ALCOHOL AND OTHER DRUG RESIDENTIAL REHABILITATION FACILITY

Part B: Health facility briefing and planning

Victorian Health and Human Services
BUILDING AUTHORITY

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Alcohol and other drug residential rehabilitation facility

Part B: Health facility briefing and planning

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1 Introduction

1.1 Preamble

This guideline has been developed for use by project staff, architects, planners, engineers, project managers and other consultants, and for end users. It is intended to assist with the planning and design of a new facility that will be fit for purpose in accordance with its designated service role and defined population.

This guideline was informed by:

- an alcohol and other drug model of care workshop facilitated by the department's Drug Policy and Reform branch, conducted with a range of service providers
- an alcohol and other drug design principles workshop facilitated by the department's Victorian Health and Human Services Building Authority and conducted with a range of service providers with Drug Policy and Reform branch in attendance
- an alcohol and other drug design principles workshop facilitated by the department's Victorian Health and Human Services Building Authority and conducted with a range of clients with Drug Policy and Reform branch in attendance
- site visits to various alcohol and other drug rehabilitation facilities.

1.2 General

This document outlines requirements for the planning and design of an alcohol and other drug residential rehabilitation unit and must be read in conjunction with generic requirements and standard components as described in Parts A, B, C and D of the *Australasian Health Facility Guidelines.*

1.3 Terminology

In the alcohol and other drug treatment context, the 'client' is the term used to refer to the person receiving treatment and support.

1.4 Therapeutic environment

The environment should be conducive to the management of complex behaviours. However, this should be achieved with a therapeutic focus so that necessary measures for safety and security are non-intrusive and do not convey a custodial ambience.

2 Treatment framework

2.1 Background

Over 30,000 Victorians receive state-funded alcohol and other drug services each year.

The Department of Health and Human Services funds health services and community sector organisations to provide alcohol and other drug treatment. This includes community health services that offer a range of primary and other health care, and specialist services that are a part of larger not for profit community organisations. Some treatment types may be provided in hospitals.

Alcohol and other drug treatment services in Victoria are delivered through the following main treatment streams:

- counselling
- withdrawal (residential and non-residential)
- rehabilitation (residential or therapeutic day program)
- care and recovery coordination (case management and service navigation)
- pharmacotherapy.

The aim is that treatment can be provided in a way that most suits the individual and their family's needs. For example, people with parenting responsibilities may prefer to attend day programs or to receive substance treatment in their home.

The type and number of services accessed will also depend on the severity of a person's clinical dependency and the complexity of their other life factors, such as experiencing homelessness or domestic violence.

Population-specific alcohol and other drug treatment services are available for people with specific needs:

- youth alcohol and other drug services
- Aboriginal alcohol and other drug services
- forensic alcohol and other drug programs and services
- specialist support for women with children.

Detailed service specifications for particular programs and services across the alcohol and other drug treatment system are provided in the department's *Alcohol and other drug program guidelines*.[1]

2.1.1 Victorian and other drug services client charter

All Victorian-funded alcohol and other drug services (AOD) are required to deliver services in ways that are consistent with the 2011 *Victorian alcohol and other drug client charter.*

The Victorian AOD program is guided by eleven treatment principles. Based on these principles, all AOD programs and services are to be:

- reflective of the complex but treatable nature of substance dependence
- person-centred
- accessible
- integrated and holistic

[1] The program guidelines can be found at https://www2.health.vic.gov.au/alcohol-and-drugs/aod-service-standards-guidelines/aod-program-guidelines

- responsive to diversity
- evidence-informed
- provide continuity of care
- involve people who are significant to the client
- inclusive of a variety of biopsychosocial approaches, interventions and modalities oriented towards people's recovery
- inclusive of the lived experience of AOD users and their families at all levels
- delivered by a suitably qualified and experienced workforce.

More information about the treatment principles can be found at the department's website <www2.health.vic.gov.au/alcohol-and-drugs/aod-service-standards-guidelines/aod-treatment-principles>[2]

The charter outlines the responsibilities of services delivering alcohol and other drug treatment in Victoria, including compliance with the *Victorian Charter of Human Rights*. It also outlines the rights and responsibilities of people using Victorian alcohol and other drug services.

Under the charter, the responsibilities of agencies providing alcohol and other drug services in Victoria are to:

- treat clients with respect, dignity and courtesy
- provide an accessible service that takes into account individual and cultural diversity
- plan and develop treatment plans and strategies in collaboration with clients
- achieve and maintain appropriate standards of proficiency and participate in ongoing professional review and development
- provide services in a safe environment and ensure that duty of care is maintained
- ensure client information is kept confidential unless disclosure is otherwise authorised
- provide adequate information to clients about organisational and independent complaints processes
- adhere to relevant professional and AOD codes of conduct and ethics
- comply with the *Victorian Charter of Human Rights*.[3]

2.1.2 Gender sensitivity and safety

Following *The gender sensitivity and safety in adult acute inpatient units project* report [4], Victoria adopted a policy of providing choice for clients to be treated in single-sex environments. This requirement, originally for mental health clients has been adopted by alcohol and drug residential rehabilitation facilities and has been incorporated into this design guideline.

The requirements regarding gender safety are set out in a Chief Psychiatrist's guideline.[5]

[2] The Client Charter can be found at <https://www2.health.vic.gov.au/alcohol-and-drugs/aod-service-standards-guidelines/aod-client-charter>

[3] The *Charter of Human Rights and Responsibilities Act 2006* can be found at: <https://www.humanrightscommission.vic.gov.au/human-rights/the-charter>

[4] *The gender sensitivity and safety in adult acute inpatient units project: Final report*, Department of Human Services, Victoria (2008)

[5] Chief Psychiatrist's guideline can be found at <*https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/safety/promoting-sexual-safety-in-inpatient-settings/sexual-safety-in-inpatient-settings-service-response*>

2.2 Description of unit

2.2.1 Description of an alcohol and other drug residential rehabilitation unit

Residential rehabilitation provides a safe and supportive environment for people to develop skills to cope with and address underlying issues leading to their alcohol and other drug use in a structured residential setting. Residential rehabilitation services in Victoria use a mix of therapeutic models, treatment intensity and length of stay.

State-funded alcohol and other drug residential rehabilitation units are typically located in a community residential setting and provide 24 hour care and support for people who have been through withdrawal or stabilisation and need to continue their treatment via residential rehabilitation.

Rehabilitation is a highly structured program including treatment (such as cognitive behavioural therapy, motivational enhancement and relapse prevention), group and peer therapy and structured activities that teach living and coping skills. In residential settings it is a live-in environment that includes accommodation, meals and recreational space.

Stays are usually approximately three months in length, although this depends on the needs of the client and the residential rehabilitation service model in operation.

