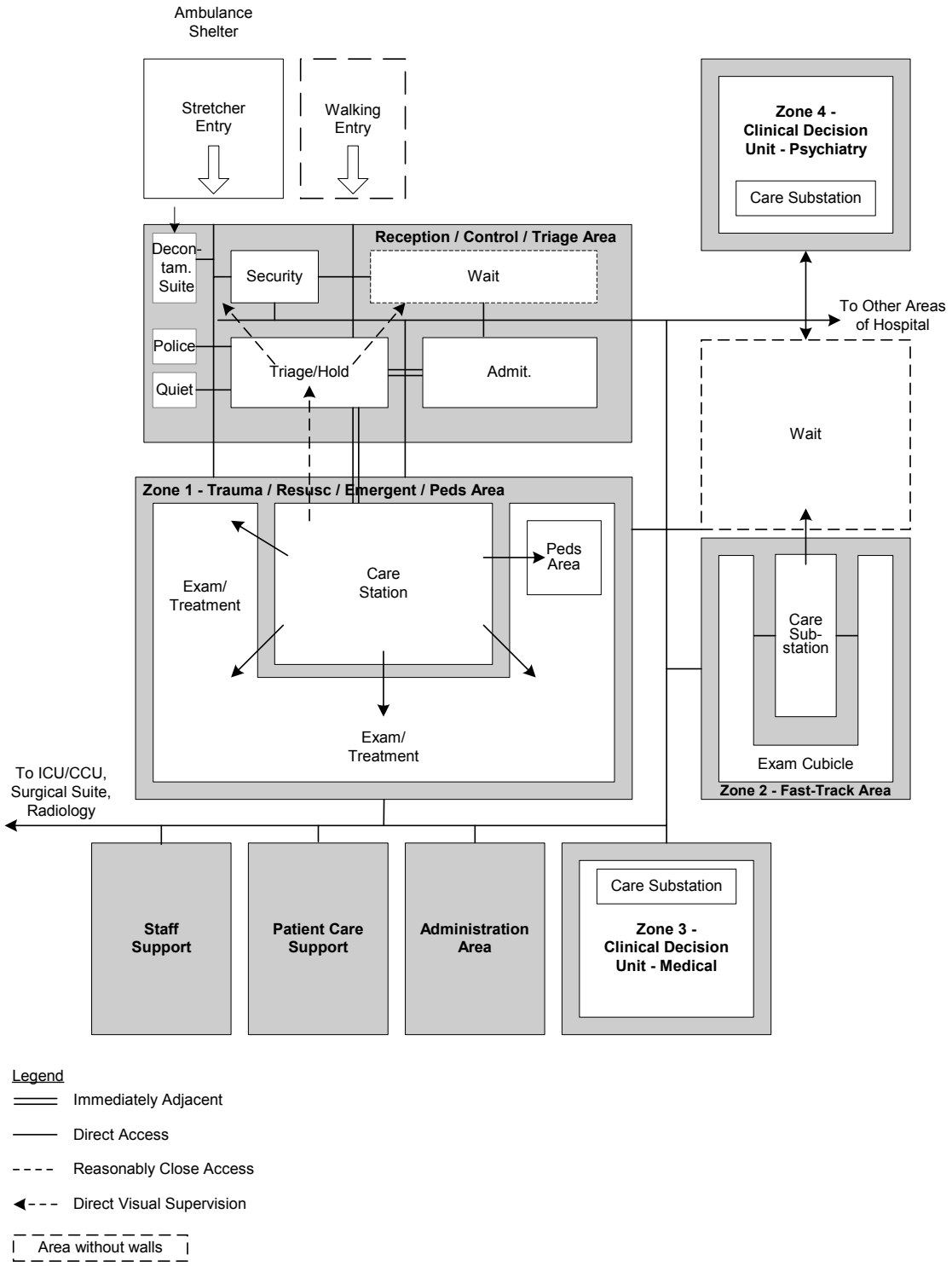
A2.5.2.14 Educational Material
Physical storage of patient educational leaflets should not be required if this can be stored on computer files and printed out when needed.

A2.5.2.15 Component Functional Diagrams
The spatial organization of this component will be generally as shown in the diagrams below.

