DESIGN GUIDELINES for
SPECIALIST PALLIATIVE CARE SETTINGS
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Introduction

The report of the National Advisory Committee on Palliative Care was published in late 2001. It outlined a structured development strategy for the planning and provision of palliative care services in Ireland, and provided an agreed blueprint as to how to proceed for all those involved in this area.

This report made many recommendations that are fundamental to the future development of palliative care services. These include, in particular, the proposal that palliative care services should be available to patients based on need, arising from both malignant and non-malignant conditions. The report also provides that the service should develop on a regional basis. It recommends a regional committee structure based on a partnership approach between the State and Voluntary sectors to allow people who have an interest in the service an opportunity to agree and make proposals on the future shape of the service, so that developments occur in an orderly and planned fashion based on the recommendations of the report.

The report acknowledges that in the past many developments in the area occurred on an ad-hoc basis. It is important that future developments, particularly capital developments, should be planned in the context of comprehensively arranged regional structures.

This report is available on the website of the Department of Health and Children, (www.doh.ie), as well as in printed form from the Department.

These design guidelines have been prepared in response to the particular recommendation in the National Advisory Committee’s report that ‘An Expert Group on Design Guides for Specialist Palliative Settings should be established to inform all relevant parties, and to ensure a national consistency of standards for all specialist palliative care settings’.

This recommendation was considered in detail and developed, resulting in the following agreed terms of reference for the Expert Group:

“To prepare guidelines, for the assistance and information of those writing design briefs, on the nature, type and size of accommodation required for specialist palliative care settings, which are to be capable of supporting fully and in the best possible way, the needs of both patients and families under their care, as well as the needs of staff working within them.”
Membership of the Expert Group is as follows:

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*Principal Officer*  
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* Replaced Mr Tadgh Delaney, Assistant Principal Officer, Department of Health and Children, during the drafting of these guidelines.

** The Group wishes to express its thanks to Mr Paul de Freine for his invaluable assistance in the drafting of these guidelines.

To assist in the preparation of these guidelines and to ensure that a wide range of views was taken into account, submissions were sought from various bodies, and responses were received from the following:

- Irish Physiotherapists in Oncology and Palliative Care Group
- Hospice and Palliative Care Social Workers Group
- Directors of Nursing of Hospices with In-Patient Units
- Macmillan Cancer Relief (c/o Donegal Hospice)
- Irish Motor Neurone Disease Association
- Nursing Department of St Patrick’s Hospital, Marymount Hospice
- Prof Nunn, Department of Public Health, Dublin Dental Hospital
For similar reasons, visits were arranged to a number of existing hospices, and informal discussions took place with the management and staff of the following units:

- Marymount Hospice, Cork
- Our Lady’s Hospice, Harold’s Cross, Dublin
- Galway Hospice, Renmore, Galway
- North West Hospice, Sligo
- St. Francis Hospice, Raheny, Dublin
- Milford Care Centre, Milford, Limerick
- St. Joseph’s Hospice, Hackney, London
- Marie Curie Centre, Belfast, Northern Ireland
- Marie Curie Centre, Newcastle, England

A visit was also made to the National Rehabilitation Hospital, Dun Laoghaire, to discuss issues around the care of patients with significant physical or sensory impairments arising from their illness.

The expert group, in their assessment of the units visited, gave particular consideration to the following issues:

- An outline of the services provided and activities undertaken
- The type of accommodation available for the delivery of these services.
- Relationships and adjacencies of building spaces, rooms, and departments.
- Success in use, and scope for improvement.
- Quality of access, circulation, space, light, and finishes.
- Provision of staff facilities.
- Provision for families, including children.
- External space and activities – gardens, parking, deliveries, and traffic.
- Plans for future development.
- Mechanical and electrical services.
- Provision of storage.
- The design and operational approach to particular facilities within the unit, such as reception, catering, pharmacy, and mortuary.
- The patients journey through the unit.

It is suggested that project and design teams might further study such issues if they visit units by way of preparation for future projects.

It is a particular wish of this group to offer guidance which will assist in the attainment of the highest possible standards of design for hospice projects, within the constraints that will exist in relation to each individual project. Future project teams should stress the importance of achieving quality environments, both internal and external, for the benefit of all those using, visiting and working in specialist palliative care facilities.
In the design of these buildings it is to be recognised that there is a need for the facility to fully support the entire range of activities and services that are to be provided. The physical structure and environment of a specialist palliative care in-patient unit should be appropriate to the needs of patients and staff, and should also be sensitive to the needs of families and friends of patients.

These guidelines do not deal with the particular palliative care needs of children, which are to be the subject of separate research and recommendations in due course.

The expert group acknowledges with gratitude the particular assistance received from the project team responsible for preparing a development brief for Marymount Hospice at St Patrick’s Hospital in Cork, whose work coincided with and contributed to the preparation of these guidelines.

The report of the National Advisory Committee on Palliative Care notes that the components of the specialist palliative care service should consist of the following:

- **Specialist In-patient Unit**
  
  ‘The specialist palliative care in-patient unit should be the core essential element of the specialist palliative care service. This unit should act as a co-ordinating centre for the delivery of specialist palliative care services in all care settings, including hospitals and the community.

  The specialist palliative care in-patient unit should provide a wide range of specialist services to patients and families, including medical, nursing, psychological and spiritual care. Reasons for admission would ordinarily include complex symptom management, psychosocial problems, and intensive rehabilitation. The specialist unit should also act as a resource for other health professionals in the area, by providing support and advice when needed. The specialist unit should also provide facilities research and education in palliative care.’

- **Specialist Satellite Unit**

  ‘In keeping with the principle of equity, it may be necessary to establish a satellite specialist palliative care in-patient unit in some health board areas with a wide geographic spread. The satellite in-patient unit would function as an extension of the lead specialist palliative care unit in the region. There should be no more than one satellite unit in any health board area.’

- **Specialist Teams in Acute General Hospitals**

  ‘The National Advisory Committee recommends that all acute general hospitals should have a specialist palliative care service. This service should be provided by an inter-disciplinary team and should be led by a consultant in palliative medicine, who would be available for a defined minimum number of sessions per week. The specialist palliative care team should consist of at least a specialist palliative care nurse, a social worker, and a secretary. Hospital
specialist palliative care teams would offer advice and support to other professional health care providers regarding the management of patients with advanced and progressive disease. Such teams would function as an extension of the lead specialist palliative care unit for the region.

- **Specialist Teams in the Community**

  ‘The specialist palliative care team should be an inter-disciplinary consultant led team, consisting of nursing staff and at least a physiotherapist, an occupational therapist and a social worker. All team members should be trained in palliative care.

  The specialist palliative care team should be based in, and led by, the specialist palliative care unit in the area. In areas with a wide geographic spread, the specialist palliative care team working in the community may be based in satellite units, which maintain close clinical, educational, and administrative links with the lead specialist palliative care unit.

  Support beds for palliative care patients are provided in a number of community hospitals around the country. They provide an intermediate level of in-patient care for patients. The specialist palliative care team working in the community may be involved in the patient’s care when appropriate.

  **In smaller general hospitals, where it may not be feasible to employ a full-time specialist palliative care team, the specialist palliative care team serving the community should provide a service to patients in the hospital.**

- **Day Care Centre/Outpatients**

  ‘Day care centres attached to specialist palliative care units provide access to all specialist palliative care services. Patients may attend day care programmes for medical and nursing care or for rehabilitation. The Committee recommends that all specialist palliative in-patient units should provide day care facilities for patients.’

- **Facilities for Support and Advice**

  ‘Bereavement support is an integral part of palliative care and should be incorporated into all specialist palliative care programmes. Bereavement support should be available in all settings where specialist palliative care is offered.’

- **Facilities for Education and Research**

  ‘Education is a core component of specialist palliative care. The culture of continuing professional education and development should be promoted among health care professionals in all disciplines that are involved in the delivery of palliative care.’
It is intended that the specialist palliative care in-patient unit should be the core essential element of the specialist palliative care service.

Equally, it is intended that specialist palliative care services in all other settings, including general hospitals and the community, should be based in or have formal links with the specialist palliative care unit.

These guidelines will offer advice on the accommodation requirements of the various settings mentioned. Most of these requirements will be identified and discussed by dealing particularly with the specialist palliative care in-patient unit, and the other settings will only therefore be discussed in general terms, or where particular needs specific to that setting have been identified.

These guidelines are to be read in conjunction with the Report of the National Advisory Committee on Palliative Care.

While these guidelines offer guidance on design issues and related matters, it important to note that future capital projects should be developed in full accordance with the normal requirements of the Department of Health and Children and the Department of Finance. Particular attention should be paid to such issues, inter alia, as appraisal of options, project planning, funding and staffing, questions of operational policy, and service linkages. A table is attached at Appendix 1, which gives an overview of the various stages to be followed in progressing a healthcare or hospital building from identification of service need through to commissioning of the completed building.

National and EU procedures are to be followed where applicable, and all statutory requirements must be complied with.

It is recommended that these guidelines be kept under periodic review, at a National, level to ensure that the advice offered and recommendations made continue to be up-to-date and relevant to the service that they are intended to support.
Characteristics of a Specialist Palliative Care Unit

A Specialist Palliative Care Unit, or hospice, is a place most commonly associated with the care of patients who are nearing the end of life. Historically, our major cities had institutions that were known locally as the ‘home for the incurables’ or ‘home for the dying’. Such institutions were perceived as sad and lonely places, and admission to such a unit represented the abandonment of all hope. Sadly, this attitudinal legacy still lingers, and is the source of much misplaced anxiety and fear.