2.2.2 Bed numbers

Current state-funded Victorian residential rehabilitation units range from eight to 100 bedrooms, which can broadly be categorised as:

- small residential rehabilitation units (less than 20 beds)
- medium residential rehabilitation units (20 - 49 beds)
- large residential rehabilitation units (50+ beds).

2.2.3 Client profile

Residential rehabilitation units tend to treat clients who seek to address the underlying issues related to their alcohol and other drug use and require a sustained period of treatment in a safe and supportive environment. Such clients may:

- be unsuitable for a non-residential program
- experience the more severe consequences of substance-related harm, such as criminal involvement or social disadvantage
- have home settings or social circumstances that are not supportive of non-residential options.

2.3 Planning

2.3.1 Operational models

There are a number of types of alcohol and other drug residential rehabilitation services currently in operation in Victoria, although different models may be developed to meet specific needs.

The existing types are:

- adult alcohol and other drug residential rehabilitation
- youth alcohol and other drug residential rehabilitation
- Aboriginal alcohol and other drug residential rehabilitation.

2.3.1.1 Adult alcohol and drug residential rehabilitation

Residential rehabilitation may be suitable for:

- clients who have experienced substance dependence and/or harm
- clients seeking to address the issues related to their alcohol and other drug use
- clients at high risk of harm from alcohol and other drug misuse impacted by multiple life complexities, such as mental illness, homelessness, family violence
- clients requiring a sustained period of structured tertiary intervention in a therapeutic environment
- clients whose home setting or social circumstances are not supportive of non-residential rehabilitation options
- clients who are assessed as treatment-ready at admission (i.e. alcohol and other drug-free, stabilised on pharmacotherapy treatment or undertaking slow-stream pharmacotherapy withdrawal treatment).

The residential rehabilitation service stream seeks to address factors underlying alcohol and other drug dependence in a structured residential setting, through a variety of therapeutic interventions. Residential rehabilitation services provide a 24-hour staffed residential treatment program of an average of three months duration. At a minimum, residential rehabilitation services:

- build on the client's comprehensive assessment and treatment plan to determine the clinical and psychosocial components of the treatment required, engaging and involving clients and families, as appropriate
- deliver treatment and support, referral and transition support (face-to-face, phone)
- provide a range of treatment interventions that support behavioural change, social and life skills development and relapse prevention including counselling and therapeutic group work
- utilise a model of care that incorporates evidence-based interventions and management approaches
- utilise symptomatic medications, pharmacotherapies and supportive care consistent with best practice and evidence-based guidelines, as required
- provide recovery-focused case management for clients including a negotiated individual treatment plan with a community reintegration component
- provide access to a medical practitioner, including general practitioners or addiction medicine specialists, to provide generalist and specialist medical support during residential rehabilitation treatment, as required
- provide access to appropriate nursing and psychological care, as required
- facilitate client access to other services appropriate to their health and welfare needs, including providers of non-residential alcohol and other drug treatment and support, mental health treatment and support, housing services, vocational training and employment skills
- deliver community re-integration support including referral into safe and appropriate accommodation where necessary

- cultivate effective and productive relationships and referrals pathways with relevant agencies, in particular alcohol and other drug providers, addiction medicine specialists, mental health providers and other community-based health/human services/support services
- work with other alcohol and other drug services to provide bridging support pre- and post-treatment to assist in client transition into and out of the residential rehabilitation setting
- provide appropriate referral to services for carers and families of those affected by alcohol and other drug use
- provide, with the appropriate consent, client summaries to the original referral source, intake service as well as to the services the client has been linked with

Facilities may be located in metropolitan and rural locations. The average length of stay will be three months.

The facility should be able to support the provision of client care and allow for family/carer visits.

2.3.1.2 Youth alcohol and other drug residential rehabilitation services

Youth residential rehabilitation services have similar aims and objectives to the adult alcohol and other drug residential rehabilitation services but provide an environment specifically for youth, recognising that young people who develop problematic substance use have particular needs and require an age-appropriate environment.

Youth residential rehabilitation services offer a range of treatment interventions, which includes behavioural treatment approaches, social and community living skills, training relevant to the young person's needs, counselling, group work and relapse prevention.

2.3.2 Hours of operation

Alcohol and other drug residential rehabilitation facilities are staffed 24 hours per day, seven days per week.

2.3.3 Models of care

Models of care may address:

- numbers of bedrooms per pod
- providing clients with a range of spaces so they can choose to sit alone or participate in small or larger group activities
- structured activity programs provided on site or in other community settings.

2.4 Operational policies

2.4.1 General

Operational policies for alcohol and drug residential rehabilitation facilities are as set out in the *Victorian Department of Health and Human Services Policy and Funding Guidelines*, *Alcohol and Other Drugs Program Guidelines*, related service specifications and performance indicators outlined in service agreements.

2.4.2 Catering arrangements

Meals are prepared in the facility. In residential rehabilitation services, the preparation of meals is typically part of a program of activities designed to assist residents to transition back to the community. Clients and carers should have access to facilities to prepare drinks and snacks outside of meal times.

2.4.3 Emergencies

Medical emergencies will be managed in accordance with the service provider's standard guidelines, procedures and protocols.

Services should consider whether the client group may require a resuscitation trolley and portable oxygen and suction within the facility. If so they should be readily available in a secure area not accessible to clients.

2.4.4 Client records

If hard copy files are stored in the facility, consideration needs to be given to secure storage and fire protection.

2.4.5 Staffing

Alcohol and other drug residential rehabilitation facility staff work as a multidisciplinary team and may include, in a permanent and/or visiting capacity:

- alcohol and other drug workers
- nursing staff
- counsellors, psychologists and other allied health staff
- social workers
- addiction medicine specialist
- administrative and clerical staff
- housekeeping staff
- medical doctor.

Staffing levels and skill mix will vary depending on the size and configuration of the unit and the service profile.

Unit design should consider the needs of visiting staff including community case managers, support workers etc.

2.5 Planning models

2.5.1 Configuration/layout

Bedrooms should be grouped into clusters or pods for distinct client groups e.g. based on gender (for sexual safety), age and/or severity or type of drugs used appropriate treatment mix and need. The pods should be made up of a mixture of single and double bedrooms and some single bedrooms with an adjoining door. Each pod should have a shared bathroom and an additional separate toilet and a quiet room. Some pods may have a kitchenette with dining area.

The ratio of double bedrooms to single is approximately 60 per cent double to 40 per cent single. Each pod to sleep up to eight clients with one bathroom per four clients.

At least one bedroom should be designed to AS1428 (BCA and Standards Australia, 2009) for independent wheelchair users and at least one bedroom should be large enough to cater for bariatric clients.

