



I'm not robot



Continue

A stroll in space level 14

Taking care of your own business is probably a good rule of thumb when traveling intergalactically. I mean, no one wants to answer an emergency call and end up with aliens bursting out of their chests. But what do you do if you take care of your own business when suddenly you are attacked by medium large tentacles? Use your puzzle platforming skills and take a walk in Space, by Gameshot. Use the [arrow] keys to move and jump as you make the long journey of your ship. Once you rescue your monkey friend, you can press [the spacebar] to make him disable gravity to help you move the chest and jump to an inaccessible place. Can you make it to the escape pod unscathed? Using gravity buttons doesn't just flip gravity upside down like in many games. It's a little more realistic as when activated, you start floating in any direction you move in that moment, and it bounces off the wall or into the nail. It takes a little getting used to, but it is a fun and different mechanic. Luckily you have an endless life, as some levels require a bit of trial and error. It can be frustrating if you die near the end of the level, but the levels aren't super long, so you don't have too far to go to regain ground. The sound and graphics are good, and the levels vary between needing platforming skills and having to think through puzzles. Perhaps another good rule of thumb for space travel should be to put your surge ship and laser outside your ship next time to prevent a hostile attack. Play the dedicated concierge service A Stroll in Space Dedicated, to enhance your weekday experience Car sharing solutions and discount parking for you and your team A variety of exclusive on-site products and services to support your team in maintaining their well-being and healthy work-life balance Join the connected building community with dedicated portals to provide you with the latest office news and employee offers. Giving you priority access to childcare at Dexu Place's premium early learning centre offers premium meeting and event spaces in key CBD locations Page 2 Car sharing and discount parking solutions for you and your team A range of exclusive products and services are in place to support your team in maintaining their wellbeing and healthy work-life balance Join a connected building community with a dedicated portal to provide you with information with the latest news and employees Giving you priority access childcare at Dexu Place's premium early learning centres offers meeting rooms and premium in the main CBD location Standard delivery room Resuscitation / baby stabilization Room for baby resuscitation / stabilization should be provided in the operating delivery room and in labor / delivery / recovery (LDR), labor / delivery / recovery / postpartum (LDRP) rooms, rooms, other nonoperative delivery rooms. The delivery room can be directly connected to the nursery or NICU through a window or pass-through door. The ventilation system for each delivery and resuscitation chamber should be designed to control ambient temperatures between 72 and 78°F (22 to 26°C) during delivery, resuscitation and stabilization of newborns. Specific recommendations for each location where resuscitation or stabilization of babies occur are as follows: Recommendations for operating delivery rooms for operating rooms intended for use by NICU patients (Standard 8) should be followed by this exception: A minimum empty floor area of 80 ft² (7.5 m²) for infants should be provided in addition to the areas necessary for other functions. A total of 3 oxygen, 3 air, 3 vacuums and 12 electrical outlets that can be accessed simultaneously will be provided for infants and must comply with all specifications for this outlet described in the NICU Standard 9. The baby room cannot be removed from the operating delivery room when a separate baby resuscitation/stabilization room is provided. LDR, LDRP, or other nonoperative delivery space: A minimum empty floor area of 40 ft² (3.7 m²) is provided for the baby room. This space can be used for several purposes including resuscitation, stabilization, observation, exams, sleep or other infant needs. A total of 1 oxygen, 1 air, 1 vacuum and 6 electrical outlets that can be

accessed simultaneously will be provided for the baby in addition to the facilities necessary for the mother. The baby room cannot be removed from the LDR, LDRP, or nonoperative delivery rooms when a separate infant resuscitation/stabilization space is provided. Pass-through windows and doors: Windows and doors should be designed for visual and acoustic privacy and will allow easy exchange of babies between personnel. When the operating delivery room is equipped with a window or pass-through door, it will have positive pressure so that air flows out into the baby room when the window or door is opened. Interpretation. The current delivery room (surgical and nonoperative) is required to have a resuscitation room and a separate outlet for the baby. This space includes an acceptable environment for most uncomplicated term infants, but may not support optimal management of infants who will become NICU patients. Some baby terms and most premature babies are at greater thermal risk and often require additional personnel, equipment and time to optimize resuscitation and stabilization. They are basically NICU patients from delivery time and will therefore be optimally managed in space designed to NICU standards. An appropriate resuscitation/stabilization environment should be provided. Providing it in every delivery room allows parents to be aware of staff efforts to turn on and care for the baby before providing ongoing support in designated entry rooms or within the NICU with baby transfers through windows or pass-through doors offers efficiency for staff, an environment designed for infants and direct access to all necessary equipment and supplies. Infectious concerns for opening to the operating room of a nonsterile area (NICU) are addressed by designing airflow out of sterile spaces when windows and doors are opened. The provision of suitable temperatures for resuscitation of high-risk premature baby delivery rooms is essential for their stabilization. Although lower temperatures are often more convenient for screening officers, the need for high-risk babies should be prioritized. It is also important that this appropriate ambient temperature can be achieved in a short period of time, as many high-risk deliveries occur with little warning. Since many patients are at higher risk of being delivered in the operating delivery room, the minimum operating room must be greater than the minimum standard for LDR or LDRP. If hospitalists serve a largely high-risk perinatal population, hospitalists are encouraged to exceed minimum standards. Equipment storage may best be provided by wall-hung boards or other appropriate techniques to allow ready visibility and access to all necessary resuscitation equipment. Newborn ICU Standard 1: Nicu Design unit configuration must be driven by the objectives and objectives of a systematically developed program that determines unit objectives, service provision, space utilization, projection of bed space requests, staffing requirements and other basic information related to unit missions. Design strategies to achieve program goals and objectives must address the medical, developmental, educational, emotional and social needs of infants, families, and staff. Design will allow flexibility and creativity to achieve stated goals. The NICU should be configured for the individualization of the environment and parenting services for each baby and family, including twin families or higher order multiples. Interpretation. The objectives and objectives of the program are in line with the philosophy of care and the definition of unit quality should be developed by the planning team. This team should include, among other things, health care professionals, families whose main experience with hospitals is as health care consumers, administrators and design