A modern hospice is a place that celebrates, enables and facilitates life and living. It is a place where patients and their families receive the highest quality of physical, psychosocial and spiritual care, delivered by a trained inter-professional team.

‘A hospice is not a building; it is a caring team. The environment is important and a caring team will be able to work better in an environment that supports their efforts’. (Hicks C, 1992)

In hospice, there is but a single focus – the optimal care of individual patients and their families in a warm, friendly and affirming environment. The physical environment of the buildings and grounds must provide a space that simultaneously addresses the varied needs of individual patients, their families and a diverse team of health care professionals and volunteers.

The Specialist Palliative Care Unit does not exist in isolation. It works in a coordinated, collaborative and interdependent fashion with the full range of healthcare services in both hospital and community settings.

In the preface to the report of the National Advisory Committee on Palliative Care, the Chairman of that group described much of the palliative care experience:

‘Palliative care is about people; it is concerned with ordinary people who find themselves facing extraordinarily difficult situations: the loss of independence, the loss of financial security, the loss of all that is safe and familiar, the loss of friends and family, the loss of future and ultimately, the loss of life. It is in part concerned with providing answers, and in greater part concerned with being there for people when there are no answers. It is in part concerned with accompanying people to a place where few are comfortable, and being there for them. It is more often dealing with uncertainty than certainty and fundamentally it seeks to respect the individual for who they are, rather than for what they do or have achieved. Dame Cicely Saunders, the founder of the modern hospice movement, wrote: ‘You matter because you are you, and you matter all the days of your life’.
In the context of palliative care, we do not always get a second chance to get things right. We have a duty of care to our patients and we also recognise the need to address the pain and suffering inevitably experienced by family members. By achieving and maintaining an optimal level of pain and symptom control for patients, we create the space and opportunity where they are free to address the many personal issues that inevitably surface at this time of life. For families, we need to ensure that as they begin to undertake the demanding work of grieving, and it is hard work, that they themselves have the opportunity to be heard and understood. The work of bereavement support begins not after the patient has died, but at the first point of contact. All of us, in sickness and in health, have a basic need to be heard and to be understood.

A hospice unit is challenged to balance a vast array of conflicting issues: it is a modern health care facility, capable of caring for extremely ill and dependent patients; yet it is home to many patients and families. As such, it must have all necessary clinical facilities in parallel with more ‘homely’ comforts. The need to establish an appropriate balance between these two aspects of the nature of a hospice, the ‘clinical’ and the ‘domestic’, will be of fundamental importance to the ultimate success of a hospice development project.

A hospice is a busy place that supports a great deal of activity; yet it must also be a calm, safe and tranquil place that facilitates quiet personal reflection. A hospice must be capable of meeting the needs of men and women, young and old, in-patients and out-patients, patients and families, those with cancer and those with other conditions, those who will be discharged home and those who will not, paid staff and volunteers. A hospice is a place where people can live, truly live, until they die.

The design of a hospice unit is an extremely complex, challenging and rewarding undertaking. It does not simply involve the design of a building. It involves creating a most special place that will support the efforts of countless thousands of patients, families and staff over very many years. In comments directed to architects, Clive Hicks RIBA ARPS, who was intimately involved with the design of many hospice units in the UK, made the following observations: ‘You will find your contact with intelligent caring people most rewarding; you will gain inspiration from the association, and will achieve a fulfilment rarely possible with the more common run of work; you may find that your hospice is something that you want to live with for the rest of your professional life. You will feel privileged to work with some very special people, who will leave a lasting impression on your life and approach to architecture’.
Operational Policy

It is recognised that existing specialist palliative care in-patient units in Ireland have developed along different paths. Variations can be seen in the ethos and spirit of different units, which in turn influence detailed matters of operational policy.

It is equally acknowledged that with an increasingly rapid rate of change in medical practice, technology and public expectation, there is a need for a certain flexibility of approach to operational policy questions, to allow for the development and natural evolution of the day-to-day delivery of services over time. In accepting this, it is important to reiterate that overall national policy in respect of palliative care services is as set down in the Report of the National Advisory Committee on Palliative Care.

It is not the intention of this document to be prescriptive about matters of operational policy that might apply in specialist palliative care settings. It is proposed here to look in general terms at various operational issues which it is felt should be supported by statements of operational policy, and to highlight certain aspects of those issues, which may have particular relevance to the design of facilities for palliative care. Project teams should ensure that the clearest possible statements of policy are included in particular project briefs, as they are fundamental to the description of functional content, and to the design team’s understanding of the project.

Statements of operational policy should be subject to periodic review, to ensure that they continue to reflect developing work practice, changes in technology, staffing, public expectation and so on, as well as keeping up to date with statutory change.
A useful checklist of issues, which need to be considered from an operational policy perspective, is set down below. This is adapted from a document originally prepared by Macmillan Cancer Services:

1. Philosophy of service

2. Patient groups
   a) Patient groups – cancer and non-cancer.
   b) Care regime – specialist, terminal, respite, and rehab., etc.
   c) Numbers – in-patient, out-patient, and day care.

3. Clinical services
   a) Description of services – in-patient, out-patient, and day care
   b) Admissions, referrals and discharges
   c) Respite and phased care
   d) Domiciliary services – home care team
   e) Communications – liaison with home care
      liaison with community services
      liaison with other hospital services
   f) Medical – clinical policies
   g) Nursing – clinical policies
   h) Educational services
   i) Volunteer support
   j) Bereavement services

4. Clinical Support
   a) Medical records
   b) Medical supplies
   c) Medical equipment
   d) Pathology services
   e) Pharmacy
   f) Radiology
   g) Infection control

5. Paramedical support services
   a) Chaplain
   b) Chiropody
   c) Dental services
   d) Dietician
   e) Social work
   f) Physiotherapy
   g) Occupational therapy
   h) Complementary therapies
   i) Role of volunteers
6. Non-clinical support services
   a) Catering - meals and refreshments for patients & visitors
   b) Domestic services and cleaning
   c) Laundry
   d) IT and data systems
   e) Telephone and communication systems
   f) Gardening
   g) Portering
   h) Library services
   i) Secretarial services
   j) Administrative support
   k) Supplies - ordering, management, storage & distribution
   l) Transport
   m) Role of volunteers
   n) Waste - clinical/non-clinical; collection, storage, & disposal

7. Patient and relative facilities
   a) Visiting hours
   b) Overnight stay
   c) Viewing of body
   d) Removals and funerals
   e) Valuables
   f) Storage and collection of property

8. Estate Services
   a) Estate management – grounds and buildings
   b) Engineering services
   c) Equipment
   d) Car parking
   e) Access and facilities for disabled people
   f) Mortuary
   g) Signposting
   h) Smoking
   i) Fire safety
   j) Security
   k) Health and Safety

9. Staff Facilities
   a) Changing
   b) Rest rooms
   c) Support

10. Audit & review
    a) Quality of service
    b) Method and frequency of audit
In addition to the above, a small number of particularly relevant issues are drawn out below for more detailed consideration and description by specific project teams in due course:

- **Catering**
  Regulations, e.g. HACCP (Hazard and Critical Control Point) Regulations, in respect of catering facilities and practice are to be complied with. A flexible regime is recommended, to suit the particular and varied needs of patients. Facilities for dining should also be flexible, to facilitate patients having meals in their beds, sitting up in their rooms, or in the day space on the ward. Facilities for relatives to prepare food, snacks, hot drinks etc., require consideration. This will be a 24-hour requirement. Staff facilities require consideration – there may be an advantage in arranging facilities so that staff can eat or take refreshments separately from patients and their visitors.

- **Staff Changing**
  The particular approach of each unit will influence this, as will the size of the unit. Consider whether a centralised changing area should be provided, or local facilities. Particular areas will have specific needs, e.g.: catering and kitchens.

- **Central Supplies and Stores**
  The storage of some of the items listed below is subject to statutory control and regulation. Otherwise the management approach to receipt, storage, and distribution of the materials and equipment listed is of critical importance. The provision of space for storage is of little value unless that space is suitably managed.

- Food & Beverages
- Flammable materials and medical gases
- Stationery
- Cleaning supplies
- Equipment
- Bed storage, wheelchairs, and other aids and appliances
- Maintenance supplies
- Sterile supplies
- Linen
• Domestic Services
A flexible approach is recommended, which should be as sympathetic as possible to the varying needs of patients and their families.

• Cleaning
• Portering
• Post & messenger
• Laundry & linen

• Waste Management & Disposal
This is an area of increasing importance given the statutory requirement to ensure that all waste is disposed of appropriately, safely and in accordance with a suitable timetable.

The range of material to be disposed of is increasingly extensive and policy statements should reflect this. Appropriate measures are to be taken to ensure the safe collection, holding, separation and disposal of all clinical waste. Under this heading there is a growing need, in hospice and palliative care settings, to deal with body fluids, especially following chemotherapy.

• Visiting times
It is recommended that an open policy of unrestricted access will apply, as this is what has been seen to best serve the interests of patients and their families in many existing units. Issues of security, control and the protection of other patients and families from noise and disturbance from visitors need to be addressed under this heading.