The plan for the alcohol and other drug facility should reflect specific operational polices, guidelines and procedures related to the model of care.

Unobtrusive observation of client areas by staff is essential but needs to be balanced with client privacy. Good sight lines from staff areas to client areas are important. All corridors and exits are required to comply with the current *BCA* requirements (Australian Building Codes Board, 2009) and the department's *Fire Risk Management Guidelines*. In developing the layout, consider emergency access/egress of clients, family and friends, police and other emergency services.

2.6 Design requirements

2.6.1 General

Individual spaces combine to form functional zones or clusters with a similar purpose. Alcohol and other drug units are typically comprised of the following functional zones:

- main entry area
- staff and support areas
- clinical areas
- private residential areas
- shared residential areas.

2.6.2 Additional space requirements

The following methods should be used to determine space allocation for communal areas used by clients.

Table 1: Additional area allocations

Space	m2
Main lounge/dining/kitchen	6m2 per person
Outdoor areas	15m2 per person
Multi-purpose rooms	3m2 per person

2.6.3 Main entry area

2.6.3.1 Entry

The main entry is the public face for arrival, reception and waiting for all persons entering the unit and should be the single point of entry. This area should function as a lobby so staff can control access to the facility and monitor arrivals and departures. The entry/reception should be warm and welcoming with enough space for a family i.e. parents and three children to sit comfortably. This area needs to allow for client privacy to mitigate interaction with other clients at this point.

No visitor should be able to directly access other parts of the unit unless admitted by staff. This requires visitors to have a means of communicating with staff inside the unit. Options include locating the office/workstations area for staff so that it can also function as a reception point, or provision of an intercom/CCTV at the main door.

The entry should be of residential scale and sit discreetly within the streetscape.

2.6.3.2 Interview room

An interview room should be provided in close proximity to the main public entry. This room may for used for admitting booked clients as well as for interviews with visitors/carers.

The interview room should be a mental health type with two exit doors and a fixed duress alarm. Furniture should be arranged to encourage informal discussion whilst not obstructing staff exit routes should the need arise. The room should be acoustically treated to protect client privacy.

The interview room will need to be large enough to comfortably seat up to five people.

Refer *Australasian Health Facility Guidelines – Interview Room Mental Health*

2.6.3.2 Consult room

A consult room should be provided in close proximity to the main entry. This room may be used by visiting clinicians. A toilet is required, access from within the consult room, for the collection of urine samples.

Some service providers may take their clients off site for doctor visits.

The consult room should be a mental health type with two exit doors and a fixed duress alarm. The room should be acoustically treated to protect client privacy.

Refer *Australasian Health Facility Guidelines – Consult Room*

2.6.3.3 Medication room/clean utility

The medication room should be provided in close proximity to the staff area and opening in to the shared client areas.

Room for the safe storage, management and dispensing of daily medication.

2.6.3.4 Toilet – visitor (unisex accessible)

A unisex accessible toilet should be provided from the main entry/waiting area for the use of visitors. The toilet will be located off the waiting area without access to the residential area of the house.

2.6.3.5 Waiting area

Throughout the day people may call in for information and or advice or relatives/significant others may be waiting with clients when presenting for admission, therefore the area should be large enough to seat six people comfortably.

2.6.5 Client residential areas

2.6.5.1 Bedrooms – single and double

Clients accessing the service should be provided with either a single bedroom of 10m2 or a shared bedroom of 18m2. Alcohol and drug residential rehabilitation facilities must also meet the department's requirements for gender sensitivity and safety.[6]

Bedrooms must be designed to the same anti-ligature standard as an acute mental health inpatient unit bedroom, utilising only hardware, fixtures and fittings that are specifically marketed and manufactured as 'anti-ligature' type and installed in accordance with manufacturer's instructions.

Clients should have the choice to lock their bedroom door. Where an electronic rather than mechanical locking mechanism is used it must not require a power transfer cable from the door frame to the door.

If door closers are required install closer at bottom of door to avoid ligature point.

The bedroom door should be fitted with anti-ligature type door hardware.

Bedroom doors must also provide staff with rapid access in the event of an emergency. Where outward opening doors are provided, these should be recessed to prevent obstruction of corridors.

An outdoor view is required from the bedrooms.

Refer *Australasian Health Facility Guidelines – bedroom mental health*

2.6.5.2 Bathrooms and toilets

Each bedroom should have access to a shared bathroom and additional toilet.

Bathrooms and ensuites must be designed to the same anti-ligature standard as an acute mental health inpatient unit ensuite, utilising only hardware, fixtures and fittings that are specifically marketed and manufactured as 'anti-ligature' type and installed in accordance with manufacturer's instructions.

Considerations for ensuites, showers and toilets include:

- recessed area for garbage bins
- recessed and durable toilet roll holders
- toilet seats that resist breakage and removal, C type seat.
- Shelves with no doors (rather than collapsible hooks) [7] for clothing and towels in a dry area
- in-fill moulded hand rails (not in accessible toilets)
- recessed soap and shampoo shelf
- 6mm polycarbonate hardcoat mirror sheet, fixed to mdf and packed to finish flush with wall tiles
- anti-tamper fixings to RPZD and TMVs.

All ensuite and bathroom doors should open outwards.

Ensuite doors, located in separate bedrooms only should be cut down at the top (preferably sloped) and bottom to reduce opportunity for self-harm.

Ensuite and bathroom doors should be fitted with an anti-ligature type privacy nib.

Shower curtains may not be required if shower cubicles have good floor-to-fall. Narrow shower heads and controlled water flows may also remove the need for shower curtains and tracks whilst also minimising splash contamination of the surrounding area.

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[6] *The gender sensitivity and safety in adult acute inpatient units project: final report*, 2008.

[7] *No hooks in the ensuite or bathroom further to the Chief Psychiatrist findings May 2016*

Solid surfaces to vanity benches should be resistant to damage by water spray. Joint welded vinyl should be used for wall and floor surfaces.

Refer *Australasian Health Facility Guidelines – ensuite mental health*

Also refer to section – Plumbing fixtures.

2.6.5.3 Shared living, dining room and kitchen areas

The kitchen, dining and living areas should be adjacent to each other to provide a domestic hub that encourages clients and staff to interact in a natural way and provides sufficient space for all clients and staff to participate in combined activities.

These areas may be used 24 hours a day, catering for a variety of activities and may be categorised as follows:

- designated lounge/s for special groups based on age, gender and other characteristics as appropriate
- television/music room with TV, multimedia players etc. in fixed cabinetry
- multifunction recreation area used by all clients in the zone (a secondary use of the dining room).

A lockable pantry/utility area should be adjacent to the kitchen to enable food or other items to be secured as and when required. One space per client.