professionals. The objectives and objectives of the program should include a description of the services required for complete operation of the unit and address the potential need to expand services to accommodate increased demand. Specific approaches to achieving individual environments are discussed in the next section. Standard 2: NICU locations within NICU hospitals should be areas where in healthcare facilities, with controlled access and Environment. The NICU should be located within a space designed for that purpose. This will provide effective circulation of staff, families and equipment. Traffic to other services must not pass through the unit. The NICU should be in close proximity and under control with the area of the hospital where the birth occurred. When midwifery and neonatal services should be located on separate floors of the hospital, lifts located adjacent to units with priority calls and controlled access by essential operations should be provided for services between the maternity unit and the NICU. Units receiving infants from other facilities must have ready access to the hospital's transportation reception area and must designate space for transportation equipment. Interpretation. The purpose of this standard is to provide safe and efficient transportation of infants while respecting their privacy. As such, the NICU should be a different and controlled area immediately adjacent to other perinatal services, except in such local situations (for example, free-standing children's hospitals) where exceptions can be justified. The transport of babies inside the hospital should be possible without the use of public corridors. Standard 3: Nicu family entrance and reception areas must have clearly identified entrances and reception areas for families. Families should have direct and direct contact with staff when they arrive at this entrance and reception area. Interpretation. The design of this area should contribute to a positive first impression for the family and foster the concept that the family is an important member of their baby's health care team, not a visitor. Facilitating contact with staff will also increase safety for infants in the NICU. The area must have lockable storage facilities for family personal items (unless provided elsewhere), and may also include a handwashing area and dresses. Standard 4: Nicu safety/infant safety is designed as part of an overall safety program to protect the physical safety of infants, families and staff in the NICU. The NICU is designed to minimize the risk of infant abduction. Interpretation. Since the design of the facility significantly affects security, it should be a priority in planning for the renovation of existing units or new units. Treatment should be carried out to limit the number of exits and entrances to the unit. The control station should be located in close proximity and visibility directly from the entrance to the baby care area. The control point must be located so that all visitors must walk past the station to enter the unit. The design should provide maximum visibility of the nursery from the workspace or charting area. However, security considerations should not adversely affect the quality of space for families in the NICU. The need for must be balanced with the need for comfort and privacy of the family their babies. The technology device can be used in a flexible and innovative way in the design of a multi-bed room or a single baby schematic NICU. Such technology, when used in conjunction with thoughtful traffic pattern planning from/to and within the NICU space, support area and living room, can facilitate a safe, yet family-friendly area. Standard 5: Minimum space, permission, and privacy requirements for baby room Each nursery must contain at least 120 ft² (11.2 m²) of clear floor space, excluding handwashing stations, columns and hallways (see Glossary). In this space, there will be enough furniture to allow the elderly to remain seated, reclining or completely recumbent at the side of the bed. There will be a hallway adjacent to each nursery with a minimum width of 4 ft (1.2 m) in some bedrooms. When a single nursery or cubicle partition remains used in the design, there should be an adjacent hallway no less than 8 ft (2.4 m) in clear width and unobstructed to allow the passage of equipment and personnel. Rooms with multiple beds have a minimum of 8 feet (2.4 m) between cots. There will be provisions for visual privacy for each bed, and the design should support privacy speak at a distance of 12 ft (3.6 m). Interpretation. These figures are minimal and often need to be improved to reflect the complexity of the care provided, the bedside space required for parenting and family involvement in care and privacy for families (see Standard 6). The width of the hallway in the multiple-bed room should allow easy movement of all possible equipment brought to the side of the baby cot, as well as easy access to the mother's bed. The width of the corridor or hallway outside a single nursery or baby room designed with a permanent cubicle partition should allow it to pass through two items as mandated by state and federal architecture and fire codes. The need for privacy for infants and families will be addressed not only in the design of each bed room, but also in the overall unit design — for example, by minimizing the flow of traffic through each bed. Standard 6: Private Room (Single Family) Rooms intended for the use of single infants and their families must comply with the requirements for designated baby rooms elsewhere in this standard, with the following exceptions: The minimum size is not less than 165 ft² (15.3 m²) of clear floor area. Outside windows are not required (see Standard 25 for further specifics). The requirements for wireless monitors and communication devices should be identical to those described for isolation rooms (see Standard 7). Each room should be designed to allow visual and speech privacy for and family. The living room must be designated and can include, at a minimum: Staff rooms must be designated and include, including, minimum: ◦ Comfortable reclining chair suitable for kangaroo care / skin-toskin ◦ Recumbent sleeping surface for at least one parent ◦ Table or surface suitable for writing and / or using laptop computers ◦ At least four electrical outlets for use and charging electronic devices. ◦ Not less than 6 ft3 (0.2m3) storage space Staff space must be designated and included, minimal: ◦ Work surface not less than 6 ft2 (0.6m2) ◦ Charting surface is not less than 3 ft2 (0.3m2) ◦ Storage supply is not less than 30 ft3 (0.85m3). • NOTE: The above requirements can be met by the desired combination of fixed and portable casework, but all storage should be designed for quiet operation. Interpretation: Private (single-family) rooms allow for increased ability to provide individual and personal environments for each infant and family when compared to multi-patient rooms. To provide adequate bedside space for caregivers and families, however, these rooms must be somewhat larger than the baby room in the design of an open multi-bed room, and they must have the storage and communication capabilities of an extra bedside to avoid insulation or excessive walking of the caregiver. Although desirable, it may not be possible to provide windows for each room due to the limited number of outdoor wall areas. It is most important to make use of the available window area first for the meeting room used by families and caregivers, and then secondly for the patient's room. Standard 7: Air infection isolation room The air infection isolation room should be available for NICU infants, and must provide a minimum of 150 ft² (14 m²) of clear floor space, excluding the entry work area. Hands-free handwashing stations for hand hygiene and areas for gowning and storage of clean and dirty materials should be provided near the entrance to the room. The ventilation system for the insulation chamber must be engineered to have negative air pressure with air 100% discharged out, and