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Introduction

Working on internship for Arrasmith, Judd, Rapp, and Associates Architects in Louisville, Kentucky, I got the privilege to be involved in a Regional Hospital for Corbin, Kentucky.

I ended up working on Corbin Baptist Regional Hospital 7 months out of the 9 months during my stay with the firm and got involved heavily in programming and concept design. Before returning back to school opposition occurred and the project ended up in court over the right of who should provide hospital care in that region of Kentucky. Today the settlement has not occurred.

I brought this project back to Ball State University as a thesis project. Being involved in hospital design brought up an interest inside me and I wanted to go further with it.

Hospitals have always attacked the needs of efficiency and staff easy accessibilities throughout a complex network. Today hospitals are looking at the economic needs alone. When I started my thesis I wanted to attack both aspects by studying and working out a project that correlated pieces as an interaction of parts instead of a separation due to function.

I take a look at the hospital as a business where the patient is the customer.
Many thanks go to a lot of people for helping me gain insights on hospital design: Arrasmith, Dunn, Kapp & Associate architects for letting me bring the project back for a thesis study; Ben Cowan for encouraging me to bring the project back and for being one of my thesis instructors; Steve Reynolds for being a thesis instructor; Dr. Robert Hiskin for being an expert in hospital design and for teaching me the basics in hospital design; Jeff Hall for instructing me in landscape design for the project and professor Hickey for the helpful criticism on the structural and mechanical systems of the project.

Overall, I want to thank the entire Ball State architectural faculty for getting me through the five years of school.

It has been a learning experience and a period of growing up in this program. Last but certainly not least, I'd like to thank my colleagues for caring and helping each one of us when we needed that extra push. It has been fun!
Before site selection began, one had to define who the users were going to be. As stated earlier, this is going to be a regional hospital. The two major cities that are benefitting from this facility are London and Corbin Kentucky. Both cities have had inadequate facilities for long term care and specialized services. As planners, we were counting on the hospital serving a 50 mile radius from Corbin.

The idea was for the smaller hospital to feed the serious ill patients to a facility that could handle such a case. Corbin just happened to be in the center of this area. When site selection began, the main consideration was to choose a site that both London and Corbin has quick access to. London, being on the north side, the site committee began to search for an area between the two towns.

Two sites were considered; one being at the intersection of Interstate 75 and state road 25. The other (which was chosen) at the intersection of state road 25 and 25E. The reasons' being as followed:

1) Views
2) Sun orientation
3) Traffic load consideration
4) Noise consideration
5) Link between Corbin to London

After making the decision of choosing the site, I could now analyze how the site was going to affect the design. Areas of concern were:

1) Traffic flow around the site
2) Views
3) Sun orientation
4) Vegetation
5) Topography
6) Summer/Winter winds

After analyzing these known facts on the site, I could now go on to concept design. I realized what I had to deal with. Keeping the known facts in mind would help in the decisions I would need to make later.
## Kentucky

*Source: Kentucky Hospital Utilization Report, Kentucky Department of Human Resources*

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<td>Harlan</td>
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SITE DEVELOPMENT

Service Yards

Automobile Parking

Orientation

Building

Hospital

View

Building Entrances

Land Contours

Landscaping
BUILDING TYPE STUDY
Building Type Study

When studying a design for thesis or a particular client, one needs to study what has been done before. The designer needs to take a completed project and analyze the highlights. He also needs to understand why it works. The opposite is true, the designer needs to pick out the faults of that project so not to use them again.

In this analysis paper on building types I studied three hospitals. One is Saint Mark's Hospital in Salt Lake City, Utah; two, Montego Bay in Jamaica; three, the Good Samaritan Hospital in Phoenix, Arizona. These three examples will give an overview of what I have been considering in hospital design.

1. St. Mark's Hospital in Salt Lake City was proposed consisting of 300 beds. The general hospital would have an extensive outpatient, psychiatric, and rehabilitation services. The complex has also planned to expand up to 600 beds.

Typical nursing floors were to have two independent nursing units of 34 beds. Each unit would be operated by two nursing teams caring for 17 patients each, all in private rooms. The use of a triangular form helps provide a balance of spaces which insures an open vista for each patient bed. Furthermore, the triangular pod allows a centrally located nurse station. The triangular unit for the number of beds stated was found to be superior in reducing the distance between nursing team stations and created a patient-nurse relationship.

The patient floor is regarded as an
entity and is analyzed in terms of five major categories of program objectives. They are: expansibility, flexibility, organization, and circulation, also involved are operational costs, and capital costs.