A small beverage bay may also be located in the dining room or separate alcove for general use by clients outside of mealtimes.

The dining room provides a defined space for clients to eat at tables, seated as small groups or individually. There should be ready access to a unisex accessible toilet.

2.6.5.4 Activity program areas

Space should be provided for group activities. The type of activities undertaken will depend on the client profile and service provider.

Activities may include:

- art
- group discussion
- music
- exercise room
- computer room
- billiard and table tennis area
- gymnasium.

Activities of daily living may also occur in the kitchen and client laundry.

Ligature requirements can be relaxed here accounting for observation.

2.6.5.5 Outdoor areas

Outdoor areas are very important spaces for clients undergoing alcohol and other drug rehabilitation.

Access should be provided from the shared lounge/dining area to a shared outdoor space with weather protection appropriate to the location. Access to the roof structure should be prevented by the inclusion of soffit lining. Door closer at ground level.

Covered verandas should have a width of at least 2.5m width to provide weather protection.

The design of outdoor areas should be domestic in nature and should be therapeutic in design utilising indigenous planting, providing opportunities such as:

- activities of daily living in addition to recreational and leisure activities
- sensory garden. Non injurious plant selection.
- kitchen garden
- animal care (e.g. chicken coop)
- greenhouse
- BBQ or pizza oven
- storage for sporting equipment
- attention should be given to detailing roof overhangs, soffit linings, guttering and drain pipes to minimise opportunities for self-harm
- subtle, motion activated night lighting.

2.6.6 Support area

Support areas comprise:

- storage – client property
- storage – general
- dirty utility
- cleaner's room
- communications room.

2.6.4 Staff and support areas

Alcohol and other drug service staff are typically a combination of clinical, allied health professionals and social work staff who deliver different service components and interventions at different times.

2.6.4.1 Staff work zone

The staff work zone contains workstations for unit staff undertaking administrative activities, making phone calls etc. It typically also functions as the reception point for people arriving at the unit.

2.6.4.2 Office – single person

A single person office is required for the unit manager.

2.6.4.3 Meeting room

A meeting room is required for:

- staff meetings
- staff education/training
- case conferences with visiting community staff
- meetings with family/carers
- group therapy sessions.

2.6.4.4 Staff amenities

A combined unisex accessible staff toilet/shower is required in the secured staff area. The number of staff toilets required will be determined by the proposed number of staff.

2.6.4.5 Staff room/kitchenette

A staff room/kitchenette is required for staff breaks. This room may also include provision of staff lockers for safe storage of personal items while staff are on duty. Staff may prefer to utilize client kitchen to prevent isolation of staff from clients.

2.6.4.6 Staff external area

A separate external area for staff should be provided from the staff room/kitchenette.

2.6.4.7 Staff sleep over

In most instances overnight staff are stand up. However the design should enable conversion of a room within the staff area to enable sleep-over staff in the future should the model of care or client profile change.

2.6.5 Car parking

Provide sufficient car parking on site for staff, visitors and some client vehicles.

2.7 Functional relationships

Alcohol and other drug facility 30 beds (29 August 2017)

Entry

Entry/admissions	Qty	Room area m2	Comments
Reception	1		
Toilet	1		Adjacent to consult room
Waiting	1		
Interview room	2		
Consult room	1		
Medication room	1		

Client residential areas

Patient areas - program / therapy / activity / shared	Qty	Room area m2	Comments
Activity area	1	70	Art room, music room, computer room, exercise area, billiard table, table tennis
Group room	1	20	
Dining	1	60	
Lounge	1	75	
Kitchen	1	60	Commercial grade equipment
Toilet – accessible	1	6	
Laundry (large)	1	12	1 x large central or a few satellite laundries
Pod 1 - bedroom	**Qty**	**Room area m2**	**Comments**
Bedroom – single	2	12	
Bedroom - double	2	20	
Bathroom – shared	2	6	Quantity dependent on number of pods 1 x per 4 clients
Lounge – quiet room	1	9	1 per pod
Toilets - shared	1	4	1 per pod
Pod 2 - Bedroom	**Qty**	**Room area m2**	**Comments**
Bedroom – single	2	12	
Bedroom - double	2	20	
Bathroom – shared	2	6	Quantity dependent on number of pods 1 x per 4 clients
Lounge – quiet room	1	9	1 per pod
Toilets - shared	1	4	1 per pod
Pod 3 - Bedroom	**Qty**	**Room area m2**	**Comments**
Bedroom – single	2	12	Adjoining door
Bedroom - double	2	20	

Bathroom – shared	2	6	Quantity dependent on number of pods 1 x per 4 clients
Lounge – quiet room	1	9	1 per pod
Toilets - shared	1	4	1 per pod
Pod 4 - Bedroom	**Qty**	**Room area m2**	**Comments**
Bedroom – single	2	12	
Bedroom - double	1	20	
Bedroom – accessible	1	18	
Bathroom – shared	1	6	Quantity depending on number of pods, 1 x per 4 clients
Ensuite – accessible	1	7	
Lounge – Quiet room	6	9	1 x per pod
Toilets – shared	1	4	1 x per pod
Kitchenette	1	9	
Pod 5 - Bedroom	**Qty**	**Room area m2**	**Comments**
Bedroom – single	2	12	Adjoining door
Bedroom – double	2	20	
Bedroom – accessible	1	18	
Bathroom - shared	2	6	Quantity dependent on number of pods. 1 x per 4 clients
Ensuite – accessible	1	7	
Lounge – quiet room	6	9	1 x per pod
Toilets – shared	1	4	1 x per pod
Beverage Bay	1	4	

Clinical support

Support	**Qty**	**Room area m2**	**Comments**
Bay - linen	1	2	
Cleaners room	1	5	
Comms room	1	9	
Disposal room	1	10	
Store – client property	1	9	
Utility – dirty sub	1	8	

Staff areas

Staff and support	**Qty**	**Room area m2**	**Comments**
Meeting room	1	20	
Office – single person	2	9	
Office – workstations	15	5.5	
Shower - staff	1	3	
Sleepover - staff	1	9	
Ensuite - staff	1	5	Adjacent to sleepover

Staff rom/kitchenette	1	20	
Toilet - staff	3	3	Quantity dependent on number of staff
Toilet – staff (accessible)	1	6	
TOTAL			
			Circulation 32%, plant and travel 8%

Refer to Attachment 2: Functional relationships diagram

3 Design

"High-quality design enhances quality of life – uplifting communities and influencing how people feel and behave – and uses resources effectively and imaginatively. Good design is about inclusive, delightful and inspiring places, creating more sustainable outcomes, and contributing to a sense of place and belonging.