• Fire Precautions
While the design of new or converted buildings for palliative care use will be required to comply with current building regulations, and the terms of a project specific fire safety certificate, the management policy that supports this should be set down carefully, to ensure the safety of a particularly vulnerable patient group, their visitors, the staff of the unit, and the facility itself.

• Landscaping
The overall environmental quality achieved in specialist palliative care facilities will be of great importance and potential benefit to patients, their visitors, and to staff members. The provision of landscaped areas, gardens, courtyards and the like will contribute greatly to this. The provision and maintenance of such areas requires consideration from the outset.
• **Admissions**

The Report of the National Advisory Committee on Palliative Care recognises that the need for palliative care services will increase in coming years, especially with the recommended extension of specialist palliative care services to patients with advanced disease of non-cancer aetiology.

This recommended extension of palliative care services is reflected in the suggestion that between 8 and 10 beds for palliative care should be provided per 100,000 of population.

This will need to be considered carefully in the drafting of admissions policies by particular units. The implications of providing for non-cancer patients could have an effect on the design and running of a unit, for example, given the longer course and particular characteristics of such diseases as multiple sclerosis, motor neurone disease, and other disorders.

All proposed projects will have to be considered in the context of the regional needs assessment studies that are to be undertaken by the Health Boards, with a view to defining the palliative care needs in each Board area. The admissions policy will be considered in the context of these studies and their conclusions.

The admissions policy of a particular unit will be required to support agreed National Policy.

• **Discharges**

A policy in relation to the discharge of patients will be important. The discharge of patients will both require and support full palliative care service integration. It is anticipated that patients will normally be discharged in the event of their achieving a certain degree of ‘wellness’.

Discharge policies should also take account of the wish of patients in relation to the preferred place of care and death.

• **Medical Records**

In broad terms all arrangements in respect of medical records should ensure that they are safe, accessible, and secure, leading to efficiency and quality in use. Issues to be considered will include computerisation of records vs. storage of paper, legal framework, Freedom of Information, security of storage, privacy, developing technology such as PACS, space requirements, and the like.

Compliance with statutory provisions in relation to periods of time for the holding of records is essential. At the time of writing it is understood that a Health Board group has recommended that records be kept for a minimum of 10 years from the time a person dies, unless litigation has been suggested or initiated.
• **Security**

Security and protection of patients, their families and visitors, and the staff of the facility are of crucial importance.

Equally, security and protection of the buildings, its contents, including equipment, finishes etc., as well as the personal belongings of those using the building, need to be considered and provided for.

This needs to be dealt with in a way that does not conflict with other policies and aspirations, such as that in respect of visiting hours, or the ambition to create an environment that is open, welcoming and reassuring for those who are using it.

• **Pharmacy**

Refer in particular to the Codes of Practice issued by the Pharmaceutical Society of Ireland, which deal with matters of good pharmaceutical practice, as well as containing guidelines on the storage of medicines. (These codes are concerned particularly with community-based pharmacies, but it is felt that they contain much that is relevant to hospice-based pharmacies).

Policies should also support compliance with relevant regulations in force at the time, such as those that exist in respect of the storage and management of controlled drugs.

Given considerations of security, staffing and the like, it is not felt that a hospice pharmacy should have the status of a ‘community pharmacy’, serving those other than the patients of the hospice.

• **Communications**

**External communications:**
- Car-parking for staff and visitors. Access to public transport where possible.
- Secure and adequately sized bicycle park.
- Policy in relation to providing for large gatherings on hospice site, eg: for removals, or for occasional large meetings, or educational courses. Policy needs to be tempered by recognition of the cost of providing such facilities, in terms of both finance and space.
- Deliveries and waste disposal
- Emergency vehicles.
- Clear circulation routes, and identification of entrances.
- Fire assembly locations.
- Access to main entrance under cover.
- Separation of pedestrian and vehicular traffic.
- Suitability for those with reduced mobility.

**Internal communications:**
- Appropriate width of corridors and doors.
- Admission of daylight and views to outside.
- Suitability for those with reduced mobility.
• **Technology**
Issues to be considered under this heading will include, inter alia:

- Requirements for Internet/Intranet
- Connections to the community
- Provision of PACS
- Computerisation of records
- Links to satellite units

• **Office Accommodation**
This section should be considered carefully in recognition of developing and changing work practices, seen recently, for example, in the area of home-care teams, where offices may be used intensively, but for limited periods only.

The scope that exists to share accommodation and/or the capacity for open plan arrangements should be explored. Equally important will be the need to exploit new and developing technology, especially ICT, to assist in delivering defined services in an efficient and appropriate manner.

The needs of different groups should be defined eg: clinicians, paramedical staff, nurses, administrative staff, volunteers and others, taking into account their particular work patterns.

• **Education**
Training and educational policies will require careful consideration. Policy statements in this area should address issues raised in the principal report in respect of linkages with other institutions, research, and so on.

• **Smoking**
Experience to date suggests that this will be a difficult and sensitive area for project teams and unit management to consider and deal with.

Nevertheless, policies in respect of smoking must take account of and comply with the current statutory position, especially in respect of smoking in the workplace, and the rights of staff and others to be protected from tobacco smoke.

Advice in this area is available from the Office of Tobacco Control (www.otc.ie) and the Department of Health and Children (www.doh.ie).

The practice of smoking outside the front door of a facility is considered undesirable.
General Design and Planning Considerations

4.1 Site Selection

The following criteria will assist in the assessment of sites for the possible development of new specialist palliative care in-patient or satellite units, and will also be relevant to the assessment of existing sites, where proposals are made to extend the facility and expand existing services. It will normally be a requirement for project teams to undertake a detailed and formal ‘Option Appraisal’ exercise in order to identify the most appropriate site for development. Such an exercise will be expected to take account of all relevant issues, including the following:

- It is essential that close, collaborative, service and operational linkages can be readily established between specialist palliative care settings and an acute hospital facility. Linkages of particular importance will be in the areas of pharmacy, radiology, and treatment interventions.

- It is desirable, subject to the availability of a site and general planning considerations, for future specialist palliative care units or satellite units to be located on the grounds of or adjacent to the acute hospital serving the broadest population base and having the widest range of diagnostic, treatment and support services available.

- Insofar as possible, the choice of site for a new specialist palliative care in-patient unit should take account of road networks and public transport facilities, in order to ensure optimal accessibility.

- Units should have a recognisable physical presence in the community, to strengthen their identity, to develop familiarity, and to ease anxiety or disorientation on admission, for both patients and their families.

- Designers should consider compatibility with the adjoining neighbourhood, to ensure that a unit harmonises with its environment, as far as possible.

- Orientation and views should provide interest and stimulation, and enhance the environmental character and quality of the unit.

- Consideration must be given to the technical suitability of a site, especially in relation to geotechnics, public utility services, site area, capacity for expansion, etc.

- The cost of acquiring a site, and of preparing it to facilitate development will be key considerations in respect of any proposed development.
• The capacity of the site to accommodate the unit itself and any projected expansion, together with associated circulation patterns, vehicular and pedestrian, (e.g. staff access, patient transport, visitors, delivery of supplies, disposal of refuse, traffic associated with removals, etc), will also need to be taken into account at the outset.

4.2 General principles of design

The avoidance of an institutional appearance and atmosphere is considered to be particularly important in relation to the need to take account of the complex emotions and perceptions of those being admitted to a hospice, as well as their families and friends.

The creation of a ‘domestic’ character in particular areas, insofar as possible, especially for the in-patient unit. This should be achieved by careful attention to such considerations as quality of light, exploiting views, use of colour, selection of furniture and finishes, and so on. In addition to being domestic in character, the physical accommodation for patients should be of interest and have a relaxed atmosphere, insofar as is feasible, and consistent with the requirements of nursing care. This balance is considered to be most important, as the hospice is essentially an acute health care facility. It is important to note that the character of a unit will be generated not only by its physical design but also by the staff and volunteers working in it.

A key consideration in the creation of an appropriate ‘atmosphere’ in a unit will be clarity of circulation. It is essential to avoid overcomplicated or confusing circulation routes, especially in the areas used by patients and visitors. A clear, legible and ‘user-friendly’ signage system (both internal and external) will be important in this regard, and should be incorporated in the design at an early stage.

The environment should offer privacy to patients and their families when required.

Sheltered outdoor spaces should be created in and around the unit for the enjoyment of patients, staff, and visitors, and to assist orientation.

Patients should be provided with a sunny aspect and a good view to the outside, insofar as this may be possible.

There should be flexibility in the planning of defined areas to maximise potential use of the facilities and to meet possible future changes, with a suggested overall expansion factor of approximately 25% to 30%. This factor will require particular consideration for each project, and should identify at briefing stage those areas of the project thought most likely to require expansion.

Careful consideration should be given to ensuring a quiet environment, with a higher than normal level of sound containment and acoustic privacy, for patients and their families. The effects of noise can be reduced by planning measures, such as locating noise generating rooms away from those requiring quietness, by
isolating sound sources with sound containing partitions and doors, by absorbing sound with acoustic materials and generally by the incorporation of floor coverings, curtains, and other materials that do not reflect sound.

In view of the possibility of unpleasant odours in bedrooms, bathrooms, WC’s, and day areas, together with the sensitivity of some patients to smells and odours, the level of ventilation provided should be of a high standard. While recognising this need for mechanical ventilation in particular areas, it is desirable that natural ventilation should be used wherever possible, and every effort should be made to avoid draughts.