This hospital fails in some objectives. One, is the hospital-visitor relationship. There needs to be a development of a pre-hospital circulation. This would give the visitor a sense of orientation and place within the complex. Secondly, admitting and waiting needs to be included with administration and business offices. Thirdly, a relationship of services to the bulk of the hospital needs to be defined, but the clarity of ancillary services runs together smoothly for the outpatient as well as the inpatient.

II. The second hospital that was worth a look was the Montego Bay Hospital in Jamaica. It consisted of a three-story base containing an extensive out-patient department, dining spaces, and general public and administrative areas. A six-story medical-surgical core articulates with and provides services for both the outpatient spaces and a ten-story nurses wing.

On-grade access at three levels permits separation of outpatient, emergency and supply traffic. Floors of the component units of the hospital are sized to take care of their particular function without excessive traffic vertically.

The nursing floors are similar to the old VA Hospital concept. Very little circulation and openness for the patient.
The patient is not able to use the floor and experience a commune atmosphere.

The base has limited coherence with the tower. In fact, it is designed as an opposite of the tower with excessive circulation and no sense of direction.

III. The third hospital is the Good Samaritan Hospital in Phoenix, Arizona. Consisting of 724 beds, and emphasis on outpatient care. The goals of providing this is based on: 1) to provide for unprecedented growth rate; 2) reduced operational costs and increased quality of care; 3) a balance program to include education, community health programs and research; 4) Advantages of corporate central management, purchasing, laundry, data processing, and food processing preparation serving the whole system.

During the design process the architects sought maximum involvement of the hospital team at each step. The team was made up of representatives of hospital management, administration, medical staff, and departmental heads. I think this design reflects that total involvement of architects and medical personnel. The hospital has a sense of continuity as a whole.

The nurses units consist of triangular pods forming squares. Keeping the nurse's station centrally located and providing outdoor views for the patients. The problem with this arrangement is that some views are not good.

I tried to pick three hospitals that are different in concepts to give an idea of the complexity of combinations a designer has to deal with. With many variables coming into
design it is tough to decide which is best.

The role of the designer is to take
the variables in hand and all the conceptual combinations formulated and come up
with a design that suits that ideal situation.
SALT LAKE CITY, UTAH
Hypothesis

In understanding a design of a particular building, one must understand the basic parts that make up that design. This is most certainly the case in hospital design. With so many overlapping systems, one must develop a hypothesis in a hurry to get the most out of a design. Without a hypothesis to set the stage, so to speak, one finds himself searching for handles to choose, but which is the right one. Setting a hypothesis can give a guide to that answer, and put in perspective a total design.

In looking at my particular project, Corbin Regional Hospital in Corbin, Kentucky, I have established a hypothesis to generate an order, within a complex framework of systems. These hypothesis are:

1) If we separate public and private areas within the hospital then a system will easily be established.

2) If we have a basic geometrical form that is derived from the triangular patient pod concept, then an idea of an efficient and psychological factors will be addressed.

3) If we use a tartan grid system to give order in structure then this will allow mechanical ductwork to penetrate the system.

These are the areas of study that I am concerned with in this design. Both number one and two are concerned with a bigger study and that deals with the
psychological factors of patients. I would now like to elaborate on each hypothesis chosen. It helps to understand the development of hypothesis in particular projects in establishing a clear, well thought out design.

In looking at the first hypothesis that I mentioned, the separation of public and private areas within the hospital, one has to understand what actually goes on within the complex. The fact that the hospital has areas such as ancillary services, support areas, receiving areas, and also hospital circulation spaces that the public has no need to be in. The opposite is true the public needs to have access to administration, admitting, and discharge, and a lobby or now known as a pre-hospital area. An establishment of coding should be adhered to for the clarity of these different spaces can be defined by materials and playing with lighting as well as ceiling and wall manipulation.

The second hypothesis that is mentioned is the basic form that has been established. It was derived from the patient pod idea where the nurse's station is centrally located. Also, the patient's rooms surround the nurse's station. This gives the freedom to the patient in walking within the pod in rehabilitation. Manipulation within the corridor allows areas for the patient to stop along his path to
see outside, and also opportunities to stop and maybe talk with other patients. This idea is to give the patient an opportunity to get out of his room as much as possible. Then it addresses the psychological factors of a patient, as well as efficiency for the nurses.