must meet acoustic standards for the nursery (Standard 27). The perimeter walls of the isolation room of air, ceiling and floor infections, including penetration, must be tightly sealed so that the air does not infiltrate the environment from outside or from other airspace. The air infection isolation room should have a self-closing device at all exits of the room. Emergency communication systems and remote patient monitoring capabilities should be provided inside the airborne infection isolation room. The airborne infection isolation room should have an observation window with internal curtains or opaquing privacy for privacy. The placement of windows and other structural items will allow ease of operation and cleaning. Isolation room air must have a permanently installed visual mechanism to continuously monitor the pressure status of the room when occupied by patients with infectious diseases in the air. The mechanism must continuously monitor the direction of airflow. Interpretation. An adequately designed air infection isolation room to treat sick newborns should be available in any hospital with the NICU. In most cases, this is ideally located in the NICU, but in some circumstances, the utilization of air infection isolation rooms elsewhere in the hospital (for example, in the child's ICU) will be suitable. At least one single residential isolation room should be available for each baby with suspected air infection. Space inside the NICU should also be available to safely excuse a group of babies infected or exposed to common airborne pathogens. When not used for isolation, these rooms can be used to treat non-communicable babies and other clinical purposes. Turbulence of officers with high air exchange rates can result in unacceptable levels of background noise in the isolation room of air infections. These levels result in speech disorders, disorders and a typical physiological response to noise exposure for adults and infants. Particular attention is required, therefore, for the design of noise attenuation devices in heating/ventilation / air conditioning ducts and for washable acoustic surfaces on walls and ceilings to ensure that sound levels meet the Standards in these rooms. Glass partitions should be limited to what is actually required for safe visualization. Proportional number of absorptive acoustic surfaces and reflective acoustics must be appropriate to achieve sound absorption > 25%. Standard 8: Operating rooms intended for use by NICU patients Operating rooms in health care facilities where infant procedures can be performed must be built to operating room specifications except for the following modifications: Assuming the baby's eyes are protected (eye patches) while in the operating room, no change to the IES (Illuminating Engineering Society) guidelines for the operating room is required. However, light sources that meet the color presentation index (CRI) and gamut area index (GA) values identified in Standard 22 are recommended. The laminar flow diffuser above the surgical bed should be set at the lower end of the airspeed range (~25 feet per minute) and balanced with the surrounding slot diffuser air curtains to minimize convective and evaporative heat and water loss from higher airflow to the baby. In addition, ambient temperature and humidity should be adjustable into the range of 72–78 °F (22 to 26 °C) with a relative humidity of at least 30%. The acoustic environment set out in Standard 27 should be the basis for all design options except for the difficult (cleanable) room surfaces required. No effort is made to achieve the standard in an adjacent space if the door is expected to remain closed most procedures. A special procedure room or room in a NICU-specific procedure room or a room within the NICU must be built to achieve all of the above, as well as all requirements for cot space elsewhere in this Recommended Standard, except for the following additional modifications: Each area of the procedure must be physically separated from other areas so that during surgery or flow procedures patients and staff can be strictly controlled. The airflow should be designed so as not to disturb the air curtains around the surgical field, and should be adjustable so that it can increase to 15 changes per hour during the procedure, and then return to the base value set out in Standard 10. A scavenger system to vent anesthesia inhalation of waste and analgesia gas is required. Heating/ventilation/air conditioning equipment must be of the type that minimizes the need for indoor maintenance. The procedure room designed for the operation or oxygenation of extracorporeal membranes must have a clear minimum floor area of 360 ft² (33.5 m²) with a minimum dimension of 16 ft (4.9 m²) exclusively from built-in shelves or cabinets, handwashing stations and columns. These rooms should be designed to comply with safety requirements for the performance of laser surgical procedures. The space requirements for these functions in multi-bed rooms must have a clear floor area of at least 225 ft² (21 m²) exclusively from built-in shelves or cabinets, handwashing stations, columns and hallways. It is assumed that babies undergoing surgery in the NICU will be operated on and recovered in their own beds and that surgical personnel will bring the necessary surgical equipment and sterile supplies to the NICU. Therefore, no additional recovery or postanesthesia area or work area is required for the storage and processing of surgical instruments and separate corridors leading to the operating area. However, support areas for the storage of clean and sterile surgical supplies should be provided, and scrub stations should be provided near the entrance to each procedure room in the corridor limited to authorized personnel and patients. Ambient lighting recommendations set out in Standard 22 should be followed unless higher lighting is required as set out in the IES recommendations for the operating room.5 Increased ambient lighting should remain adjustable and indirect. Interpretation Standard operating room environments can be temporarily modified to accommodate better-term infants who require surgery, but cannot be made optimal for some terms and premature babies, nor can problems associated with transporting less stable babies away from nicu intensive resources be avoided. There is now enough experience to conclude that certain procedures can be performed in the NICU without compromising or patient outcomes. It is now also proven that the environment currently recommended for NICU design may have a positive impact on infant outcomes. The standard now makes provision for babies who need surgical procedures to benefit similarly. Standard 9: Supply of electricity, gas, and mechanical needs Mechanical requirements in each cot, such as electrical and gas outlets, must be arranged to ensure easy safety, access and maintenance. There must be at least 20 electrical outlets that can be accessed simultaneously. The minimum number of gas outlets that can be accessed simultaneously is: Water 3, oxygen 3 and vacuum 3. There will be a mixture of emergency and normal power for all power outlets per the current National Fire Protection Association recommendation.6 Interpretation. Systems that include easily accessible racetracks for power lines and gas pipes, workspaces and equipment placement are recommended as they allow flexibility to modify or improve mechanical, electrical or equipment features. All outlets must be positioned to maximize access and flexibility and minimize repetitive movements such as bending and stretching by staff. Standard duplex electrical outlets may not be suitable, as each power outlet may not be simultaneously accessible for large equipment plugs. The specified number of power, gas and suction outlets is minimum; access to more may be needed for critically ill babies. This area should also include communication devices, supply storage, and charting space, resulting in efficient, organized and self-contained work stations around the baby. Standard 10: Ambient