The Architect and other design team members shall inform themselves about, and have regard to, the latest thinking on palliative care facilities and settings when designing new buildings or extending existing units for hospice purposes.

The design team shall seek to provide a design solution that meets the specified standards within the stated capital allocation, and which provides a facility that will be economical in terms of running costs. Where possible, fittings and finishes that are low maintenance should be chosen and specified in preference to those that are not.

Project teams are encouraged to adopt and promote the principles of integrated design and universal access for those with disabilities.

Design proposals shall comply fully with all statutory requirements, including planning permission, fire safety certification, building regulations, and the like.

Reference should be made to the wide range of other guidance material that is available to project and design teams when preparing both briefs and designs, e.g.: the various publications of the NHS Estates, Irish and British Standards, the Building Regulations guidance documents, and the like.

The incorporation of appropriate artworks in palliative care facilities is to be encouraged. The ‘per-cent for art scheme’ will apply to projects that are publicly funded, even in part. The visual (but not necessarily physical) integration of artworks is considered important, and this should be considered at an early stage in the design process. It is equally important to approach this subject not just as a ‘once-off’ exercise, but in the context of an ongoing policy that encourages creative application, and the engagement of staff, patients and the broader community served by the unit, in the process.

4.3 Internal circulation spaces

4.3.1 Horizontal:

The unit should be planned in an efficient and compact way in order to minimise travel distances for those using the building.
It is recommended that circulation routes for in-patients and day attendees should be segregated, insofar as this may be possible.

Long corridors should be kept to a minimum, to avoid an institutional atmosphere. Where possible, circulation spaces should be designed to accommodate appropriate activities, and should also be enlivened by natural light, views to the outside, and by facilitating social exchange.

Circulation spaces should be wide enough to allow for the anticipated movement of people and equipment. Providing the necessary room for moving and turning of wheelchairs and hospital beds is particularly important in all areas used by in-patients.

Management of units should consider the impact of operational policies on circulation spaces, especially with a view to the avoidance of congestion. Where possible, the timing of significant internal traffic movements should be planned and co-ordinated with this in mind.

4.3.2 Vertical:
Where planning permits, it may be preferable for all patient areas to be located on the one floor level, and for this floor to have communication with the outside, ideally at ground floor level.

If it is necessary to plan a unit on more than one level, it is considered highly desirable that facilities for those attending on a day basis should be located at entrance level.

A passenger lift of sufficient dimensions to accommodate the movement of a patient in a hospital bed, with appropriate supporting equipment and staff, should be provided.

The requirements of Part M of the Building Regulations in respect of access for people with disabilities are to be complied with, and the principle of integrated design and full accessibility should be adopted to the maximum practicable extent.

Steps should be completely avoided at all entrances intended for use by patients and day attendees.

4.4 Siting relationships and adjacencies:
Planning efficiency and economy is to be considered carefully in the design of new units, together with the revenue implications of planning decisions.

An understanding of the core and non-core activities of the proposed unit is essential to this. Where space is limited, it may be possible to locate ‘non-core’ functions remotely, or off-site.
Equally, an approach to anticipated future expansion requirements should be identified, to allow, insofar as possible, for orderly development over time, within an efficient structure.

Planning relationships should be developed which will allow for the sharing of support spaces, such as meeting rooms, interview rooms, waiting areas, WC’s, and the like.

It is as important to separate certain areas as it is to connect others, and again the point is made that in-patient facilities and circulation routes should, where possible, be separate from those for day attendees.

Within the in-patient unit it is recommended that patients accommodation should be at main entrance level, which in turn should preferably be at ground floor or garden level. Patient’s rooms should also have relatively easy access to facilities for therapies, although this recommendation is qualified by recognition of the need, in many cases, for such services to be delivered at the patient’s bed. See also paragraph 5.6.6 below.

4.5 Furniture and finishes
The selection of furniture and fittings should take account of the following considerations: Performance, (including clinical and infection control), appearance, durability, maintenance, flexibility in use, fire safety, cost, acoustics, and so on.

Ease of use for those with sensory or physical disability is of primary importance.

Among the most critical items for selection will be the beds, mattresses and chairs for patients. Beds of adjustable height to allow for nursing on the one hand, and independent transfer on the other are considered desirable.

4.6 External design
How a palliative care facility presents itself to the public will be of considerable importance, for various reasons. The external design should be appropriate to its context, be human in scale, of high quality, and achieve an open and welcoming character. It should not in any way reinforce the feelings of fear and anxiety of many attending, especially for the first time.

Clear circulation routes and signage are of particular importance, and, as noted above, will greatly assist in creating such a welcoming character.

In addition to the normal activities and functions of the exterior of an acute care setting, such as access, parking, deliveries, storage, and so on, a hospice is likely to have additional particular requirements.
Occasional large gatherings may have to be accommodated, for removals, fundraising, educational and other purposes.

Current patterns of work may impose pressures on staff car parking facilities, for example when the home care team attend on site in the mornings, or when staff members (e.g. chaplains or consultants) with responsibilities elsewhere arrive on site.

A balance is required between these considerations of practical everyday activity, and the wish to provide outdoor space for quiet retreat, for all users of the buildings, in the form of garden spaces to occupy and enjoy, or simply to view from inside. An approach to the maintenance and funding of gardens should be considered at the outset.
5. Functional Content

5.1 In-patient Unit

In-patient accommodation, whether in a specialist palliative care in-patient unit or a satellite specialist unit, should provide a wide range of specialist services to patients and their families, including medical, nursing, paramedical, psychosocial and spiritual care. Reasons for admission would ordinarily include complex symptom management, psychosocial problems, and intensive rehabilitation.

Where appropriate the recommendations contained in these guidelines should also apply to accommodation for specialist palliative care purposes in acute general hospitals, i.e. offices and treatment rooms, as noted in the report of the National Advisory Committee on Palliative Care, which recommends the delivery of palliative care services as opposed to the provision of designated palliative care beds in Acute General Hospitals.

The Report of the National Advisory Committee on Palliative Care recommends the provision of 1 specialist palliative care unit per Health Board area and that 8 -10 palliative care beds should be provided per 100,000 population.

For operational, nursing and other reasons, including the wish to realise a ‘domestic’ character and scale in the unit, it is felt that the optimum ward size should be in the order of 16 to 20 in-patient beds. It is acknowledged that smaller ward sizes will apply in certain cases, for example in satellite units in particular areas, where population figures indicate a lower requirement. The minimum recommended ward size is 10 beds.

Given the current level of bed provision, and the various recommendations noted above, it is likely that a typical new specialist palliative care in-patient unit will consist of 2 wards which will be able to accommodate approximately 18 patients each.

For reasons to do with nursing, observation of patients, treatment, and, not least, the particular needs of palliative care patients and their families, it is recommended that in the order of 50% of in-patient beds will be provided in single rooms, with en-suite bathroom facilities attached.

Because of the particular needs of patients, the involvement of families, and the severity of illness and presentation, 2-bed rooms are to be avoided, as they can give rise to difficulties in use. It has been established informally in preparing these guidelines that such rooms are not popular with patients.

Four-bed rooms, on the other hand are considered to be quite suitable. Care must, however, be taken in the design of 4-bed rooms, to address a number of particular requirements. Individual spaces should be created within these larger...
rooms, for example by use of furniture, room dividers, and careful planning, to protect the privacy and dignity of patients and their families. Each bed space should enjoy natural light and where possible a view to the outside, (these can be shared, to avoid undue restriction on planning the ward). An arrangement where 2 beds are positioned directly opposite one another is generally to be avoided, again for reasons of privacy and dignity.

Direct access to the outside from the ward is desirable, if it is possible to achieve without undue difficulty, especially if there is a garden or a view to be enjoyed. The width of any external door provided should be sufficient to allow the passage of a bed. In such an instance, steps should be avoided at the threshold, and a safe balcony, terrace or other paved area should be provided.

A particular challenge in respect of bedroom accommodation will be the need to create an environment that is not obviously clinical, yet which meets the requirements of the medical, nursing, paramedical, and support staff in giving care. The needs of patients will change over the duration of their time in the palliative care unit. Those whose symptoms are well controlled will be encouraged to live as full a life as possible for as long as possible. They will also have major care needs, particularly at the terminal phase. Families will spend a lot of time with patients during the final days of their life. The accommodation must be able to adapt to these changing requirements.

Design of wards, and supporting operational policies, should allow for the greatest flexibility in terms of the gender mix of patients at any given time.

The design of patient accommodation, including wards, and supporting operational policies, should facilitate the achievement of high standards of privacy and dignity for patients.

5.1.1 Single bedrooms, with en-suite WC and shower facilities.

Single rooms will preferably be grouped together, should be of sufficient size to accommodate the patient comfortably, and should include space for a sitting area to be used by the patient and family members.

Space should also be provided for a relative to rest or sleep, in comfort. Such provision might usefully double up for other daytime use, e.g. by means of a window seat that converts to use as a visitors bed, as required. A wall mounted, ‘pull-down’ type extra bed would be equally satisfactory. Storage space for extra pillows, linen and blankets should be provided.