The third hypothesis deals with structuring the tower complex. The reasoning of using a tartan system is allowing so much for structure now. Then when laying out the patient rooms and nurse's stations, I have already accounted for the structure and will cut cost. This reason will cut down in errors as well as headaches.

These are some of the major hypotheses for my design. With introduction of hypo-

theses many ideas spin off creating a more uniform design. The most important thing in design is a starting point. Hypotheses give the designer that start and development of concepts creates a much simpler and more unified result.
Program

In understanding the needs of regional hospital planning it took a lot of research to develop the program. Studies were conducted in the Corbin area to determine the users, hospital needs, and population expectancies. A regional hospital is a complex network of integral parts. The first step in developing the program was to determine these parts. The whole program was broke down into these pieces:

1) Nurse Units
2) Ancillary Services
3) Administration Services
4) Circulation
5) Logistical Services

From this step we could then put departments under these categories. This gave an organizational process of analyzing each different aspect of hospital services.

Developing rough square footages for the program was also a problem. While at Arrasmith, Judd, Rapp and Associates, I got the opportunity to analyze and synthesize hospitals that the firm had done. I put together a package that presented a basic program of each hospital. Included were rough square footages of departments. I brought this back to my thesis and tried to adhere to it the best I could.

In the following pages of the program section, one will find a program typed out. I also wanted to define some of theses departements to give the reader an understanding of some of the spaces needed in hospital design.
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<td>b) inpatient</td>
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</tr>
<tr>
<td></td>
<td>c) outpatient</td>
<td></td>
</tr>
<tr>
<td></td>
<td>d) staff</td>
<td></td>
</tr>
<tr>
<td></td>
<td>e) community</td>
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<td></td>
<td>f) public relations</td>
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<td>Medical Library</td>
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RELATIONSHIP OF HOSPITAL TO THE PUBLIC

Board of Trustees

Hospital Administration

Hospital Personnel

Patients

Medical Staff

Fund Raisers
Regional health care starts here. Understanding the patients needs, such as privacy, nurse involvement, and views from the patients' rooms, all need to be considered. Both vertical and horizontal circulation between rooms and services should play an important role. Links should occur in some areas such as: OB, Delivery and Surgery, Intensive Care and Coronary Care.

A study was conducted by Arrasmith, Judi, and Hopp Associates Architects of the need for a health care facility in Corbin, Kentucky. The need, in that area, resulted into a 250 bed facility. The study also pointed out the need for expandibility.

The bed distribution for the nursing units is as follows:

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<tr>
<td>surgical</td>
<td>25</td>
<td>31</td>
<td>87</td>
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<tr>
<td>Obstetrical Care</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>surgical</td>
<td>8</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>nursery</td>
<td>24 (bassinets)</td>
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</tr>
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<td>Intensive Care</td>
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<td>intensive</td>
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<tr>
<td>coronary</td>
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Departmental planning and adjacencies within these services should accommodate the following considerations:
MEDICAL AND SURGICAL CARE

The ideal situation for a medical and surgical unit is between 30 to 34 beds. The design considered is 34 beds per unit. The units should be planned so that the patients are not isolated from the nurses' station. The nurses' station should be centrally located to minimize the distance for nurse care and also to maximize the relationship between the nurses and the patients. The nurses' unit should contain the following:

a) Nurses' station  h) Mechanical area
b) Doctors' dictation  i) Housing
c) Medi-prep  j) Exam room
d) Clean utility  k) Tub room
e) Dirty utility  l) Sitz bath
f) Pantry  m) Pneumatic tube
g) Storage

OBSTETRICAL CARE

This unit should be located adjacent to delivery and nursery services. It will contain independent staffing of both labor/delivery and nursery. The maternity service contains basically the same services as medical and surgical units.

NURSERY

The nursery needs to be located near the obstetric unit for easy accessibility at feeding time. Planning should permit visual observation from a work station required to sustain each nursery. View windows from corridors outside the nursery unit are also required. Space required for each bassinet for regular care is 24 sq.ft.
Within the program of the nursery, 3 rooms will be needed to hold the cribs, 24 cribs in total.