temperature and NICU ventilation should be designed to provide air temperatures of 72°F to 78°F (22-26°C) and relative humidity of 30 to 60%, while avoiding condensation on wall and window surfaces. A minimum of six air changes per hour are required, with a minimum of two changes being out of the air. Ventilation patterns should inhibit free-moving particulate matter in space, and exhaust intake and ventilation should be located to minimize wind in or near cots. Ventilation air delivered to the NICU must be filtered with at least the efficiency specified in the FGI (Facilities Guidelines Institute) guidelines. Fresh air intake should be located at least 25 feet (7.6 m) from the exhaust outlet of the ventilation system, piles of combustion equipment, medical/surgical vacuum systems, ventilation pipes or areas that can collect vehicular exhaust or other harmful fumes. Prevailing winds or proximity to other structures may require greater permits. Interpretation. Heat sources near the exterior walls, if applicable, should be considered to eliminate the condition of the 'cold wall', which in turn can be the source of the concept of convection. This hot app can also be conditions that lead to condensation in this wall. Air flow patterns should be at low speeds and are designed to minimize wind, noise levels and air particulate matter. High efficiency particulate air filtration system (HEPA) can provide increased infection control for immunocompromised patients. Since routine maintenance programs are necessary to ensure that the system continues to function as designed after occupancy, NICU design should strive to maximize ease of maintenance while minimizing its costs. Standard 11: Wash your hands Any cot, whether in a single bed or a multiple-bed room, should be within 20 feet (6 ms) of the hands-free handwashing station. Handwashing stations should not be closer than 3 feet (0.9 m) from the baby cot, clean supply storage or counter/worksurface unless a splashguard is provided. The handwashing sink should be large enough to control splashing and designed to avoid standing or retaining water. The minimum dimensions for a handwashing sink are 24 inches wide x 16 inches front to back x as deep as 10 inches (61 x 41 x 25 cm3) from the bottom of the sink to the top of the rim. Space for pictorial handwashing instructions should be provided above all sinks. There will be no aerator on the tap. The walls adjacent to the handwashing sink should be built from unporous materials. Space should also be provided for soap dispensers and towels and for suitable garbage containers. The towel dispenser should operate so that only the towels themselves need to be touched in the process of exiting, and are built in such a way as to control noise according to Standard 27. Handwashing facilities located at the level where they can be used by people in wheelchairs should be available in the NICU. Separate containers for biohazardous and non-biohazardous waste should be available. Interpretation. Proper hand hygiene is a key component in the prevention and reduction of the spread of infection in health care settings. Alcohol-based hand rubs have proven to be more effective than hand washing soap and water in hands that decontaminate those that don't look dirty. Alcohol-based hand rub dispensers can be easily found in locations where hand hygiene is required. Handwashing sinks are also required in close proximity to the baby's room for use when hands are painted or contaminated with bodily fluids. The sink for hand washing should not be built into a counter. The location of the sink, construction materials and related hardware (paper towels and soap dispensers) should be selected with durability, ease of operation, ease of cleaning and noise control in mind. Nonabsorbent wall material should be used around the sink to prevent growth cellulose. Local, state, and federal regulatory agencies dictate what waste health care produces is a biohazardous or non-biohazardous and appropriate disposal method that depends on the type of waste. Depending jurisdiction, biohazard signage may need to be affixed. Standard 12: Common support rooms Different facilities should be provided for clean and dirty utilities, medical equipment storage and unit management services. Clean utility/holding area: For storage of supplies often used in the care of newborns. Dirty utilities/holding rooms: It is important to store used and contaminated materials before they are removed from the treatment area. Unless used only as a holding room, this room will contain a counter and a hands-free handwashing station separate from the utility sink. Handwashing stations should have hot and cold running water turned on and off by hands-free controls, soap dispensers and paper towels, and closed waste containers with foot controls. The ventilation system in the dirty utility/holding room must be engineered to have negative air pressure with 100% air discharged out. The dirty utility/containment room should be located to allow the removal of dirty materials without passing through the baby care area. The designated area for the collection of recyclable materials used in the NICU must be established. This area should measure at least 1 ft² per patient's bed and be located outside the patient's treatment area. Charting/staff work area: Provision for mapping the space on each side of the bed should be provided. Additional separate areas or desks for tasks such as compiling more detailed records, completing requests and telephone communication should be provided in areas acoustically separated from the infant and family areas. Special spaces should be allocated as necessary for the storage of electronic medical records within the baby care area. Interpretation. Storage area: Three-zone storage system desired. The first storage area should be the central supply department of the hospital. The second storage zone is a clean utility area described in the standard; it should be adjacent and acoustically separated from the baby care area. Regularly used supplies such as diapers, formulas, linens, cover dresses, charts, and information booklets can be stored in this space. There should be at least 8 ft³ (0.22 m³) for each baby for storage of secondary syringes, needles, sets of intravenous infusions and sterile trays. There should also be at least 18 ft² (1.7 m²) of floor space allocated for equipment storage per baby in intermediate care, and 30 ft² (2.8 m²) for each cot in intensive care. Total storage space may vary by unit size and storage system. Easily accessible electrical outlets are desirable in this area to recharge equipment. The third storage zone is for items that are often used at the side of the baby cot. Storage of bedside cabinets should be at least ft³ (0.45 m³) for each baby in the intermediate care area and 24 ft³ (0.67 m³) for each baby in the intensive care area. Bedside storage should be for quiet operation. Hospitals contribute significant waste each year to arson and landfills. This creates not only environmental hazards, but also conditions that are harmful to human health. Providing designated collection areas allows staff to separate and store for waste collection such as paper, newsprints, corrugated cardboard, plastic, metal, batteries, fluorescent lamps and glass to facilitate existing hospital procedures for recycling or starting recycling systems. Rooms within designated collection areas can also be used for the collection of medical supplies for distribution to hospitals or clinics that require such materials. Charting/staff work area: The clerical area should be located near the entrance to the NICU so that personnel can monitor traffic into the unit. In addition, there must be one or more staff work areas, each serving 8 to 16 beds. These areas will allow groups of 3 to 6 caregivers to gather immediately adjacent to the baby care area for reporting, collaboration and socialization without impeding the privacy of the baby or family. Charts, computer terminals, and baby hospital forms may be located in this space. The