The Office of the Victorian Government Architect (OVGA) believes that good design plays a significant role in the efficient delivery of high-quality health care. Well-documented research shows that better buildings lead to better health outcomes. Well-designed spaces have been able to demonstrate improved patient recovery times, improved morale, increased staff efficiency and reduced staff turnover. The design process can be a catalyst for change, encouraging fresh approaches to both the organisation of health care and the design of the environments in which it takes place. Intelligent, sensitive, and innovative design approaches can make a significant contribution to the quality of life of patients and the working lives of hospital staff." [8]

3.1 General

The facility should be located within a mixed residential area whenever possible and its external appearance should be appropriate to the neighbourhood character. Ideally located to provide good links to other services and community facilities. The facility should be close to public transport, public sporting facilitates and close to emergency services.

3.2 Building strategies

Architects, designers, engineers and builders should be aware that while an alcohol and drug residential rehabilitation facility is intended to be residential in character, the fabric must be considerably more robust than is typical for domestic construction. Particular attention should be paid to walls, doors, ceilings and glazing, both in terms of acoustic management and the potential for damage by clients and for clients to self-harm.

3.3 Access

The residence must be accessible, safe and conducive to providing support and treatment. Adult alcohol and other drug residential rehabilitation services also need to provide a suitable environment for different age groups and a mixed gender client group, with due consideration given to issues of privacy, personal space, safety and carer and client preferences.

The public entrance area will be the first point of access for all clients coming into the service. In design, this area needs to be warm, welcoming and clearly delineate the domestic feel of the service.

All persons attending the centre should be made to feel welcome. This centre is not designed to be a secure unit and the external doors should be left unlocked during office hours (Mon - Fri 9.00 am - 5.00 pm).

An entry lobby should be provided to enable staff to better supervise and manage arrivals and departures.

[8] The Office of the Victoria Government Architect

3.4 Parking requirements

Parking is required for on-site staff, visiting staff and other visitors. The number of on-site car parking spaces provided will be determined in accordance with local authority planning requirements, the number of staff at the residence at any one time and the availability of on-street parking.

Wherever possible, avoid providing a single, large asphalted area for car parking immediately at the front of the facility as this will detract from its residential appearance. On larger sites consider placing car parks along the side of the facility or provide two or more smaller parking areas with landscape buffers.

Consider lighting to incorporate crime prevention through environmental design (CPTED) principles.

3.5 Disaster planning

Evacuation plans are required in the event of a fire or other emergency to ensure the safety of staff and clients. Unit layout needs to identify secure assembly areas should evacuation be required.

Essential services such as minimum lighting to allow clients observation, telephones, duress alarm system the central computer, lighting and electronic locks should be connected to the emergency power supply.

3.6 Infection control

3.6.1 Hand basins

Hand basins are required in treatment and medication rooms. Staff should still have ready access to a hand basin in staff only area.

3.7 Environmental considerations

3.7.1 Acoustics

The design of the unit should seek to minimise disturbance to residents through unwanted noise from external sources. Utilise CPTED principles. Strategies include:

- selecting a location that is not subject to noise from incompatible adjoining uses
- positioning the facility on the site so it has adequate setbacks from any potential noise sources
- locating resident bedrooms furthest from any potential noise sources e.g. away from the street frontage and any traffic noise.

The siting of the facility should also seek to minimise the impact on neighbours of any noise originating from within the facility. Strategies include:

- avoiding locating outdoor recreation areas along a property boundary where neighbours windows are in close proximity.

The design of the unit should also seek to minimise disturbance to residents from any internal noise. Acoustic considerations will apply to day areas of the building (living, dining and activity rooms) and interview rooms. Strategies include:

- acoustically treating walls between bedrooms
- avoiding extensive use of hard surfacing in communal areas where groups of residents gather
- providing doors to corridors that connect communal areas to bedroom pods
- avoiding air grilles and other factors, particularly in treatment and support areas, to ensure confidentiality and avoid transfer of conversations.

3.7.2 Natural light

The design should maximise natural light within the facility, particularly to communal areas that are used most frequently during the daytime.

3.7.3 Interior decor

All furniture, fixtures and fittings used in private resident areas e.g. bedrooms and bathrooms and ensuites must be of a type specifically manufactured and marketed as 'anti-ligature' type.

Integral blinds are preferred in bedrooms.

Shared communal areas can be of a more residential type but should avoid any obvious potential risks of resident self-harm.

3.7.4 Statutory compliance

All premises used to deliver alcohol and other drug residential rehabilitation services will be compliant with the Building Code of Australia as specified in Part A3 Classification of Buildings and Structures and Australian Standards.

BCA Part A3 Classification states:

"Class 3: a residential building, other than a building of Class 1 or 2, which is a common place of long term or transient living for a number of unrelated persons, including …d) accommodation for the aged, children or people with disabilities"

An electronic communication system that is specified in the Victorian Appendix to the BCA is only required to be installed in residential aged care buildings. Alcohol and drug residential rehabilitation services are not a residential aged care building as defined in the BCA and therefore this provisions is not applicable. Alcohol and drug residential rehabilitation services have a specific requirement that such a communication system is not installed. This is consistent with the BCA.

Hot water temperature to showers and baths must also be compliant with the BCA

3.7.5 Building form/character

The primary goal of the facility is the provision of a safe and secure environment in which clients can continue to progress in their treatment and rehabilitation. The basic concept is to maintain a domestic like design/layout, as far as possible promoting a sense of continuity with everyday life in the community.

The building should:

- be of residential scale and character, not just in terms of external appearance but in the way internal and external spaces are arranged relative to each other e.g. the kitchen, dining and living area should be designed to enable comfortable conversation between occupants of those spaces
- be arranged on the site so that there are well-proportioned, accessible outdoor areas
- be arranged on the site and designed to prevent oversight from adjoining properties as far as practicable
- provide a variety and hierarchy of spaces to meet the range of client needs for personal and shared spaces e.g. that allow opportunities for clients to have quiet, individual reflection, to participate in small group activities and to come together as a full group of all residents and staff and possible visitors
- provide clear lines of sight to internal and external areas that enable staff to have a sense of where residents are at any particular time

- reduce travel distances for staff and provide clear lines of sight so they can remain aware of the location of other staff and residents and can respond in the event of any incidents
- clearly differentiate between client areas and staff only areas
- enable clients to feel safe in the environment e.g. avoid hidden nooks, provide clients the ability to their room
- enable clients to move freely between indoor and outdoor spaces
- provide outdoor spaces that flow logically from shared internal areas, provide shelter during different seasons of the year and minimise clashes between quiet, passive recreation areas and more active recreation areas
- enable gender separation and/or separation of different cohorts of clients
- be designed to minimise energy and water consumption and non-renewable resources
- provide for effective sun control, light penetration and thermal performance, maximising the benefits of passive solar design.