PEDIATRIC CARE

A lot of new studies have been conducted in child hospitalization. The biggest concern in all the studies was the idea of providing a home atmosphere and parent involvement. A room type study that is being looked at is a two bed unit where one bed is for the parent of the child. This allows more parent involvement and helps the child psychologically in a time of despair.
40 Beds

260 S.F. per Bed

Al. Expanded

More Efficient

40 Beds

16 Beds

235 S.F. per Bed

40 Beds

160 Beds - 235 S.F. per Bed

280 S.F. per Bed

40 Beds

40 Beds

40 Beds

40 Beds

Al. Beds

40 Beds

40 Beds

40 Beds

FACIMEN SUITE
Dine room: 14' x 14'

Bedroom: 12' x 12'

Master Bedroom: 14' x 14'

Hot tub: 9' x 9'

30x30 ft

275 sq ft / bed

5.5 ft / bed
Advantages of a Triangular Scheme

Nursing Departments

Admit

Patient Care Divisions

Discharge

Internal Medicine

Laboratory
BMR, EKG, EEG, X-Ray
Pharmacy
Physical Med.
Traffic Patterns, Patient Care

- Laboratory
- Surgery
- Delivery
- X Ray
- Patients Room
- Serving Kitchen
- Exam Treatment
- Medication Preparation
- Nurses Station
- Utility Room
FROM DESIGN FOR OBSTETRIC AND PEDIATRIC FACILITIES

HEMATAL INTENSIVE CARE

NEED 60 SQ FT PER INFANT

4 FOOT INTERVAL (OR 6 FT CENTERS) WITH 6 FOOT CENTER

ABLE IF INCUBATORS ALIGNED ON EITHER SIDE

Height from Wall Condition: 17'-0" WIDTH

2'-0"

4'-0"

2'-0"

4'-0"

1'-0"

4'-0"

1'-0"

2'-0"

2'-0"

4'-0" 23'-6" LENGTH

1'-6"

4'-0"


**HOSPITAL - FULL-TERM NURSERY**

**CODE** SAYS: FROM SECTION 8 PARA 2

Exit Room No More Than 8 Bassinets, can increase to 16 if the extra bassinets are of equation type.

**SPACE REQUIRED**: Minimum 24 sq ft per bassinet for regular care, minimum 40 sq ft for isolation bassinets.

![Diagram of bassinet arrangement]

**HEED**: 280 sq ft

22 x 13
Ancillary services today offer diagnoses, therapy or other forms of treatment and are on an increase of demand nationwide. Today, technology has outgrown the hospitals of yesterday. More room is needed to house the equipment provided by today's standard of health care. More services are now directed towards outpatient care. Patients today, to avoid expensive stays in the hospital, use the outpatient services. This allows the outpatient to recover at home but still have the same benefits as an inpatient.

Radiology is an example of technology growing in leaps and bounds. At Ball Memorial Hospital of Muncie, Indiana, the radiology department was designed for future expansion of ten years. Today, after 4 years of service to the community, they have used that space.

The design solution must make an accommodation in floor plan to offer the capabilities in growth, but keeping in mind relationships of services. Their relationships should be based upon logical traffic flow of such a patient at all times.

Orientation is the key to allow the patient to understand where he is by clear definitions of spaces, radiology, laboratory, physical therapy, respiratory therapy, outpatient surgery, and emergency
services should be grouped and defined for the reason of orientation.

**EMERGENCY/OUTPATIENT**

Emergency and outpatient are considered to be two different aspects of ancillary care, but yet they are related in the idea they both serve the outpatient community. Definition of both areas should be prevalent from the exterior. Emergency defines what the service is for. Outpatient deals with the people for minor operations (surgi-center), physical therapy, or respiratory therapy.

In a regional hospital facility an emergency can occur over a wide area. Quickness is important in a successful emergency unit. Included in this hospital is a proposal of a helicopter transportation, as well as an ambulance, and walk-in emergency. Two separate entrances should be provided. One entry for walk-in emergency, and the second one for the ambulance and helicopter.

Outpatient services that have been mentioned will be the bulk of this area. The outpatient should have a separate entry from other functions and should be clearly defined.

Planning should also permit movement of an emergency patient to radiology and outpatient surgery without crossing into public areas.
Surgery/delivery is ideally located near emergency, x-ray and laboratory for the easy movement of emergency patients, radiology technicians to the cystoscopy and orthopedic x-ray control station, and gross tissue specimens respectively. In a hospital of this size, for nurse supervision and development of swing bed possibilities, it is also ideally located contiguous to the inpatient care units.

As discussed earlier, the close relationship of recovery, concentrated care and surgical acute care permits centralization of trained nursing personnel, step-down patient care, swing utilization of beds, and joint utilization of nurse support facilities. Also, adjacencies between labor, delivery, post-partum beds, and nurseries permits similar flexibility and economy of staffing and facilities utilization.