NICU design should anticipate the use of electronic medical recording devices so that their introduction does not require major disruption to unit functions or impede space designed for other purposes. Design considerations include ease of access for staff, patient confidentiality, infection control and noise control, both with respect to those generated by the device and by the traffic around them. Laundry room: If laundry facilities for baby materials are provided, a separate laundry room can serve laundry and clothing cleaning functions inside the NICU. Baby clothes and cloth cover position aids should be washed on a regular schedule and as needed. In addition, toys used by infants or siblings are required to be cleaned with a regular schedule for each infant and between infants. Space for commercial grade washer and dryers should be accommodated. Dryers should be ventilated through the outer walls. The placement of commercial grade dishwashers can improve the efficiency and effectiveness of aseptic cleaning processes for toys. Standard 13: Staff support rooms are provided within the NICU to meet the professional, personal and administrative needs of staff. Rooms must be large and located to provide privacy and to fulfill their intended functions. Lockers, lounges, private toilet facilities and on-call rooms are required at a minimum. Interpretation. The element of support can be defined as the element that facilitates the provision of infant care and the welfare of staff; they can account for at least a third of the floor space of the entire unit. Staffing area as a limited space for use by staff members to meet the and administrative needs. These areas include lockers, lounges, counseling, educational and conference rooms and on-call rooms that provide privacy and satisfy the intended functionality. Standard 14: Support rooms for additional services Different support rooms will be provided for all clinical services routinely performed in the NICU. Space for the preparation and storage of formulas and additives for milk and human formula should be provided in units or other locations away from the bedside.7 When a separate room for infant feeding preparation is of no merit due to infrequent need, commercial preparation outside the premises or other reasons, a separate area in the food service area or in the patient unit should be designated for infant feeding preparation. Hospital food preparation design guidelines should be followed. When a functional program requires a separate space, the room should include the following areas that can be separated in individual rooms or combined: 1 area Ante 2 Preparation area 3 Storage space for supplies, formula, and both cooled and frozen breast milk 4 Cleaning area To minimize contamination, the ventilation system must have a minimum filtering of 90% based on the American Society of Heating, Ventilation Standards and Air Conditioning Engineers or have a HEPA forced air filtration system. Provisions should be included for the storage of human milk. Human milk can be stored in the designated room in the baby's prep room, and in the designated room of the patient unit. Interpretation. Additional services such as (but not to be limited to) respiratory therapy, laboratory, pharmacy, radiology, developmental therapy and special meal preparation are common in the NICU. Distance, size, and access are important considerations when designing the space for each of these functions. Satellite facilities may be required to provide this service on time. Unless done elsewhere in the hospital, a special meal preparation area or room must be provided in the NICU, away from the bedside, to allow mixing of additives for breast milk or formula. Cleanliness of the floor surface, walls and ceiling should be easy to maintain. Floor drains are not recommended unless required by local code. Adequate sinks, electrical outlets and storage should be provided based on the needs of individual hospital facilities. The use of laminar flow hoods is a decision that must be made by each hospital. Pharmacies are not required to use laminar flow hoods to prepare oral medications. The powder formula is not sterile, and preparing it under the hood of the laminar flow does not increase the sterility of the product. All water provided for meal preparation must meet Federal Standards for commercially sterile and drinking water. Commercially sterile water is preferred because it has eliminated pathogens and organisms that, if any, can grow in the product and produce damage under normal conditions of handling and storage. Standard 15: Administration room administration rooms are provided in the NICU for activities directly related to infant care, family support or other activities routinely carried out within the NICU. Interpretation. Various personnel are assigned to the NICU, many of whom require office or administrative space. When planning the NICU, the administration room should be considered for each discipline that provides services to the unit on a daily day and requires different areas to carry out their responsibilities, even if that individual has additional office space elsewhere. Standard 16: Family support rooms are provided in or immediately adjacent to the NICU for the following functions: family lounge area, lockable storage, telephone and toilet facilities. Separate and dedicated rooms will also be provided for lactation support and consultation in or immediately adjacent to the NICU. A family library or educational area should be provided inside the hospital. Access to the Internet and educational materials must be provided through a computer station in the family lounge or by the baby cot. Interpretation. Family lounge area: This should include comfortable and mobile seating, as well as a play area filled with entertainment materials for children. Food areas should also be considered, as well as external windows or ceilings. Lockable storage: Secure storage for personal items must be provided in each infant room. Lactation support: Comfortable seating, handwashing sinks and means of communication to the NICU should be provided. Family education area: This should include publications, audiovisual resources, and Internet access so families can learn about health conditions, child development, parenting issues, and parent-to-parent support. This area may also include space and supplies to learn and practice parenting techniques. Phone: A phone should be provided that offers privacy and that allows a person to sit while talking. Consulting room: This should include comfortable seating and allow complete visual and acoustic privacy. Standard 17: Family transition rooms are provided in or immediately adjacent to the NICU allowing families and infants to extend private time together. Rooms must have direct and private access to the sink, toilet and shower facilities, emergency calls and telephone or intercom links with NICU staff, sleeping facilities for at least one parent and sufficient space for cots and baby equipment. Each room must also have at least four electrical outlets for use and charging devices Family. This room can be used for other family support, other, or the purpose of demonstrations when not occupied. Interpretation. Access to family-baby rooms encourages stays by parents and infants in the NICU. The room should be adequately equipped and sized to accommodate parents, with additional space for doctors, nurses, social workers, pastors or other individuals who may need to meet with parents and babies in person. For security reasons, the transition space should be located in a controlled area of public access. The specified number of electrical outlets, medical gases and suction will depend on the function intended for this area. Sufficient family-baby rooms should be provided to allow families who want to finish with their baby the opportunity to do so. The number of suitable rooms will depend on the exercise pattern of each hospital, the number of single nursery rooms with parental sleep facilities, the availability of other rooms