3.8 Space standards and components

3.8.1 Human engineering

Human engineering covers those aspects of design that permit effective, appropriate, safe and dignified use by all people, including those with disabilities. It includes occupational ergonomics, which aims to fit the work practices, furniture, fittings and equipment (FF&E) and work environment to the physical and cognitive capabilities of all persons using the building.

As the requirements of occupational health and safety and antidiscrimination legislation will apply, this section must be read in conjunction with the section on Safety and Security below, in addition to other OHS related guidelines.

3.8.2 Ergonomics

The build and design of the unit should not expose clients, staff, visitors and maintenance personnel to risks or injury.

3.8.3 Access and mobility

In line with the *Commonwealth Disability Discrimination Act 1992* (Commonwealth of Australia, 1992), at least one bedroom and ensuite should be provided for independent wheelchair users.

Reception desks should be designed so that at least one place is wheelchair accessible on both sides.

Ramps and turning circles need to address anticipated traffic including movement of independent wheelchair users.

3.8.4 Building elements

Building elements include walls, floors, ceilings, doors, windows and corridors and are addressed in detail in Part C 3 - Space Standards and Dimensions of the *Australasian Health Facility Guidelines*.

Carefully consider the fabric of the building, particularly wall construction, to ensure it is robust enough to withstand abuse and appropriate use of materials such as impact-resistant glass and low maintenance/resilient surfaces.

In areas of high traffic and potential damage, impact resistant materials should be substituted.

Minimise opportunities for self-harm. In particular, client bedrooms and ensuites must be designed to the same anti-ligature standards as an acute mental health inpatient unit.

3.8.5 Doors

Provide solid core doors and door frames that meet all relevant BCA and fire regulation standards.

All doors to client bedrooms, ensuites and toilets must be able to be easily opened by staff to gain access in an emergency.

All hardware to bedroom doors, including hinges, door knobs and hinges must be of a type specifically manufactured and marketed as anti-ligature type.

If door closers are required install closer at bottom of door to avoid ligature point.

3.8.6 Windows and glazing

In client areas, all window frames should be heavy duty (commercial frame) construction and securely fixed to the wall fabric.

In areas where damage to glass may be anticipated, larger pane sizes should be avoided as smaller panes are inherently stronger for a given thickness than larger panes. Impact-resistant and shatter-proof Grade A safety glass to comply with Australian Standards. Polycarbonate is not recommended as it suffers from surface scratching and deteriorates, thus reducing vision.

If openable windows are specified to resident bedrooms, these should be of a type that has all required safety features integrated within the unit rather than a combination of elements that try to achieve the required performance standard i.e. they should be a type specifically manufactured and marketed as ‘anti-ligature’, prevent passing of contraband, prevent clients exiting via the window (particularly if the window is above ground floor level), robust, and attractive and comply with the BCA and DHHS *Fire Risk Management Guidelines.*

3.9 Safety and security

3.9.1 Risk management and harm minimisation

Safety and security risks should be considered during the planning and design phases and continue to be addressed and reviewed during the construction, commissioning and post occupancy stages.

3.9.2 General principles

A safe environment in alcohol and drug residential rehabilitation units is more likely to be achieved when good design is allied with appropriate staffing levels and operational policies.

The Unit should not only be safe but feel safe. Security may be physical or psychological and barriers may be real or symbolic, but all should be unobtrusive. The aim should be to provide the least restrictive environment that still provides a safe environment.

The design layout should assist staff to carry out their duties safely and to supervise clients by allowing or restricting access to areas in a manner which is consistent with clients' needs/abilities. Staff should be able to view client movements and activities as naturally as possible, whenever necessary.

3.9.3 Access control

Clients will attend the alcohol and other drug residential rehabilitation unit on a voluntary basis. However, the Unit should be designed so that staff can monitor client arrivals and departures. If a client leaves without approval they are considered to be discharging themselves. Clients in residential rehabilitation will eventually gain the status to arrive and depart with approval.

Security features should also be provided to prevent unauthorised entry to the unit.

There should be 'staff-only' administrative and support areas that staff access via swipe card.

All rooms should be lockable including all corridor cupboard doors including fire hose reel cabinets.

All meeting rooms used by clients, including counselling/examination rooms require two means of egress and duress alarms – fixed, personal or a combination of these.

3.9.4 Closed circuit television surveillance

The use of closed circuit TV (CCTV) for client surveillance is not supported within alcohol and other drug residential rehabilitation facilities.

3.9.5 Duress alarm system

A system of personal duress alarms with a 5m2 radius of position and location finders should operate throughout the unit and in all outdoor areas, so that there is limited need for fixed duress alarm points.

The optimum approach is a combination of personal alarms with location finders linked to a real time monitor facility and some fixed alarms particularly in areas where staff work in a relatively fixed position such as reception, to ensure there is a back-up system if one system fails.

Visiting staff should be provided with, and trained in, the use of personal duress alarms.

An appropriate response mechanism should be in place. There should be sufficient number of personal alarms to ensure all staff and relevant visiting staff can carry one while in the unit. The charger for personal alarms should be located in a staff-only area accessible 24 hours per day.

Location of fixed duress call points is critical to ensure that:

- staff can actually reach them without having to cross the path of the client or distressed family member
- they cannot be activated by clients or children
- they cannot be activated accidentally e.g. by a chair being pushed back.

3.9.6 Perimeter fencing and security

Residential type fencing only is required to an alcohol and other drug residential rehabilitation unit although consideration should be given to:

- preventing any children who may be visiting the site from wandering
- encouraging clients to enter and exit the unit through the main entry
- protecting privacy of clients, particularly in outdoor areas
- discouraging unauthorised intruders.

Avoid blind spots to facilitate good observation of clients by staff and vice versa.

3.10 Finishes

3.10.1 Ceiling finishes

Ceiling linings to client bedrooms and ensuites should be constructed from solid sheet.

Pay attention to detailing of ceiling air conditioning outlets, lights and fire detectors in client bedrooms and ensuites to ensure they are tamper-proof and meet anti-ligature requirements.

3.10.2 Flooring

Non-slip flooring is required in wet areas and all flooring should be easily cleaned.

Consider the use of cushioned vinyl in corridors, activity rooms and areas where groups gather.

Flooring in client bedrooms may include carpet but careful consideration should be given to cleaning and replacement.

3.10.3 Wall finishes

Ensure that wall linings are washable, robust and resistant to physical impact.

Vinyl joints should be welded.

3.11 Fixtures and fittings

3.11.1 Definitions

Fixtures and fittings are defined as follows:

- **fixtures:** fixed items that require service connection (e.g. electrical, hydraulic, and mechanical) and includes hand basins, light fittings, etc.
- **fittings:** fixed items attached to walls, floors or ceilings that do not require service connections such as curtain tracks, mirrors, blinds, joinery, pin boards, etc.