A2.5.2.15.1 *Macro Relationship Diagram*



A2.5.2.15.2 *Micro Relationship Diagram*



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A2.5.3 Schedule of Accommodation *(Note: Spaces listed in parentheses ( ) are spaces supporting services provided by Project Co and are included in the total net square metres.)*

Ref	Space	Area Requirements units	nsm/unit	nsm
	Reception/Control/Triage Area			
1	Ambulance Shelter	1		(120.0)[1]
2	Storage, Emergency/Disaster Supplies	1		8.0
	Decontamination Suite			
3	Entry Vestibule	1		10.0
4	Decontamination Room	1		14.0
5	Office, Security	1		(15.0)
6	Storage Alcove, Wheelchairs/Stretchers	1		11.0
7	Reception/Triage Desk/Admitting/Registration Area	1		30.0
8	Office, Clerical	1		12.0
9	Stretcher Patient Holding Bay/Triage/Admit Area	1		12.0 [2]
10	Waiting Area, Pre-Admit/Post Treatment Patients/Public	1		60.0
10-1	Waiting Room, Isolation	1		15.0
10-2	Washroom	1		4.5
11	Child Play Area	1		5.0
12	Washroom, Public, Wheelchair Type	2	4.5	9.0
13	Vending Machine Alcove	1		(2.5)
14	Public Telephone Area	1		3.5
15	Family Grieving/Quiet Room	1		9.0
16	Family Grieving/Quiet Room	1		12.0

[1] *Assumed covered exterior space, therefore outside total building area.*

[2] *Includes 2 stretchers, counter and sink.*

A Outpatient Services

A2 EMERGENCY

Ref	Space	Area Requirements units	nsm/unit	nsm
17	Office, Social Worker	2	12.0	24.0
18	Office, SANE Nurse	1		14.0
19	Workroom/Paramedics/Police	1		9.0
	Subtotal			279.5
	Zone 1 – Trauma/Resuscitation/Emergent/Peds Care Area			
20	Trauma/Resuscitation Room	1		50.0
21				
21-1	Exam Room, Isolation (with Ante Room A2-22)	2	13.0	26.0
21-2	Exam room, Private	2	13.0	26.0
22	Ante Room	2	4.0	8.0
23	Washroom, Patient, Wheelchair Type	1		4.5
24	Exam Cubicle, General	16	13.0	208.0
25	Washroom, Patient Wheelchair Type	2	4.5	9.0
26	Alcove, Telehealth Cart	1		1.0
	Pediatrics Area			
27	Peds Exam Room, Stretcher, Isolation	2	8.5	17.0
28	Ante Room	2	4.0	8.0
29	Peds Exam Room, Stretcher	1		17.0
30	Washroom, Patient, Wheelchair Type	1		4.5
31	Central Care Station/Charting Area	1		24.0
32	Pneumatic Tube Station	1		1.0
33	Consultation Area	1		7.5
34	Office Equipment Room	1		7.0
35	PACS Viewing Station	1		6.0

A Outpatient Services

A2 EMERGENCY

Ref	Space	Area Requirements units	nsm/unit	nsm
36	Team Charting Area	1		8.0
37	Nourishment Centre	1		(6.0)
38	Crash Cart Alcove	1		0.5
39	Medications Room	1		8.0
40	Alcove, Linen Cart	1		(1.0)
41	Soiled Utility Room	1		(11.0)
42	Washroom, Staff	1		2.5
43	Housekeeping Closet	1		(5.0)
	Subtotal			466.5
	Zone 2 - Fast-Track Area - Adult			
44	Waiting Room	1		35.0
45	Washroom, Patient, Wheelchair Type	2	4.5	9.0
46	Exam Cubicle, Stretcher	8	8.5	68.0
47	Exam Room, OB/Gyne	2	12.0	24.0
48	Washroom, Patient, Wheelchair Access	1		3.5
49	Exam Room, EENT	1		13.0
50	Procedure Room	1		14.0
51	Storage, Supplies	1		6.0
52	Care Substation/Charting	1		20.0
53	Pneumatic Tube Station	1		1.0
54	Office Equipment Room	1		7.0
55	PACS Viewing Station	1		6.0
56	Medications Room	1		8.0
57	Alcove, Linen Cart	1		(1.0)