Each single room should have sufficient space around the bed to allow for the full range of high dependency nursing activities to take place, and for the safe use and positioning of equipment, hoists, and the like. The management of some oral and dental problems may also be undertaken at the patient’s bedside.
It is recommended that one or two single bedrooms in each specialist unit or satellite unit should be equipped with electrically operated ceiling hoists, for the benefit of patients and staff alike, allowing for the transfer of patients from bed to a chair, or to the en-suite bathroom. Consideration should be given to the provision of electrical supplies and structural support to allow for future installation of more hoists in due course, should they be thought necessary, particularly in the context of ‘no-lifting’ policies that may apply in units. It is recommended that piped oxygen, air and suction be provided to each bed-head.

Natural lighting and ventilation are to be used, insofar as it is practicable and appropriate to do so. Artificial lighting should be provided, to include dimmable night lighting, reading lights at the bed and at the patient’s sitting area, as well as sufficient light to allow therapeutic procedures to be carried out in the room. A simple adjustable ventilation and air extract system should be provided to deal with problems of malodour in all bathrooms and bedrooms.

It is recommended that patient’s rooms will be provided with telephone facilities, data points (for staff use in particular), as well as T.V. and radio. Patients should have access to drinking water and ice making facilities.

Rooms should be furnished with a wardrobe and bedside locker. Some facility for secure storage of patient’s personal valuables should also be provided. It would be appropriate to ensure that some space is provided for the display of personal belongings and photographs that patients may wish to have with them.

In facilities where a policy of self-medication applies for selected patients, a suitable, lockable personal drug cupboard will have to be provided.

All bedrooms and bathrooms should be wheelchair accessible. Shower rooms should be designed to facilitate two carers assisting a patient. Shower controls should be close to the edge of the cubicle. A shower seat should be provided in each cubicle. The shower room should have space for the storage of patient hygiene needs, and associated nursing requisites, to include basin, bedpan, urinal, wipes, and towels.

A curtain should be provided inside the door of each single room, in order to maintain patient contact, while protecting patient privacy.

The basin should allow the patient to sit at it to wash. Taps are to be chosen that are suitable for patients with reduced dexterity.

The vanity mirror should be fitted at a level that will allow it to be used from a standing or sitting position. It should be capable of being concealed when not wanted.
The toilet bowl should be positioned to allow a carer to give assistance from either or both sides, where planning permits. En-suite layouts should be designed in such a way to facilitate left-hand or right-hand use, to ensure the availability of WC facilities that permit lateral transfer in each direction.

Space is to be provided for a seat, a bin, and a clinical waste bin.

Two nurse call bells, which are strategically located, should be provided in the room. Other mechanical and electrical considerations are referred to in chapter 6.

Taking account of the specific and particular needs of single rooms as noted above, it is recommended that in new developments they should be up to 25 m² each in floor area, including the en-suite bathroom. The provision of various individually sized rooms up to this limit may be appropriate.

5.1.2 4-bed rooms, en-suite

The recommendations set down in the previous section dealing with single rooms will in the main apply equally to the 4-bed rooms.

It is accepted that facilities for visitors or family members to stay over night may be reduced in the 4-bed rooms by comparison with the single rooms already described. Each bed space should however, as a minimum, have a reclining armchair for the benefit of visitors.

It is also recommended that separate accommodation be provided away from the ward for relatives who wish to stay over with a patient, and this is described below at paragraph 5.1.14.

In addition, a small sitting area should be provided for the enjoyment of patients and visitors. This should preferably have natural light and a view to the outside.

Taking account of the particular requirements of these rooms, it is recommended that new 4-bed rooms, including en-suite accommodation, should be up to 60m² each. Provision of individually sized rooms up to this limit may be appropriate.

5.1.3 Isolation room

At least one single room on each ward will be designed for use as an isolation room to cater for patients with infectious disease. Such rooms will have an ante-room or lobby with a wash hand basin and a clothes rack for protective clothing. Future project teams should re-evaluate this scale of provision to ensure that an appropriate number of isolation rooms are allowed.
An air management system will be required for the isolation rooms. This system must meet current standards in respect of the control of infection. The need for a system that can deal quickly with problems of malodour is reiterated.

Otherwise the requirements of the room will be similar to those of the standard hospice single bedroom.

Where a single room is provided for isolation purposes, an additional area of 4m² is to be allocated for the necessary lobby, containing gowning bay and utility area.

5.1.4 Nurses’ station
The nurses’ station will be the focal point for supervision, care, and communication on the ward. It should be so positioned that the nurse(s) or ward clerk on duty can communicate easily with patients and have immediate and direct access to patients, particularly those most seriously ill. It is envisaged that visitors to the ward will report to the nurses’ station. It is recognised that the recommendation to increase the percentage of single rooms will impact on the ability to establish visual contact between the nurses’ station and the majority of patient beds, and other means of communication (as well as operational policy) must compensate for this to an appropriate degree.

The nurses’ station should also be within easy access and view for patients and public.

It should allow for at least 2 people to work comfortably, (on a 24 hour basis) as well as providing space and support for ward staff.

5.1.5 Ward office
This should be adjacent to the nurses’ station. Administrative and management activities will be carried out here. The possibility of interviewing and speaking to relatives here should be allowed for, although the ward office should primarily be the base for all ward staff, including nurses, paramedical staff, students, and doctors.

5.1.6 Treatment room
The treatment room will cater for diagnostic, routine and emergency treatment, (including dental treatment), anaesthetic intervention and facilitate nursing and medical procedures, including wound dressings. This room is to be provided with suitable cabinets for storage of materials, worktops for carrying out procedures, laying out of documents and writing of notes, as well as space for the storage of dressing trolleys.

This room should have a wash-hand basin with lever-operated taps.
5.1.7 Medicines room

This room will be used for the storage and preparation of the wide range of drugs and associated pharmaceutical supplies used in palliative care. It is essential that project and design teams develop operational policies and designs for this accommodation to ensure compliance with relevant statutory provisions in respect of the storage, handling and supply of drugs and medicines, including chemotherapy and controlled drugs.

Security provisions will be particularly important here. Consideration will need to be given to the risk of providing windows to this room. Equally, protective systems such as intruder and panic alarms, CCTV, locks, intercom, and other technology, will need careful consideration.

This room may be used by a number of people as their work base, and the quality of environment created will need to reflect that. This may determine the need to provide windows, (i.e. a good quality of light will be needed), and require that the security risks be otherwise dealt with.

The colour and design of worktops should facilitate reading contents of containers, and the location of small items, especially tablets, that may fall onto it.

This room should have a wash hand basin with lever-operated taps.

5.1.8 Day room

Day accommodation will be provided for patients and their visitors, to relax and sit away from their bedrooms. It should allow for small group gatherings, and social activities. A television and music system should be provided here, as should I.T. facilities for patient use.

The provision of a single large day room is not recommended. It is felt that the provision of two small day rooms would be preferable, as this arrangement would allow for greater flexibility in use. One of these rooms could be designated as a ‘quiet room’, (see 5.1.9 below). In addition to general use by patients, a day room may be used for discussions with families, for families to gather after bereavement, or for a family member to stay overnight, if available and suitably furnished.

As proposed in relation to patient’s bedrooms, it is desirable that dayrooms should have access to a garden, terrace or balcony. There should be no steps into this room.

The width of all doors into this room should accommodate a bed and there should be strategically placed call bells. A toilet for patient use should be provided close to this room.

The size of day rooms will depend on the size of the unit, the number of patients, and similar considerations.
5.1.9 Quiet room
The quiet room will also be used as a day room as described above, but without the television or music system. A more restful, contemplative atmosphere should prevail here. It should be located carefully in the unit, away from busy areas and noise generating activities.

It is envisaged that this room will be small, for use by no more than 5 or 6 people at any given time.

5.1.10 Assisted bathroom
This room should have doors wide enough to allow for the easy passage of a patients bed with medical equipment attached.

Given that all new in-patient accommodation in palliative care settings, whether in single or 4-bed rooms, should have en-suite bathroom accommodation attached, it is recommended that there should be one general assisted bathroom provided per ward. Where more than one assisted bathroom is provided, (i.e. in units where there is more than one ward), it is recommended that different types of bath are installed in each, to allow for the varied needs of the patients. ‘Whirlpool’ type baths were noted to be popular with patients in the units visited.

In addition to the sanitary fittings of bath, basin (with elbow operated taps), w.c., and bidet, this room should accommodate a wheelchair, a standard chair and a stretcher trolley. Management should discourage storage of other items in this area. The ambient temperature of this room should be such as to ensure the comfort of patients using it.

A ceiling hoist should be provided to assist with the transfer of patients. The normal requirement to store relevant supplies, linen, and so on will apply, together with the need to provide a nurse call system.

Where relevant, the comments made above in relation to en-suite bathrooms should also be taken into account.

5.1.11 Ward therapies room (Rehabilitation room)
It is recommended that space be provided on the ward for the rehabilitation needs (physiotherapy, occupational therapy and speech therapy) of patients who are beginning to avail of these services or who are too ill to travel to the main Rehabilitation Department described below.

Some of these services will also be provided at the patient’s bedside.
The ward rehabilitation room will therefore accommodate a basic range of rehabilitation equipment, and it should be sized to reflect this, with a floor area up to 15m$^2$.

The following accommodation (5.1.12 – 5.1.18) is to be provided, but may be shared between wards, should planning permit, in order to avoid unnecessary duplication, and to maximise the potential use of all facilities provided. These rooms should be easily accessible from the in patient ward areas.