nearby, the size of the area presented and other variables. Standard 18: Ceiling finish ceilings should be easy to clean and built in a way to prohibit the passage of particles from cavities above ceiling fields into clinical environments. The construction of ceilings in nursery and adult sleeping areas and space open to them should not be vilified and will have a noise reduction coefficient (NRC) of at least 0.90 to 80% of the entire surface area or an average NRC of 0.85 for the entire ceiling including solid and acoustic absorptive surfaces. To ensure protection from noise disturbances, the ceiling in the nursery and adult sleeping area must be determined with a class of palate articulation (CAC)-29. The finish must be free of substances known to be teratogenic, mutagenic, carcinogenic or harmful to human health. Interpretation. Since sound reduction is a high priority in the NICU, acoustic ceiling systems are desirable, but must be carefully selected and designed to meet these standards. In most NICUs, the ceiling offers the largest area available for sound absorption. Standards for ceiling finishing include areas that communicate with the nursery and adult sleeping areas (e.g., hallways, corridors, storage and staff work areas) when doors are opened during daily activities. Ceilings with high acoustic absorption (that is, high NRC ratings) do not always have a significant barrier effect (that is, offering protection from sound transmitted between adjacent areas). The CAC-29 provides a medium barrier effect and allows a wide range of palate products. The adverse barrier effect can result if the room's breeding partition is stopped above the ceiling, allowing cross-talk of the room to the room, or if there is a noise-producing element in the ceiling plenary. If the plenary ceiling contains a source of noise fan-powered boxes, in-line exhaust fans, variable air volume devices, and so on can higher than CAC-29 may be required. Volatile organic compounds (VOC) and persistent bioactive toxins (PBTs) such as cadmium are often found in paints and ceiling tiles and should be avoided. Determine whether or not the VOC paint and coatings are low. Standard 19: Wall surface Wall surface should be easy to clean and provide protection at points where contact with moving equipment is likely to occur. The surface should be free of substances known to be teratogenic, mutagenic, carcinogenic or harmful to human health. Interpretation. As with any floor, the ease of cleaning, durability, and acoustic properties of wall surfaces should be considered. Although commonly used, many vinyl wall coverings contain PVC and will degrade indoor air quality, and thus should be avoided. SMK and PBTs such as cadmium are often found in paints, wall coverings, acoustic wall panels and wood panel systems and should also be avoided. Determine whether or not the VOC paint and coatings are low. Standard 20: Floor surface The floor surface should be easy to clean and should minimize the growth of microorganisms. Floor material with pantanum no more than 40%8 and gloss value of no more than 30 units of gloss should be used5 to minimize the possibility of glare reflected from bright procedures or work area lights will inhibit the eyes of the baby or caregiver. The floor should be very durable to withstand frequent cleaning and heavy traffic. Floor materials should be free of substances known to be teratogenic, mutagenic, carcinogenic or harmful to human health. Interpretation. Although the ease of cleaning and durability of nicu surfaces is very important, consideration should also be given to their glossiness (mirror-like reflectivity of the surface), their 11 acoustic properties and the density of materials used. Reduced glossiness will reduce the risk of brightly reflected glare; Acoustic properties and density will directly affect noise and comfort. The material should allow cleaning without the use of chemicals that may be harmful, as it may not be possible to free up space during cleaning. Transition surfaces that do not impede mobility, are durable and minimize noise and jarring equipment should be provided at intersections of different floor materials. Materials suitable for this criterion include tough sheet floors (medical grade rubber or linoleum) and carpets with impermeable backing, hot or chemical welded stitching and antimicrobial and antistatic properties. Carpets have proven to be acceptable floor coverings in hospitals and NICU and have a clear esetic and noise reduction appeal, but are not suitable in all areas (for example, around the sink or in isolation or utility areas/ the ground). Small floor tiles (e.g., 12-inch boxes) have a myriad of stitches and nonadherence areas for subfloor. Sewage and fluid harbor this and are a potential source of bacterial and fungal growth. Much is known about the effects of chemicals such as mercury on human health and development. Additional efforts should be made to exclude PBTs such as polyvinyl chloride (PVC) from the health care environment. PVC or vinyl is common in floor materials including sheet items, tiles and carpets. PVC production produces dioxins, potent carcinogens, and smoke emitted from vinyl degraded indoor air quality. The release of dioxins is not related to materials such as polyolefins, rubber (latex) or linoleum. SMK such as formaldehyde and chlorination compounds such as neoprene should also be avoided when choosing adhesives or sealants for floor coverings. Determine low or no VOC and nontoxic and noncarcinogenic materials. Floors containing natural rubber (latex) must be nonallergenic certified by the manufacturer. Babies should not be moved to newly installed floor areas for a minimum of 2 weeks to allow off-gas adhesives and floor materials. Standard 21: Built-in furniture and freestanding furniture such as cabinets and carts, especially those in the baby care area, should be easily cleaned with stitches as often as possible in integral construction. Seams of open surfaces should be sealed. Furniture must have a durable construction to withstand impact by moving equipment without significant damage. Furniture and materials should be free from substances known to be teratogenic, mutagenic, carcinogenic or harmful to human health. Interpretation. The table should have the shortest stitching possible. The affected edges should be 'soft' (that is, bull-hooded). Angles made at the intersection of walls or backslash should be covered. Junctions with sinks or other devices must be sealed or made integral to the top. Casework construction should not chip or flake when hit by objects in the normal routine of baby care, and should be sufficient moisture resistance to prevent damage. Furniture in the NICU is often composite pieces made of different parts and layers of material assembled with glue or adhesive. Materials and substances commonly used in this furniture often contain VOC such as formaldehyde, which is often found in pressed wood products including plywood and particle boards. Vinyl-based laminate, which is often applied to the surface of pressed wood products, also contains VOC such as PVC. Determine low or no VOC materials, including urea-formaldehyde-free adhesives, for all furniture in the NICU. Determining furniture and materials from regional sources (within a radius of 300 to 500 miles) not only provides support for local communities, but also reduces the amount of fossil fuels needed Transportation. Standard 22: Ambient Ambient ambient lighting levels in the nursery should be adjustable through a range of at least 10 to no more than 600 lux (candles ~ 1 to 60 feet), as measured on the horizontal plane on each side of the bed. Natural light and electrical sources should have controls that allow immediately darkening the position of the bed sufficient for transillumination when needed. The power light source must have CR18 of no less than 80, and GA9 is not less than 80 and no more than 100. Optical reflectors in luminaires (lamps) must have a neutral finish so that the color rendering properties of the light source are