Good design can provide resident bedrooms and ensuites that are attractive yet safe, without an overly “institutional” feel.

All fixtures, fittings and furnishings used in the resident bedrooms and ensuites must be of a type specifically manufactured and marketed as ‘anti-ligature’ type installed in accordance with manufacturer’s instructions. Where the project team cannot identify an anti-ligature item for a specific use, they must seek advice from the department’s alcohol and other drug program and the Design Services unit, Victorian Health and Human Services Building Authority.

3.11.2 Furniture

Furniture should promote a domestic, home-like atmosphere but loose furniture should be sturdy enough to prevent use as a weapon.

Built-in furniture should be considered wherever possible.

The type of bed provided to client bedrooms should be selected carefully taking into consideration anti-ligature requirements and OHS issues for staff.

Mattresses should have a high fire resistance rating and should not be inner sprung.

3.11.3 Artwork, signage and mirrors

Artwork, mirrors and signage should be rigidly fixed to walls with concealed, flush, tamper-proof mountings. Artwork based on non-tear able fabric may be considered. Consideration should be given to involving the client and carers in the selection of art works.

Ensure that mirrors are made from acrylic impact-resistant and shatterproof construction, are scratch proof and free from distortion.

3.11.4 Plumbing fixtures

All exposed plumbing fixtures including shower heads, taps and waste pipes should be anti-ligature type, tamper-proof and resistant to breakage and removal. This should apply to client toilets and to all staff and visitor toilets that may be accessible to clients.

Services such as sink and basin wastes which may be easily damaged or used as ligature points should be concealed.

Toilet cisterns should be enclosed behind the wall with ease of access for maintenance.

3.11.5 Rails and handles

Grab rails and hand rails should be anti-ligature type. When selecting the anti-ligature grab rails to be used for toilets and showers consider the means of water drainage to prevent build-up of mould.

All door and cupboard handles/knobs and hinges are to be anti-ligature type. Fittings moulded to incorporate hand pulls are preferred.

3.11.6 Shower curtains and tracks

The design of ensuites and bathrooms should seek to remove the need for shower curtains and tracks where possible. This can be achieved if the shower cubicle is appropriately sited, floors graded appropriately and water rate is controlled to prevent excessive splashing.

Where installed, shower tracks must be anti-ligature type, plastic and mounted flush to the ceiling to prevent the possibility of attaching anything such as cords or belts. It is critical to ensure that the entire track plus hooks has a fifteen kilogram breaking strain to ensure that if curtains are gathered into a single cluster the aggregate does not exceed fifteen kilograms.

3.11.7 Window treatments

Curtains, Holland blinds or any other type of blinds or curtains with cords should not be used in client bedrooms. However, alternative means of providing privacy should be considered.

Where curtains or blinds are provided in areas accessible to clients these must be anti-ligature type.

Enclosed integral venetian blinds with flush controls or electronic controls are an option where privacy and sun shading are required. Venetian blinds must be fully retractable

Ideally external shading of windows (eaves, awnings, etc.) addressing environmental considerations should be the preferred option while applying the same safety principles for fittings and fixtures.

If curtains are selected for use in client recreational areas, provide tracks flush to the ceiling with a breaking strain of fifteen kilograms (as for shower curtains). Consideration should also be given to fabric type, with respect to weight/thickness and ease of tearing.

3.11.8 Lighting

All lighting provisions and fixtures are to suit the building chosen and be within acceptable residential/medical industry standards. Exposed or accessible fluorescent tubes or incandescent bulbs should be avoided.

Security lighting (particularly to client outdoor areas). Emergency lighting throughout.

Other light fittings, smoke and thermal detectors should be tamper - proof and anti-ligature.

3.12 Building services requirements

3.12.1 Electrical services

Power outlets in client bedrooms should be fitted with residual current devices.

3.12.2 Fire safety

In general, fire requirements are covered by the Building Code of Australia, the *Fire Risk Management Guidelines* and the New Zealand equivalent, and AS1603 Automatic Fire detection and Alarm Systems (Standards Australia, 1997).

Despite no smoking rules, clients will often try to smoke in secret. Smoke detectors should therefore be installed in ensuites. Detectors should be tamper-proof or located so as to be inaccessible to clients.

Detectors should be anti-ligature type and tamper proof or located as to be inaccessible to clients.

Fire mimic panels should be installed in staff stations.

Fire hose reels should be located in recessed cabinets with lockable doors (no exposed fire hose reels).

Locking of fire services will require consultation with local fire services and involve staff in managing an evacuation situation.

All fabrics, soft furnishings and items such as mattresses should have a low flame index.

3.12.3 Information and communication systems

Communication systems may provide for:

- alarm systems where necessary
- duress alarms – personal and fixed
- telephone services for staff, clients and visitors. The extent of provision, location, and type i.e. fixed or portable with charging docking stations will need to be addressed in the planning stage to identify space for attaching of charging docking stations
- fixed and cordless telephones for use by clients should be considered
- computer and internet access for clients and staff - teleconferencing, videoconferencing and telecounselling facilities that are used for staff education, management and client services.

Make adequate provision for cabling and power outlets for computers and consideration for wireless technology.

3.12.4 Staff and emergency call system

The need for a client call system in bedrooms and bathrooms should be assessed. Call buttons may not always be in easy reach of the client, systems can be abused and most clients are ambulant and capable of asking for assistance. If installed, the system should allow staff override.

3.12.5 Ventilation and air handling

Consideration should be given to the type of heating and cooling units, ventilation outlets and equipment installed in private and resident areas to minimise opportunities for self-harm.

The following is applicable:

- use air grilles and diffusers that are anti-ligature type and tamper resistant
- provide tamper-resistant fasteners where these are exposed
- construct all convector or heating, ventilation, and air conditioning (HVAC) enclosures exposed in the room with rounded corners and with closures fastened with tamper-resistant screws
- use HVAC equipment that minimises the need for maintenance within the room
- air conditioning vents should be fixed to the ceiling to prevent access to the roof cavity
- avoid panel heaters in resident bedrooms are not supported.

4 Components of the unit

4.1 Standard components

Rooms/spaces are defined as standard and non-standard components. Standard components (SC) refer to rooms/spaces for which room data sheets, room layout sheets (drawings) and textual descriptions have been developed. Their availability in these guidelines is indicated by 'Y' in the SC column of the Schedule of Accommodation.

Standard components are provided to assist with the development of a project, they indicate a compliant layout but other layouts are acceptable as long as they achieve all required performance standards.

Refer to Part B, Section 90 and to room data and room layout sheets of the *Australasian Health Facility Guidelines*.