5.1.12 Wheelchair and equipment store
The location of this room requires careful consideration to ensure that it is visually acceptable. There may be some scope to use space above wheelchairs for storage also, but it will be necessary to ensure that safe access to any items stored here is not compromised. Large doors into storage areas may be of value, or the provision of a second door, but in any event successful use of storage areas depends to a large extent on an appropriate operational policy being in place. The provision of storage spaces needs to be considered in the context of proposed policies, particularly in relation to centralisation of stores, monitoring and tracking of stored items, and approach to deliveries (e.g. “just in time”).

5.1.13 Complementary therapy room
A quiet room should be provided for complementary therapies, including aromatherapy, acupuncture, music therapy, and the like. A quiet comfortable environment is required, free from outside distraction, and capable of reasonable control in terms of acoustic attenuation, quality of light and degree of ventilation.

5.1.14 Flower room
A small room, in which two people can work, should be provided, with simple facilities to deal with the large numbers of flowers received in the hospice, to prepare displays, and the like. It will require a sink and drainer, work surface, drawers, shelves, and space for a bin.

5.1.15 Family room
Provision should be made for family members to stay on the unit overnight, or to rest while in the hospice, in addition to the facility provided in the patient’s room. At least one bed/sitting room (twin bedded), with en-suite bathroom should be provided in each specialist palliative care in-patient unit, for the use of patient’s families. Simple kitchenette facilities should be available to those using family rooms, as well as to other relatives and visitors of patients.
5.1.16 Interview room
This room should be capable of flexible use. Its principal function will be to cater for meetings between staff and patients and their families. The door should be wide enough to allow for the easy movement of a wheelchair, or, on occasion, a bed. The room should be large enough to accommodate approximately 10 people, and should have a non-clinical and comfortable character. The room will also be used to accommodate distressed families after a death. A telephone point should be provided.

Depending on the level of other related accommodation provided it may be appropriate to provide one interview room per ward.

5.1.17 Store for patient's belongings
A small room or cupboard space should be provided, for the storage of personal effects and items belonging to deceased patients, while awaiting their collection by the patient's family or estate.

5.1.18 Contemplation room
A very small (non-denominational) space is envisaged, for quiet reflection, contemplation or prayer. It is for the use of patients and their visitors in particular, ideally not more than 2 or 3 at any given time.

The character of this room should be sympathetic to this function, and issues around acoustic separation, quality of light, views to outside and so on should be considered in its design.

5.1.19 Other in-patient ward accommodation
A range of other facilities and spaces should be provided on the ward of the specialised palliative care in-patient unit. These will, in common with other acute settings, generally include provision for such requirements as:

- Ward pantry and kitchenette
- Dirty utility and sluice room
- Clean utility room
- Linen store
- Cleaner's room
- Patient's toilet
- Public toilets
- Staff toilets

It is not felt that particular design implications arise from the provision of these facilities in a palliative care setting, and further detailed description of these rooms is not necessary here.
5.2 Community Palliative Care

The principal issue to be addressed in respect of accommodation for the community or ‘homecare’ service is that of work patterns and hours.

Current practice frequently involves intense use of homecare accommodation for limited periods, especially early in the morning and late afternoon. It is important to seek to maximise the use and potential of all facilities provided, and to this end it recommended that future client groups look carefully at how best to structure and manage this service.

Issues to be examined will include the potential of working from home, the use of developing information and communication technologies, the patterns of attendance at ‘base’, and the feasibility of sharing accommodation with others in the unit. For example, it may be possible for rooms within the unit to be managed, in such a way as to allow their use by the home care team at certain times, and by others outside those prescribed periods.

The essential accommodation requirement for each team will include office space, in which each member of the team can work, being equipped with a desk, phone and pc, together with lockable storage space for confidential records, and the like. It is recommended that each ‘team’ office should be open in plan, to facilitate easy communication and sharing of information and advice. It may be possible for such office accommodation to be shared between teams, depending on work patterns.

In addition to the above, meeting rooms should be provided for the home care team, for general discussions, briefings, and the like. These rooms should be designed and located to facilitate their use by other groups within the unit to the greatest extent that is reasonably achievable. Such a room could be used, for example, by home care staff to meet prospective patients and their families, or by other members of staff for meetings, conferences, and the like.

The broader implications of such decisions about the type and amount of accommodation to be provided for use by the home-care team, including, for example, the provision of dedicated car parking spaces, will also need to be taken into account.

Based on recent experience in the delivery of palliative care services, and on the anticipated direction of future developments, it is recommended that the facility to expand the home-care element be protected.

5.3 Day Care

The day care unit will provide access for patients to all specialist palliative care services. Patients are likely to be admitted to day care programmes for nursing care, medical treatment and rehabilitation. It is envisaged that accommodation will be provided for a range of activities, including medical and nursing procedures, personal care, physiotherapy, occupational therapy, complementary therapies, relaxation, and ‘diversional’ activities such as music and art therapy.
Space requirements include provision of an office for the day care co-ordinator. There should be adequate space for the storage of equipment (wheelchairs, drip-stands, etc.), and materials to support the range of activities listed above.

A standard medical treatment room should be provided in this area, to facilitate the nursing and medical treatment requirements of day patients. Subject to the model of care proposed there may be a requirement in particular units for out-patient consulting rooms to be provided, and in such cases they should be arranged in conventional form, in a suite of up to three inter-connecting rooms, where justified by likely demand, (to facilitate easy communication), each room to have an examination couch, desk, phone and p.c.

The “personal care” function will normally require provision of facilities for hairdressing and chiropody (or podiatry), which should be accommodated in separate spaces. In addition, it is recommended that day care attendees will have access to an assisted bathroom, preferably with ‘jacuzzi’ type bath.

Access to outdoor space or a garden from the day care area is desirable.

5.4 Pharmacy
The accommodation to be provided will depend on the size of the unit, the numbers to be accommodated, the operational policies that are adopted in relation to this area of activity, and other local factors, such as the whether or not the unit is attached to an acute general hospital.

As noted above, the guidance contained in the Codes of Practice issued by the Pharmaceutical Society of Ireland is of value and should be referred to. The focus of these guidelines is essentially towards community pharmacies, but much of the information contained in them is also relevant to hospice-based pharmacies.

5.5 Catering
General accommodation requirements will depend on the policies that are adopted in respect of catering, and, as mentioned above, local circumstances.

In addition to providing for the needs of patients and staff, it is recommended that some provision be made for the needs of family members who may spend long periods of time in the unit. A small kitchenette for their use, preferably located off the ward, should be provided to facilitate the preparation and consumption of hot drinks, snacks, or light meals. Such provision should recognize related health and safety issues.

Office accommodation should be provided, where appropriate, for a catering manager/nutritionist.
5.6 Rehabilitation Department, including Physiotherapy, Occupational therapy, and Speech and Language therapy.

It is desirable that facilities for various therapies (physiotherapy, occupational therapy, and speech therapy) are provided close to one another, to facilitate speedy referrals, joint working, and the flexible use of departmental accommodation. This will also assist in the development of a desirable multidisciplinary team approach, including therapists, social workers, psychologists, dieticians, nurses, and the medical team.

Given the anticipated severity and complexity of illness amongst in-patients, there will be a need in some instances for therapeutic interventions to be made at the patient’s bedside, and the recommendations in respect of appropriate bedroom floor areas take account of this (para 5.1.1), as well as that in respect of the provision of a small ‘therapies’ room on each ward (para 5.1.11), both as noted above.

It is desirable, insofar as planning may permit, that this department should be conveniently located for the use of both in-patients and day-patients, preferably at ground level. It is very important, however, that access to this facility by either group of users should not require passing through the space occupied by the other.

Accommodation to be provided will include both clinical and administrative areas.

The clinical accommodation should provide for the delivery of the therapeutic service, and should accommodate the equipment necessary to deliver that service. It should also be subdivided as necessary to take account of patient’s dignity and need for privacy, as well as the requirements of the particular equipment and treatments proposed.

Drinking water should be provided, and clinical spaces in the rehabilitation department should allow for the installation of an integrated music system. Spaces in this department should be bright, well lit, and have good ventilation. Consideration may be given to the need for blackout blinds and dimmable lighting in appropriate areas. Where planning permits, access to, or a view outside is desirable, for the benefit of both patients and staff.

5.6.1 Physiotherapy room

This is the main space of the department, and will be used for rehabilitation purposes in particular. It must accommodate the range of equipment required to deliver the defined service. The proposed floor area must be sufficient for the safe use of all equipment installed, and the ceiling height should allow for overhead activities and the installation of ceiling mounted equipment. Emergency call buttons should be provided in convenient locations, in the main space and in any separate treatment cubicles provided. There should be a staff base here, with good observation of the treatment areas.
Future project teams should determine the type and quantity of equipment required, based on a study of the needs of their patients, and floor areas should be defined accordingly.

While general activities will take place in this main space, the provision of adjacent but separate multi-purpose treatment cubicles is also recommended, for reasons of privacy and confidentiality. The number of such cubicles will be a function of the number of patients to be catered for, and of staff proposed, as well as the type of treatment to be offered.

Changing areas, incorporating shower and WC facilities, are to be provided in this department for both patients and staff. The amount of such accommodation to be provided will again be a function of the anticipated use and the numbers involved.

5.6.2 Treatment cubicles
Particular clinical services may be offered to patients within this department, especially in relation to dyspnoea, and lymphoedema.