Inpatient movement to surgery is from the nursing unit to patient preparation, to operating room, to recovery and back to the patient care units, surgical outpatients check-in at the control station and move through the dressing and locker area to the patient rep cubicles. From patient prep their movement is to the operating room, to recovery, and back to patient prep and dressing before discharge. Maternity patients are admitted to labor, move to the delivery room (or possibly to one of the operating rooms of cesarian sections),
and from the delivery are either moved directly to a post-partum bed or routed through surgical recovery when indicated. The baby is bathed in the delivery room and moved directly to the nurseries.

The surgical section (and possibly, the delivery section as well, if practicable for one delivery room) should be planned on the triple corridor arrangement. This planning permits separation of traffic flow between clean and soiled supplies, personnel, physicians, and patients. Clean supplies, personnel, and surgeons enter the operating rooms from an internal clean supply and staff corridor. Locker facilities should be planned so that staff enter from the outside, move through the lounge and changing areas and don a scrub gown before entering the clean supply corridor. Upon completion of a procedure, patient, soiled material, and staff are all considered dirty and they leave the operating room via the peripheral corridor. The patient moves on to the recovery area, soiled material to soiled collection rooms, and staff to the locker rooms where they leave their scrub gowns, bathe, change, and leave the department or prepare for re-entry to the clean supply corridor the next case.

While this flow would also be desirable for the delivery room, its separation from the operating rooms on the one hand and the joint utilization of locker facil-
ities on the other may not permit it.

Upon completion of the surgical caseload, the nurses move to central sterile supply for the reprocessing and sterilization of instruments and the preparation of surgical packs. For ease of starting and operation, space economies, and elimination of double handling of supplies, it would be very desirable to plan central sterile supply contiguous to the operating room block in such a way that sterile supplies move directly to the clean supply corridor in surgery and that soiled materials move directly from operating rooms to the soiled receiving and decontamination area in central sterile supply.

Two of the four operating rooms are equipped with surgical tables and fixed x-ray equipment for cystoscopy and orthopedic work. Planning, however, should not preclude the use of these rooms for other surgical procedures. These two rooms should flank a control station and dark room, and the cystoscopy room should be located for ease of access to the outpatient surgery staging area.

Recovery should be located near the operating rooms, convenient to the surgeons' changing area and lounge, and adjacent, if possible, to concentrated care and acute surgical care. Facility should include recovery beds in cubicles with
The exception of one bed for isolation or terminal cases which is to be enclosed with glazed partitions permitting observation from the recovery nurses station.

Surgery and delivery should be located on an outside wall at ground level with the major patient movement and clean supply corridors located perpendicular to the outside wall and operating, delivery, and recovery rooms positioned for horizontal expansion while maintaining general organization and traffic flow.

RADIOLOGY

Serves in and out-patients for diagnostic and treatment work in radiography and fluoroscopy. It should be located near the outpatient/emergency department and nursing units for ease of access by patients, and adjacency to surgery would permit coverage of cystoscopy and orthopedic x-ray procedures and processing by x-ray technicians.

As stated previously, radiology outpatient waiting can be combined with waiting for exam/consultation, laboratory, and physical therapy outpatients. Depending on planning, it may also be possible to provide one central reception and control point for all of these outpatient functions. Inpatients arrive in the radiology department by stretcher or wheelchair and a separate inpatient/series
waiting area is located accessible to hospital corridors so that inpatient flow can be independent of outpatient traffic.

Three dressing cubicles and a toilet are provided for each of the two x-ray rooms. Outpatients move through dressing, to the x-ray room, return to the dressing cubicle, are discharged when the film has been viewed for technical clarity, dress and leave. The three dressing cubicles permits staging of patients so that there is no interruption in the use of x-ray equipment. The toilet should be planned so that it is accessible from the x-ray room and from the dressing cubicles. Patients undergoing series examinations wait in the inpatient waiting area between exposures.

The x-ray rooms are both equipped for radiographic and fluoroscopic procedures and should be planned flanking a dark room and control station so that one technician can work in both rooms passing film through cassette pass books to a darkroom technician or entering the darkroom and processing the film himself between each patient. Planning should permit the radiologist to move between the two darkened rooms without entering a lighted area when he is doing fluoroscopy.