4.2 Non-standard components

Non-standard components are unit-specific and are listed and described below:

- kitchen
- meeting room
- multifunctional activity space
- secure entry zone and airlocks
- store – clean linen.

4.2.1 Kitchen

4.2.1.1 Description and function

The kitchen is used for the preparation of meals and snacks for residents. Residents may participate in meal preparation so the kitchen should be sized to enable multiple users at the one time and accommodate commercial grade kitchen equipment including a commercial grade coffee machine used for training.

Food preparation and consumption is a key component of social interaction and group communication. The preparation and provision of food is a critical feature in creating and maintaining a domestic atmosphere within the alcohol and drug residential rehabilitation and it is also a major life role.

In keeping with the domestic feel of the residence and the requirement that alcohol and drug residential rehabilitation prepares clients for life within the community, the following are of key importance in the provision of food and meals:

- flexibility/availability of food, hot and cold drinks and access to food preparation facilities outside of meal times
- choice of different foods
- ability to prepare food in a culturally-relevant way
- adherence to the Australia and New Zealand food standards code, Standard 3.3.1 Food safety programs for food services to vulnerable persons.

4.2.1.2 Location and relationships

The kitchen should be co-located with the shared dining and living areas.

4.2.1.3 Considerations

It is desirable for the kitchen to be open plan type to facilitate easy communication between staff and residents in the shared dining and living areas.

A separate, lockable pantry should be considered to enable secure storage of food items and equipment if required.

The kitchen should have the capacity for staff to lock away any items that may present a potential safety risk when the kitchen is unsupervised.

4.2.2 Meeting room/visitor room

4.2.2.1 Description and function

A meeting room/visitor room is required to enable staff to have team meetings, liaise with visiting clinical staff, hold family meetings and as a location for family/carers to visit consumers.

4.2.2.2 Considerations

The meeting room should be provided close to the entry as well as the staff base. If possible, access should be provided to a pleasant outdoor space to accommodate visiting children.

4.2.3 Activity area

4.2.3.1 Description and function

An activity area is required for residents to participate in structured programs during the day and for use as a recreational space at other times.

4.2.3.2 Location and relationships

The activity area should be located in the resident's shared area.

4.2.3.3 Considerations

The fit-out of the activity area will reflect the needs of residents and the programs provided by the service e.g. it may function as an art space or as a music room. The room should be fitted with lockable joinery units that enable items required for one activity to be put away when another activity is underway.

4.2.4 Resident laundry

4.2.4.1 Description and function

The resident laundry is provided to enable consumers to undertake their own personal laundry.

4.2.4.2 Considerations

The laundry should be lockable with access controlled by staff. Careful consideration should be given to how washing machines and dryers are installed so that they do not provide exposed pipes and taps. This may be achieved by installing them within a niche or in a joinery unit that restricts access to the rear of the machines.

Laundry troughs should be fitted with anti-ligature tapware and waste pipes shrouded to prevent access.

Products typically used in a laundry and that may be harmful if ingested should be stored within a locked cabinet with access provided by staff.

Separate lockable storage per consumer should be considered for storage of personal laundry consumables.

Attachment 1: Schedule of Accommodation

A generic schedule of accommodation for a 30-bed alcohol and other drug residential rehabilitation facility is shown below. This schedule must be used in conjunction with this guideline.

Generic 30 bed residential rehabilitation

Alcohol and other drug facility 30 beds (29 August 2017)

Entry

Entry/admissions	Qty	Room area m2	Comments
Reception	1		
Toilet	1		Adjacent to consult room
Waiting	1		
Interview room	2		
Consult room	1		
Medication room	1		

Client residential areas

Patient areas - program / therapy / activity / shared	Qty	Room area m2	Comments
Activity area	1	70	Art room, music room, computer room, exercise area, billiard table, table tennis
Group room	1	20	
Dining	1	60	
Lounge	1	75	
Kitchen	1	60	Commercial grade equipment
Toilet – accessible	1	6	
Laundry (large)	1	12	1 x large central or a few satellite laundries
Pod 1 - bedroom	**Qty**	**Room area m2**	**Comments**
Bedroom – single	2	12	
Bedroom - double	2	20	
Bathroom – shared	2	6	Quantity dependent on number of pods 1 x per 4 clients
Lounge – quiet room	1	9	1 per pod
Toilets - shared	1	4	1 per pod
Pod 2 - Bedroom	**Qty**	**Room area m2**	**Comments**
Bedroom – single	2	12	
Bedroom - double	2	20	
Bathroom – shared	2	6	Quantity dependent on number of pods 1 x per 4 clients
Lounge – quiet room	1	9	1 per pod

Toilets - shared	1	4	1 per pod
Pod 3 - Bedroom	**Qty**	**Room area m2**	**Comments**
Bedroom – single	2	12	Adjoining door
Bedroom - double	2	20	
Bathroom – shared	2	6	Quantity dependent on number of pods 1 x per 4 clients
Lounge – quiet room	1	9	1 per pod
Toilets - shared	1	4	1 per pod
Pod 4 - Bedroom	**Qty**	**Room area m2**	**Comments**
Bedroom – single	2	12	
Bedroom - double	1	20	
Bedroom – accessible	1	18	
Bathroom – shared	1	6	Quantity depending on number of pods, 1 x per 4 clients
Ensuite – accessible	1	7	
Lounge – Quiet room	6	9	1 x per pod
Toilets – shared	1	4	1 x per pod
Kitchenette	1	9	
Pod 5 - Bedroom	**Qty**	**Room area m2**	**Comments**
Bedroom – single	2	12	Adjoining door
Bedroom – double	2	20	
Bedroom – accessible	1	18	
Bathroom - shared	2	6	Quantity dependent on number of pods. 1 x per 4 clients
Ensuite – accessible	1	7	
Lounge – quiet room	6	9	1 x per pod
Toilets – shared	1	4	1 x per pod
Beverage Bay	1	4	

Clinical support

Support	**Qty**	**Room area m2**	**Comments**
Bay - linen	1	2	
Cleaners room	1	5	
Comms room	1	9	
Disposal room	1	10	
Store – client property	1	9	
Utility – dirty sub	1	8	

Staff areas

Staff and support	**Qty**	**Room area m2**	**Comments**
Meeting room	1	20	

Office – single person	2	9	
Office – workstations	15	5.5	
Shower - staff	1	3	
Sleepover - staff	1	9	
Ensuite - staff	1	5	Adjacent to sleepover
Staff rom/kitchenette	1	20	
Toilet - staff	3	3	Quantity dependent on number of staff
Toilet – staff (accessible)	1	6	
TOTAL			
			Circulation 32%, plant and travel 8%

Attachment 2: Functional relationships diagram