It is recommended that the relevant treatments should be delivered in the multi-purpose treatment cubicles located off the physiotherapy space. Designated storage should be provided for these functions. At least one treatment cubicle should therefore have an en-suite WC and shower, as well as storage space for related materials and supplies.

5.6.3 Rehabilitation Department storage
Suitable storage is required for the various pieces of equipment used in this department, as well as for wheelchairs, aids and appliances.

5.6.4 Preparation room
A well-ventilated space is required for the preparation of ‘hotpacks’, and icepacks. This room will require a non-slip floor finish, storage space for equipment and materials to be used, as well as a sink and drainer.

5.6.5 Wax room
A separate room in which wax treatments can be prepared and given is recommended. The floor here should also be non-slip, and may require ‘bundling’ to protect against spillage. As with the preparation room, space is required for storage of equipment and materials, and a sink and drainer should be provided.
5.6.6 Rehabilitation Department administration and support
This department will require the normal range of support accommodation, including reception desk and waiting area, toilets for patients (wheelchair accessible), staff toilets and changing facilities (although changing facilities may be centralised), storage, and offices.

5.6.7 Occupational Therapy
Accommodation for occupational therapy should be immediately beside, or integrated with, that for physiotherapy, and all facilities, including those for support functions, should be shared to the optimum extent possible, as noted above.

Space will be required for office use, storage and splinting. Accommodation for the latter will require adequate ventilation, and particular attention should be paid to fire precautions.

Occupational therapy treatment will cover two areas – general activities (including activities that are recreational, vocational, and specific to the patient), and activities for daily living, (ADL). The need for all accommodation to be fully accessible for people with disabilities is again stressed.

The area for “activities for daily living” should simulate a domestic environment and should consist of a bedroom (containing bedroom furniture, hoists, etc.), a bathroom, and a kitchen, appropriately fitted out and equipped.

5.6.8 Speech and Language Therapy
In palliative care settings this discipline will be particularly concerned with communication, including the use of aids and appliances, and the treatment of those with swallowing difficulties. Close links to O.T. and physiotherapy are desirable. An office space, which is capable of being used for consultations with patients and carers, is required, which should also have secure storage for expensive equipment.

5.7 Social Work Department
The accommodation requirements of this Department consist essentially of workstations for the Department’s staff, as well as an adequate number of accessible interview rooms for meetings with patients, their families and members of the public. Interview rooms will be used for various purposes, including bereavement counselling.
Careful consideration should be given to its location. It is felt on balance, where planning permits, that it should be close to the accommodation for day-patients. Nevertheless, there should be easy access to the interview rooms from both in-patient and out-patient areas.

An interview room, where possible, should be located on each ward. These rooms should be capable of being used flexibly, for various other purposes, subject to appropriate management.

To provide for the informal and unplanned nature of some of the communications that take place between social workers and others, attention is again drawn to the desirability of incorporating comfortable seating in various locations, with a degree of privacy, off corridors and elsewhere in the public areas of the unit. These spaces will also encourage and facilitate casual social exchange, and other day-to-day activities in a suitable way.

Consideration should be given to the provision of a play area for children, possibly adjacent to the in-patient accommodation, or within a general waiting area. It is recognised that the question of supervising such a facility will be critical to the decision as to its feasibility, and a considered operational policy in this regard is essential, to ensure the protection and safety of children, staff and the facility itself. It is necessary to address this issue at an early stage in the development of the project brief.

5.8 Bereavement support

This should be looked at in the context of the recommendations of the Report of the National Advisory Committee on Palliative Care. Current bereavement services generally follow one of the following patterns:

- Unplanned ‘drop-in’ by one or two people for informal consultation.
- Organised activity by trained volunteers, generally for small numbers.
- Focused or client specific counselling, e.g., for an adolescent group, possibly in the community.
- Bereavement service, commemorative Mass, and the like (unpredictable attendance levels).

Ideally the facilities noted elsewhere in this guideline document will be designed to be capable of accommodating these activities.

5.9 Spiritual and Pastoral Care

Palliative care by definition takes an overall, holistic view of the patient and his or her family. This includes addressing the spiritual needs of patients, particularly in the later stages of illness, when death is imminent. Facilities should be provided in the in patient unit, for suitably trained chaplains to give
spiritual and pastoral care. Such facilities should be designed to offer optimum flexibility in use, and cater insofar as is reasonably practical for the needs of different religions.

A space should be provided for multi-denominational use, as a chapel, prayer room or quiet room for individual contemplation. This room should be capable of accommodating approximately 10 to 12 people on a daily basis, including wheelchair and bed access. It should, if possible, be capable of enlargement to accommodate larger numbers on occasion. (A demountable partition or large sliding doors between this room and a day room, for example, might be considered suitable for this purpose). This is separate from, but complementary to, the “contemplation room” mentioned above.

An integrated sound system linked to the wards is desirable, for the benefit of those too ill to leave their beds.

An office should be provided for the use of the chaplain(s), for administrative purposes, as well as for discussion with and counselling of patients and their families.

5.10 Mortuary

The mortuary in new specialist palliative care units will be essentially for the holding of remains in a suitable place after the death of a patient, and for the viewing of the body by the patient’s family. The ‘compassionate’ dimension of the accommodation will be more important than the ‘clinical’.

Essentially the facility will allow for the laying out of a body in a ‘viewing’ room, (essentially arranged as a conventional bedroom), with a private room and w.c. for relatives attached. It will also provide a space for appropriate holding or storage of bodies, pending viewing and removal.

It is not envisaged that post-mortem examinations or embalming will take place in specialist palliative care settings. All relevant Health and Safety issues are to be taken into account.

The question of environmental control, especially ambient temperature, requires careful consideration. Similarly, the location of the mortuary requires consideration, as do the issues of access and egress. The sensitivities of other patients and their families are to be respected.

It will be important to clarify certain policy questions, particularly in relation to removals, and funerals.
5.11 Education and Training Department

It is recommended that specific design guidance, which may be required on this subject, should be obtained from other sources with particular experience and expertise.

Health Building Note No. 42, for example, published by NHS Estates, (1989), deals with accommodation for education and training in healthcare settings. Other guidance will be available from organisations and agencies whose principal responsibility lies in the provision of such facilities, especially those for third level education.

The linkages that are recommended in the principal report between palliative care settings, universities and research centres will require clear definition to allow assessment of how best to accommodate the educational and training needs of particular settings in the future.

Future project teams will be required to establish and justify their needs in relation to education, as with other components of the proposed service. These needs will have to be based on support defined and agreed operational policies, and be expressed in terms that describe, inter alia, the range and type of course and programme likely to be developed and offered, the number of staff and students envisaged, the pattern and frequency of courses, as well as their duration and timetable.

Proposals for accommodation for educational purposes will require prior assessment of the various options that might be open for consideration by a particular project team in respect of this function. In developing such proposals, it will be important to consider issues like access and circulation patterns, and preferred location of an education department. It will also be necessary to consider accommodation necessary to support the educational function, such as wc’s, foyer, catering, car parking, and the like, as well as technological support in the form of facilities for video-conferencing, internet access, and so on.

5.12 Administration

Much of the preceding has been based on the principles of maximising use of space and ensuring flexibility. The different aspects of the service will require different degrees of administrative support. It is anticipated that there will be significant scope for sharing of facilities, and ensuring efficient administrative support in the context of the recommendations noted above.

The role of volunteers may be such that provision of a ‘staff room’ for volunteers might be appropriate.
Environmental and Building Services

In addition to the normal range of mechanical and electrical issues that should be considered by both project and design teams in respect of the development of facilities for acute health care, a list of particular concerns relating to palliative care settings is set down below for more detailed consideration:

- The general principles of sustainability and conservation.
- The importance of initial design decisions in respect of their impact on energy consumption and conservation.
- An integrated design approach – issues such as building size, orientation, form, location, fenestration, structure, patterns of use, material specifications and the like should be considered at the earliest stage.
- In-patient areas of the hospice will be in use on a 24-hour basis. The thermal comfort of all building users requires careful attention.
- Importance of natural ventilation where possible – fine control may be desirable to avoid drafts and discomfort.
- There may be particular requirements for mechanical ventilation and rapid air changes in parts of the unit, especially to deal with the dissipation and removal of odours, which some patients can find particularly offensive.
- Services to bed-heads should be considered carefully. As a minimum provision, piped oxygen and suction are required at each bed-head, together with four twin socket outlets.
- The need to reconcile the standards of an acute healthcare facility with the aspiration to achieve ‘domestic’ character in parts of the unit should be addressed from the mechanical and electrical perspective such as:
  - Acoustic quality of the unit’s environment.
  - Lighting levels throughout.
  - Communications, eg: nurse call systems, security systems, alarms, telecommunications, data and IT.
• The potential of ‘assistive’ technology. There may be some benefit for patients with reduced mobility or dexterity in having at least one bedroom per ward equipped with relatively ‘low tech’ systems to facilitate patient control over such things as communications, (phone, tv, etc.), environment (lighting, ventilation), and others, (e.g. motorised door). Any system proposed must be ‘user friendly’, with minimal training requirements.