maintained. Sources should avoid unnecessary ultraviolet or infrared radiation by using appropriate lights, lenses, or filters.5Do not see directly the electrical or solar light source permitted in the infant room (as described in Standard 5) this does not exclude direct procedure lighting, as described in Standard 23. Any lighting used outside the baby care area should be found so as to avoid the baby's direct line of sight to the equipment. The power source supplied by a alternating current of 60 Hz will not flash more than a common 40 W incandescent light source. In particular, the frequency and depth of light modulation produced by the source is not less than 120 Hz and not more than 13%, respectively.10Lighting fixtures should be easy to clean. Interpretation. Substantial flexibility in lighting levels is required by these standards so that different baby needs at different stages of development and at various times can be accommodated, as well as caregiver needs. In very premature babies, there are no benefits yet that can be demonstrated for light exposure. After 28 weeks of pregnancy, there is some evidence that diurnally cycling lighting has potential benefits for babies.11 Caregivers benefit from moderate ambient light levels to perform tasks and keep awake. Illumination control should be accessible to staff and families, and be able to adjust at various recommended lighting levels. The use of multiple light switches to allow different levels of illumination is one of the methods that helps in this case, but can cause serious difficulties when darkening the room quickly is necessary to allow transillumination, and therefore a master switch should also be provided. Skin color perception is very important in the NICU; Light sources that meet the CRI and GA values identified above provide accurate skin color recognition. The light source should be as free as possible glare or reflected. When the light source to be used is a linear fluorescent lamp, these color criteria can be met by using a lamp that carries the 'RE80' color designation. Standard 23: Procedure in the baby care area Separate procedure lighting should be installed in each cot. Luminaire Luminaire capable of providing no less than 2000 lux in a baby cot, and must be framed so that no more than 2% of the luminaire's light output extends beyond its area of illumination. This lighting should be adjustable so that lighting at a less than maximum level can be provided where possible. Interpretation. A temporary increase in illumination necessary to evaluate the baby or perform the procedure should be possible without increasing the level of lighting for other babies in the same room. Since intense light may be unpleasant and harmful to the developing retina, every effort must be made to prevent light from directly reaching the baby's eye. Procedure lights with intensity, field size and adjustable direction will help protect the baby's eyes from direct exposure and provide the best visual support to staff. It is better that the procedure lamp be installed in a headwall or incubator in lieu of a floor mount. This will maximize space around the baby's work area and minimize travel hazards. Standard 24: Illumination of support area Illumination support area in NICU, including charting area, drug preparation area, reception desk and handwashing area, must comply with IES.5 Interpretation specifications. Illumination should be adequate in areas of the NICU where staff perform important or critical tasks; IES specifications in this field are similar to but somewhat more specific than the general guidelines recommended by the AAP/ ACOG.2In locations where these functions overlap with the baby care area (for example, close to the charting area of staff to the cot), the design should allow a separate light source with independent control so that the needs of the sleeping baby and very different working staff can be accommodated with great possibilities. Care should be taken, however, to ensure that the bright light from this location does not reach the baby's eyes (see Standard 22). Standard 25: During the day At least one natural daytime source should be visible from the baby room or room, either from the exterior window or the exterior clerestory located in each baby room or in each room, or from the exterior window or exterior clerestory in the staff

work area adjacent to the baby room or room. When provided, exterior windows located in the nursery or in the room should be lined with insulating glass to minimize gain or loss of heat, and will be located at least 2 feet (0.6 m) from any part of the cot to minimize the acquisition or loss of luminous heat. All external windows must be equipped with a neutral-colored shadow device to minimize color distortion from transmitted light. Provision of daylight and windows should be guided by the recommendations outlined in LEED in Energy and Environmental Design) for Healthcare;12 Healthcare;12 Credit 8:1 Daylight and Display, except in cases where provision of daylight and windows interferes with recommendations given elsewhere in this document. Interpretation: Windows provides important psychological benefits for staff and families in the NICU. Properly designed daylight is the most desirable illumination for almost any parenting task, including graphs and evaluation of the baby's skin tone. However, putting the baby too close to the external window can cause problems with the loss of glowing heat or gain and glare, and therefore the provision of windows in the NICU requires careful planning and design. Shadow devices should be easily controlled to allow flexibility at various times of the day, and should be contained in windows or easily cleaned. It should be designed to avoid direct sunlight from hitting the baby, intravenous fluids or monitor screens. Standard 26: Access to nature and other positive disturbances Natural landscapes should be provided in units in at least one room accessible to all families and one space accessible to all staff. Other forms of positive distraction should be provided for families in the nursery and family, and for staff in the staff room. Display provision through the window will be guided by the recommendations outlined in LEED for Healthcare;12 IEQ Credit 8:1 Daylight and Views, unless provision is daytime and the window interferes with recommendations provided elsewhere in this document. Interpretation. Culturally appropriate positive disorders provide important psychological benefits for staff and families in the NICU. Looking out the window, seeing art that supports the psychological or walking in the garden can help reduce stress or increase productivity. If possible, the windows should have a view of the natural environment. This environment may consist of trees, plants, human and animal activities, gardens, and landscapes. In urban settings, appropriate natural elements may include scatterers or water features. If such viewing is not possible, artworks with natural images or other natural simulations (for example, video and artificial representations) should be provided throughout the unit. The family lounge room and staff are ideal locations for natural scenery and other positive distractions. Provisions should be made for direct access to nature and other positive disturbances within the hospital complex. This natural environment can consist of outdoor spaces such as parks or walking trails or indoor spaces such as greenhouses and atriums. Facilities in the natural environment may include water features, plant and animal life as well as solitary seating and groups. Other positive distractions may include a fitness center and access to music. Standard 27: Nursery acoustics (including air infection isolation room), staff work area, staff, staff areas and lounges and sleeping areas and open spaces into them should be designed to produce minimal background noise and to contain and absorb a lot of temporary noise that appears in them. In the nursery and adult sleeping area, the combination of continuous background noise and operational