An automatic processor is used which discharges film to a viewing and sorting area. At this point the film
is checked for acceptability and the film is available at this point for initial viewing by radiologists and physicians. Processed films are collected periodically by the film file clerk, matched with previous films for that patient, and taken to the radiologist's office for reading and dictation. The typed report is combined with the film and returned to the file area. The radiologist's office and reading room also serves as a viewing and consultation area and should be conveniently located with respect to film sorting and film files. Planning should separate patient flow from film processing, viewing, consultation, and files. The radiologist's control point should link the patient and staff areas and the radiologist's office, while outside patient flow, should be accessible to patients. Physicians entering the viewing and consultation areas should be able to do so without encountering patient traffic.

Radiology can be expected to expand in response to increasing use by inpatients and outpatients and expanding diagnostic techniques. The department should be located on an outside wall and planned so that horizontal expansion can occur without compromise of patient and staff traffic and film processing procedures.

LABORATORY

The laboratory is known to facilitate procedures which can be consolidated such as: urinalysis, hematology, chemistry,
and possibly seriology. The laboratory should be centrally located within the hospital. It serves many departments and it is a link of transformation of service to ancillary departments. It is anticipated that the laboratory should be increasingly important diagnostic tool with expansion of both service and technology.

It is important, therefore, that the laboratory be located and planned for horizontal expansion and/or internal modification with minimal disruption of service.
Hospital Patients' Travel

- Main Entrance
- Separate Entrance
- Ambulance Entrance

- Admitting
- Information

- Emergency
- Surgery
- Delivery

- Radiology
- Physical Medicine
- ER, Xrays, EKG
- Patient Care Divisions
administrative services

The organizational, management, board of trustees, and record keeping tasks that are required for the effective provision of health care fall within the jurisdiction of administrative services. The business of hospital facility is as important to the patient and the community as the direct care rendered by the nursing staff.

Administrative services provides a link between public and hospital oriented services. They provide a soft image for the public view as a relax atmosphere within a complex network.

MEDICAL RECORDS

This area will be convenient to physicians entering the hospital at the entry doctors designated for them. It will provide a space for transcribing and file storage, but also for the dictating center for visiting physicians. This area should also include a lounge and a library for the doctors and staff.

ADMINISTRATION

Will be designed to accomodate the administrator and his administrative staff. In addition to waiting, secretarial and conference areas, other related administrative functions of the hospital will be consolidated, such as nursing personnel.

Administration can also provide a buffer zone of public to semi-public and private areas. Administration can provide an image to the public zone.
BUSINESS OFFICE

All admitting and discharge procedures will fall into the jurisdiction of this department. In addition, insurance, credit, posting and general accounting functions will be performed in this department. As a support to the business office, computer facilities and business machines will be included.

PUBLIC AREAS

In addition to the spaces and functions provided within each of the hospital departments, there will be functions scattered throughout the hospital that serve patients, visitors, staff and employees. Vending facilities, lounges, toilets, telephones, reception point, and a gift shop.
logistical services

The non-clinical support services which sustain the delivery of medical care through the provision of necessary supplies and services will include general stores, housekeeping, dietary. These departments will be grouped due to their relationship to the delivery point as well as the need to segregate these services from the patient care and public areas of the hospital.

PURCHASING/GENERAL STORES

Material management functions of the hospital will be handled by this department. All goods entering the hospital (including dietary deliveries) will come to this central receiving point. Other hospital departments will then be supplied by a cart exchange system eliminating from the general stores function.

HOUSEKEEPING/LINEN

Supplies will come from the general stores department. Trash collected at various points of use within the hospital will be transported to a centralized compactor for removal. The housekeeping department will also control the linen management function. No laundry will be provided within the facility and all laundry materials will be delivered to the hospital on a contract basis.

DIETARY

Designed to employ a conventional preparation and serving system. The food will be prepared within the kitchen for use in the cafeteria as well as the
patient care areas. Once portioned and organized on trays, the meals are delivered by carts to the nursing unit via service elevators. This system will offer considerable flexibility and should be planned so as to be modified as technology allows functional response. Cafeteria and dining facilities are an integral part of the dietary department.
Department Relationships

After covering the program and space analysis, I now needed to understand the relationships of departments. The best tool I found was to use bubble diagrams and relate departments to each other in order of importance. By doing this step it gave me the opportunity to understand what areas need to be next to each other. Also it gave me some key spaces that other spaces can revolve around. Such spaces as laboratory, admitting, and administration can buffer two different services. These elements can enhance circulation and spatial relationships.
Pre-Hospital

Functional Relationships
Functional Relationships
Functional Relationships
Functional Relationships
Functional Relationships
Autopsy is isolated from all other ancillary services.
Functional Relationships
Functional Relationships
Functional Relationships
CONCEPTS