• Specific IT developments, such as the provision of PACS, (and related links with both primary and secondary care services), computerisation of medical records, or laboratory reporting systems. It is essential to ensure suitability and compatibility of such systems with those elsewhere in the region.
Planning and Development Process

7.1 Existing Guidelines and procedures

These guidelines should be read in conjunction with existing guidance developed and circulated by:

- The Hospital Planning Office of the Department of Health and Children;
- The Department of Finance
- EU directives and national procurement procedures.

A list of these guidelines is at Appendix 1. It should be noted that these guidelines and directives are applicable to the development of all capital projects.

7.2 Option Appraisal

Proposals for public sector investment invariably exceed the resources available. Choice and priority setting are inescapable. The systematic appraisal and professional management of all capital projects helps to ensure that the best choices are made and that the best value for money is obtained.

The purpose of this stage is to ensure that, in as objective a manner as possible, all feasible options that can satisfy an identified service need in the Health Agency’s Strategic Plan are considered and a preferred option selected.

The team preparing the Option Appraisal should systematically identify all options capable of meeting the service objective including the “zero option” i.e. do nothing or only that which is required to comply with statutory regulations. This forms the “bench mark” by which the other options are judged.

The factors for each option, which should be considered in selecting a preferred option are Quality, Time, Cost, Strategy, Content, Consequences for existing service, Location and siting, Time table and Phasing, Capital Costs, and Running Costs.

At the outset of the Option Appraisal, the Department of Health and Children will have issued a preliminary budget for the required Departmental Accommodation on an “all new” basis with a normal allowance for “On-costs” (all works costs, other than Departmental Costs, related to the particular option and its site). This budget may be used as a cost starting point for each option adjusting the amounts for various factors such as use of existing buildings, site conditions etc. to calculate an overall option works cost.
7.3 Cost Control

The primary objective of cost control is achieving the most economically advantageous solution to the service requirements set out in the brief. The most significant cost factor over the life of the development will be the revenue or running costs of the unit. The Design Team should therefore, in consultation with the Client, place particular emphasis on the running cost effect of options being considered during Option Appraisal/Feasibility stage.

Cost control concerns all members of the Project and Design Teams and is broadly divided into two parts:

Pre-contract:

This is the most important stage of cost control as most of the construction costs and the revenue or running costs of the development are decided relatively early in the design process.

It is necessary to ensure that the Construction Cost Limit is adhered to throughout all stages of the design process.

The Design Team should, however, always keep in mind the consequential revenue or running costs of any design decision and the primary cost control objective of achieving the most economically advantageous solution. The design must always be tailored to the Construction Cost Limit.

The departments and schedules of net floor areas in the Brief reflect the accommodation which, on the basis of a preliminary option appraisal, the Client considers can reasonably be achieved, to an acceptable functional and quality standard, for the Construction Cost Limit.

It may be necessary to modify the Brief following Option Appraisal/Feasibility stage to reflect affordable accommodation.

Post-contract:

Post-contract cost control involves ensuring that, from placing the contact to the issue of the Final Certificate, control is exercised to ensure the Final Account is agreed within the Latest Approved Sum (see also “Health Facilities Procurement-Capital Works (construction) - Post Contract Progress and Cost Control Procedures, ref. 10C”)

7.4 Cost Limit

A Construction Cost Limit is set and this figure forms part of the approved design brief for the project. The cost limit is set at a stated date and is based on market prices achievable by competitive tender at that date.

Adjustments will be made to the cost limit for price movements that occur after the said date until the Designated Date of the tender and thereafter to cover
costs due to allowable wage and price variations due under the conditions of contract, where applicable.

Where a tender is fixed price or where a fixed price premium is negotiated post tender due allowance will be made to the cost limit.

7.6 EU and National Procurement Procedures
These procedures are mandatory in relation to publicly funded projects in all fields, including healthcare, and must be built into any project management plan from the outset.

Non-compliance can have a profound effect on project programmes, and any challenge to the process later could be time consuming and costly.

**National Guidelines and Thresholds**
The National Guidelines on Public Procurement (1994 edition), or the “Green Book”, set out the procedures to be followed by Government Departments, local and regional authorities and other public sector bodies dependent upon State funding in the award of contracts.

It is stated in the Green Book that it is “a basic principle of Government procurement that competitive tendering should always be used unless exceptional circumstances apply”.

The Green Book guidelines apply to the procurement of all contracts which fall below the thresholds set out in the Public Sector Directives.

The principles governing the rules of procurement under EU law also apply to contracts falling below the thresholds.

**EC Public Procurement Directives**
The EC Public Procurement Directives have been transposed into Irish law and comprise the following three Directives:

- Directive 92/50/EEC as amended (the’ Services Directive’) which covers contracts with service providers for the provision of services such as property management services, architectural, engineering, surveying, project management and consultancy services.
- Directive 93/36/EEC as amended (the’ Supplies Directive’) which covers any items of supply such as the purchase of plant, equipment and materials.
**Current Threshold Values**

The current thresholds (up to 31st December 2003), in respect of the above directives are:

- Works €6,242,028
- Services €249,681 (Local & Public Authorities)
  €162,293 (Government Departments)
- Supplies €249,681 (Local & Public Authorities)
  €162,293 (Government Departments)

The above thresholds are net of VAT and are revised every 24 months.

### 7.7 Funding

Funding for Health Facilities is currently provided through the National Development Plan. A multi-annual funding approach has been adopted for the first time in 2004 in respect of the health estate. This is considered to be critical from a planning perspective.

Traditionally funding for Palliative Care Facilities has been provided through the Voluntary sector. It is envisaged that in future these facilities will receive state funding, to support the existing structures in place in the Voluntary Sector. This shared approach is seen as vital to maintaining local support and involvement in the planning and provision of the units.

### 7.8 Protection of the State’s Interest

It is not clear at the time of writing what pattern of funding will emerge in relation to the future development of hospice facilities, although it is likely that the role of voluntary subscriptions will continue to be significant.

It will, however, be necessary in the case of hospice facilities developed with the support of public capital investment, to recognise the need to protect the State’s long-term interest in that investment. Arrangements to recognise this investment by the State in all capital projects funded in whole or in part by the Exchequer, will have to be put in place.

Issues to be addressed will include, inter alia, ownership arrangements in respect of sites or buildings or both, the concept of value for money, the service and policy context within which development proposals are advanced, the revenue implications of proposed development, as well as the need to secure the continued use of facilities for their intended purpose.

Future project teams should seek early advice on the implications of these concerns for the particular project proposals for which they are responsible.
7.9 Stages Flow Chart

The table below gives an overview of the various stages to be followed in progressing a health facility building from identification of service need to completion of functional commissioning. Detailed procedural information is available in manuals (see Appendix 1) for each topic.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Action</th>
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<tbody>
<tr>
<td>Strategic Plan</td>
<td>Department of Health and Client</td>
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</tbody>
</table>
| Option Appraisal| Prelim. Brief  
|               | Option Appraisal  
|               | Preferred Option                                                      |
| Stage 1       | Client and Department of Health                                         |
| Stage 2       | Feasibility Study  
|               | Outline DCP proposal  
|               | Finalise Design Brief  
|               | Finalise Cost Limit                                                   |
| Stage 3       | Feasibility Team or Design Team                                         |
| Stage 4       | Design Team                                                            |
| Stage 5       | Design Team                                                            |
| Stage 6       | Design Team and Contractor(s)                                           |
| Stage 7       | Client                                                                  |
| Stage 8       | Client and Department of Health                                         |
Appendix 1

Relevant guidance documents and directives relating to tendering procedures and contracts include the following listed below:

**European Union Procurement Directives (http://simap.eu.int)**
- Directive 93/36/ECC (Supplies Directive)
- Directive 93/37/ECC (Works Directive)
- Directive 93/38/ECC (Utilities Directive)
- Directive 92/50/ECC (Services Directive)
- Directive 92/13/ECC (Remedies Directive)
- Directive 89/5665/ECC (Compliance Directive)

**National Procurement Rules (Government Publications Office Tel: (01) 661 3111)**
Public Procurement 1994 Edition

**Department of Finance**
Guidelines for the Appraisal and Management of Capital Expenditure Proposals in the Public Sector, Department of Finance, July 1994 (www.irlgov.ie/finance/publications/otherpubs/capexguide.htm)

**Department of Health and Children**
Department of Health & Children Accounting Standards for Health Boards (1/1/94)
Department of Health & Children Accounting Standards for Voluntary Hospitals (1/1/99)

Health Facilities Procurement – Capital Works (Construction)
- 1C Overview of Planning Stages and Procedures (Draft)*
- 2C Option Appraisal Procedures
- 3C Client
- 4C Brief (Draft)*
- 5C Select Design Team (Draft)*
- 6C Indentures – Project manager
- 7C Health and Safety
- 8C Design (Draft)*
- 9C Tender and Contract (version 2)
- 10C Post Contract Progress and Cost Control Procedures
- 11C Final Account, Evaluation and Feedback (Draft)*

* Some of the draft guidelines are available from the Hospital Planning Office in the Department of Health and Children"
Indentures of Engagement, Conditions of Engagement, Preparation of Documents and Fees

- Architect (Ref. H.P.O.6’A/R1)
- Quantity Surveyor (Ref. H.P.O.6’QS/R1)
- Civil and Structural Engineer (Ref. H.P.O.6/C&S/R9/94)
- Mechanical and Electrical Engineer (Ref. H.P.O.6/M&E/R9/94)

**Forum for the Construction Industry**

**Local Authority Regulations**

**National Development Finance Agency Act**