A Outpatient Services

A2 EMERGENCY

Ref	Space	Area Requirements units	nsm/unit	nsm
58	Soiled Utility Room	1		(10.0)
	Subtotal			225.5
	Zone 3 – Clinical Decision Unit – Medical			
59	Holding Cubicle, Patient	8	8.5	68.0
60	Washroom, Patient, Wheelchair Type	1		4.5
61	Care Substation/Charting	1		10.0
62	Pneumatic Tube Station	1		1.0
63	Team Charting Area	1		6.0
64	Medications Work Area	1		6.0
65	Clean Supply Area	1		(3.0)
66	Soiled Utility Room	1		(7.0)
67	Alcove, Linen Cart	1		(1.0)
68	Dictation Cubicle	1		(1.5)
	Subtotal			108.0
	Zone 4 – Clinical Decision Unit – Psychiatry			
69	Secure/Observation Unit	2	14.0	28.0
70	Shower Room	1		3.0
71	Washroom, Patient, Wheelchair Type	1		4.5
72	Stretcher, Patient	4	8.5	34.0 [3]
73	Interview Room	1		11.0
74	Sitting/Lounge Area, Patients	1		14.0
75	Washroom, Patient, Wheelchair Type	1		4.5

[3] *Includes 2 sinks in addition to 4 stretchers.*

A Outpatient Services

A2 EMERGENCY

Ref	Space	Area Requirements units	nsm/unit	nsm
76	Care Substation/Charting Area	1		10.0
77	Pneumatic Tube Station	1		1.0
78	Team Charting	1		6.0
79	Medications Room	1		6.0
80	Clean Supply Area	1		(4.0)
81	Soiled Utility Room	1		(8.0)
82	Alcove, Linen Cart	1		(1.0)
83	Dictation Area	1		(1.5)
84	Office, Psych After Hours Mental Health Worker	1		9.0
	Subtotal			145.5
	Shared Support Area			
85	Storage, Equipment	1		30.0
86	Body Holding Room	1		8.0
87	Storage, Red Cross Loan Cupboard	1		8.0
88	Food Services Galley	1		(12.0)
89	Storage, Mobile X-Ray	1		3.5
90	Central Clean Supply Holding Room	1		(30.0)
91	Central Soiled Holding Room	1		(15.0)
92	Housekeeping Closet	1		(5.0)
	Subtotal			111.5
	Administrative Area			
93	Office, Medical Director	1		9.0
94	Office, Nurse Manager	1		9.0
95	Office, Nursing Supervisor	1		9.0

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A2 EMERGENCY

Ref	Space	Area Requirements units	nsm/unit	nsm
96	Multipurpose/Conference Room	1		25.0
97	Office, Nurse Clinician	1		9.0
98	Office, Administration	1		9.0
	Subtotal			70.0
	Staff Support Area			
99	Break/Team Room, Staff	1		24.0
100	Staff Locker Room	1		9.5
101	Washroom, Staff	1		7.5
102	On-Call Room	1		7.0
103	Washroom, On-Call	1		4.0
	Subtotal			52.0
	Total			**1458.5**

A2.6 DESIGN GUIDANCE

Project Co shall comply with:

- Standards, *Hospital-Based Psychiatric Emergency Services: Observation Units*, Ministry of Health and Ministry Responsible for Seniors, March 2000

A2.7 OTHER SPECIFICATIONS

Emergency services are primarily based in the Emergency department, however, emergency resuscitation services are also provided throughout the facilities.

Specific requirements for these include:

A Outpatient Services

A2 EMERGENCY

- Dedicated space for parking and storage of resuscitation (crash) carts. These will be provided in Surgical Services, Comprehensive Cardiology Care Unit, Intensive/Stepdown Care Units and on each inpatient floor or general ward area and in the Cancer Centre if one is not easily accessible from the Abbotsford Hospital. These areas should not obscure corridors and will be under constant staff observation and control.

Other specifications that will be consulted are:

A1 Ambulatory Care Centre
A3 General Day Care Unit
B1 Comprehensive Cardiology Care Unit
B2 General Medical/Surgical Inpatient Care Units
B4 Intensive/Stepdown Care Units
B5 Maternal Child Program
C7 Surgical Services