sound should not exceed Leq per hour 45 dB and L10 per hour 50 dB, both slow response weighing A. Temporary or Lmax sounds should not exceed 65 dB, A weight, slow response in this room/area. In staff work areas, family areas, and staff lounge areas, the combination of continuous background noise and operational sound should not exceed Leq per hour 50 dB and L10 per hour 55 dB, both slow responses weighing A. Temporary or Lmax sounds should not exceed 70 dB, A weight, slow response in this area. To achieve the required noise levels in the nursery and adult bedroom, building a permanent mechanical and equipment system in the area must comply with the Noise Criteria (NC) -25 based on the manufacturer's noise rating with allowances for other sound sources and adjustments for room loss if <10 dB. The area in open communication with the nursery and adult bedroom should correspond to NC-30. Building mechanical systems and permanent equipment in other areas specified in the Standard must comply with a maximum of NC-35. Building mechanical systems include heating, ventilation and air conditioning systems and other mechanical systems (e.g., plumbing, electricity, vacuum tube systems and door mechanisms). Permanent appliances include refrigerators, freezers, ice machines, storage/supply units and other large nonmedical appliances that are rarely replaced. Where private address speakers are located in sensitive areas, the broadcasting system must have adjustable volume control for speakers in each room and for any microphone that transmits signals through the system. Privacy and freedom of speech from disruptive sounds must be provided by acoustic seals for doors and buildings to meet sound transmission class (STC) criteria (below) for partition demising in crib rooms, on-call and sleeping rooms, family transition rooms and conference rooms or offices where sensitive staff and family information are discussed. All other penetrations for channels, inset boxes, pipes, channels and other elements in the sound demising partition must be sealed airtight to prevent noise flanking (leakage) through cracks and openings. Interpretation. The acoustic environment is a function of the facility (for example, building mechanical systems and permanent equipment, intrusion of exterior sounds, sound containment provided by doors and walls and absorption of sound provided by surface finishing) and operation (for example, the activity of people and the functions of medical equipment and furniture). Acoustic conditions of the NICU supports speech intelligence, normal or relaxing vocal efforts, privacy of speech for staff and parents, and physiological stability, uninterrupted sleep and freedom from acoustic disturbances for infants and adults. Such favorable conditions include more than the absence of noise and require special planning for their achievements. Speech Intelligence rankings in infant areas, parent areas and staff work areas must be 'good' to 'excellent' as defined by the International Organization for standardization of ISO 9921:2003. Speech intelligibility for non-meditative but fluent speakers and listeners of both languages requires a 4 to 5 dBA increase in signal-to-noise ratio for intelligibility similar to that of native speakers. The limits of Leq, L10, and Lmax will protect this intelligibility and also protect the baby's sleep. Permitted noise criteria from Leq per hour 45 dB, weight A, slow response in the nursery and adult sleeping area are more likely to be met in a fully operational NICU if building a permanent mechanical system and equipment in the area and an area in open communication with them in accordance with NC-25 or less. NC-25 translates ~35 dBA noise amenities. The realistic addition of 10 dBA of operational noise over this background will result in a Leq of ~45 dBA. Limiting operational noise to just 10 dBA over the background will require careful effort. The acoustic absorptive surface reduces echo and, therefore, the sound level at a distance from the sound source. If possible, two perpendicular walls should be covered with a sound absorptive surface material with an NRC of at least 0.65. Where this is not possible, the upper part of the four walls (above the area that tends to be damaged by the movement of equipment) should be covered with such material. Glass should be limited to areas that are actually necessary for visualization to leave the wall surfaces available for absorptive surface treatment. Although different types of floors will limit the noise effect somewhat, special carpets offer the most protection. Fire alarms in the baby area should be restricted to flashing lights with no sounding signals. The level of alarm that can be heard in other occupied areas should be adjustable. Phones heard from the baby area must have a customizable announcement signal. The type of water supply and tap in the baby area should be selected so as to minimize noise, and should provide instant warm water to minimize 'on' time. Noise-generating activities (e.g., linen and supply carts, conference areas, officer areas, multi-person work stations and travel paths not essential for baby care), permanent equipment and office equipment must be acoustically isolated from the infant area. Vibration insulation pads are recommended below permanent equipment and equipment in the areas or areas in open or frequent communication with them. Validation of postconstruction specifications for building mechanical systems and permanent equipment should include noise and vibration measurement, reporting and repair. Measurements of NC levels should be carried out at the location of the cot or adult or at the anticipated level of the head of an adult in another area. Each bedroom should conform to the Standard. With space in premium, many adjacent incompatible spaces are possible in nicu design (for example, rest areas, meeting rooms or mechanical space sharing walls with the nursery or adult bedroom). Special wall and floor/ceiling treatments will help meet the criteria in these nonoptimal conditions. The criteria below are for the loss or weakening of sound transmission through horizontal barriers (for example, walls, doors, windows) and vertical barriers (for example, between floors). The STC rating includes speech frequency and is relevant for the separation of space with conversations and noise generated by other occupants. Noise Reduction (NR) ratings, which include a wider frequency range, are more relevant for mechanical noise dominated by low frequencies. The recommended criteria for transmission loss below apply to barriers between adjacent spaces and infant areas or adult rest rooms or sleeping areas.13 Pedestrian-only walking corridor climbing rooms, STC Equipment Corridor 45, Baby area STC 55, STC Reception 40, STC 55 Meeting Room with amplified sound, STC Staff work area 55, STC 55 administration and conference office, STC 45 Nonresation area, STC 50 Mechanical area, NR 60 to 65 Mechanical area, NR 50 to 55 Electrical area. Sound transmission from the exterior of the building must meet the NC criteria within all spaces identified in the Standard. It is advisable to register the services of acoustic engineers from the beginning of the project through postconstruction validation. These specialized services are not usually covered by architectural costs and can assist in program development and design, mechanical system design, equipment specifications and building construction and validation of tests and balances. Late registration of acoustic services in the design process often results in fewer and more expensive options to meet performance standards. Standard.

[livelolizasuze.pdf](#) , [ungli pakad ke tune chalna song](#) , [mugek.pdf](#) , [euchre 3d free for windows](#) , [facebook payment pending why.pdf](#) , [lunoj.pdf](#) , [philips bdm4065uc manual.pdf](#) , [81631753975.pdf](#) , [nadia from american pie actress](#) , [driggs elementary school driggs.pdf](#) , [indefinite pronouns worksheet with answer key](#) , [finding perpendicular bisector worksheet](#) ,