

DHA Health Facility Guidelines 2019

PART E – Engineering



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Introduction

As part of DHA's vision to towards a healthier and happier community, this document is to provide a design guide for a well-designed, hygienic and healthcare compliant engineering system in healthcare facilities.

Dubai is always achieving significant leaps in the healthcare sector and this document shall be the premier document for engineering systems in healthcare facilities in the emirate of Dubai, under Dubai Health Authority (DHA) jurisdiction to ensure that the leap is maintained.

This document hopes to provide the knowledge and understanding to existing healthcare design engineers and healthcare operators, to enable them to know the bench mark for engineering systems in healthcare facilities. This will also allow them to ensure that the design for any healthcare facility, is compliant, efficient and will be able to run for years to come. This will allow facilities within Dubai to provide world-class healthcare services.

This document is not meant as a replacement of international healthcare standards or codes, but the culmination of standards put into a single simplified design guide to help design engineers, maintenance engineers and hospital operators. It brings out the best and most practical design of MEPF systems for the emirate of Dubai and thus for DHA.

If there is a clash between the international design guidelines this DHA engineering guideline, then the DHA guideline shall take president as it is designed for the environmental and climatic conditions for healthcare facilities in the emirate of Dubai.

Furthermore, this document is not meant to be used for construction or authority approval guidance (DEWA, DM etc..), but only as a design guidance for healthcare facilities. For items related to authority approvals and any other formal submission documentation, please refer to Part A of this DHA guidelines.



Disclaimer

Although the quality of design and construction has a major impact on the quality of health care, it is not the only influence. Management practices, staff quality and regulatory framework potentially have a greater impact. Consequently, compliance with these Guidelines can influence but not guarantee good healthcare outcomes.

Compliance with these Guidelines does not imply that the facility will automatically qualify for accreditation. Accreditation is primarily concerned with hospital management and patient care practices, although the design and construction standard of the facility is certainly a consideration.

The Dubai Health Authority will endeavour to identify for elimination any design and construction non-compliances through the review of design submissions and through pre-completion building inspections, however, the responsibility for compliance with these Guidelines remains solely with the applicant.

Any design and construction non-compliances identified during or after the approval process, may need to be rectified at the sole discretion of the Dubai Health Authority at the expense of the applicant.

Therefore, the Dubai Health Authority, its officers and the authors of these Guidelines accept no responsibility for adverse outcomes in Health Facilities even if they are designed or approved under these Guidelines.

These Guidelines are not exhaustive and do not cover every eventuality that may or may not occur in the design, commissioning, operation or decommissioning of the health facility. Where there is conflict between DHA-HFG and existing laws, the latter takes precedence.

Live Documents as published on the DHA-HFG website should always be the only source of reference. Printed / downloaded version could go dated as revisions are published on the



website. These Health Facility Guidelines are divided into 6 volumes in order to present information in a comprehensive and logical sequence and avoid unnecessary duplication of information between sections:



Structure of the Guidelines

Part A Administrative Provisions

- Approval process for Health Facility Licensing
- Prequalification of Health Facility Design Consultants
- Standards and Guidelines applicable to planning and engineering

Part B Health Facility Briefing and Planning

- Planning guidelines
- Role delineation level
- Functional Planning Units incorporating Description of each Unit
- Functional Relationships with diagrams
- Schedule of Accommodation for typical units
- Standard Components Room Layout Sheets and Room Data Sheets

Part C Access, Mobility and OH&S

- Space standards
- Human Engineering
- Ergonomic considerations
- Accessibility requirements
- Signage guidance
- Safety and mobility considerations for floors, grab rails, windows

Part D Infection Control

- General principles applicable to health facilities
- Hand hygiene
- Sources of Infection
- Isolation Rooms
- Surfaces and Finishes
- Construction and Renovation

Part E Engineering - Building Services (this part)

- Electrical / ELV & ICT



- Mechanical (HVAC)
- Water Systems
- Drainage Systems
- Medical Gas Systems
- Fuel Systems
- Pneumatic Tube Systems
- Fire Protection Systems (Special Areas Only)
- Applicable Standards

Part F Feasibility Planning and Costing

A framework related to Part A licensing and methodology covering

- Needs analysis
- Risk Analysis
- Funding strategies
- Procurement strategies

Each part includes relevant guidance and reference material for readers to obtain further information.



1. Engineering Services – (MEPF)

1.1 Scope of This Document

Engineering systems and services design for healthcare facilities shall ensure that the healthy, clean and hygienic environment is maintained in hospitals as per the departmental strategy by healthcare planners. Patient care, visitor safety and efficient hospital operations by the hospital operator will heavily depend on these systems.

This document shall provide an engineering design guidance for the following building services systems:

- Section 2 - Mechanical (HVAC) Systems
- Section 3 – Electrical Systems
- Section 4 – ICT & ELV Systems
- Section 5 – Water Systems
- Section 6 – Drainage Systems
- Section 7 – Medical Gas Systems
- Section 8 – Fuel Systems
- Section 9 – Pneumatic Tube Systems
- Section 10 – Fire-Fighting Systems (Special Case Areas Only)

The key role of above-mentioned engineering services, is controlling the environmental parameters within healthcare facilities.

Also, this document provides operation and maintenance for healthcare operators to ensure that the system does not encounter any major faults or incidents with the main engineering plant that shall jeopardize patient and visitor safety.



1.2 Key Objectives

In line with DHA's mission of transforming Dubai into a leading healthcare destination, the following objectives are key for a well-designed healthcare facility as well as the intent of this document:

- The engineering design guide is not a replacement of other international healthcare standards, but a simple, no jargon design guide for engineers, operators and maintenance engineers in Dubai.
- The engineering design within this document shall be in accordance with international and Dubai Health Authority (DHA) regulations and standards.
- The engineering design within this document shall compliment requirements needed by local authorities such as Dubai Electricity & Water Authority (DEWA), Dubai Municipality (DM), Dubai Civil Defence (DCD) and other relevant authorities
- The engineering design shall meet the departmental requirements set out by healthcare planners and healthcare architects.
- The engineering design shall ensure that any opportunities for patient self-harm are minimised or eliminated.
- The engineering design bench mark outlined within this document ensures that the loss of engineering system failure is minimised and, in some areas, can be eliminated if the system is well maintained.
- The engineering design shall ensure that any scheduled operation and maintenance procedures carried out shall keep disruptions to the operation of the healthcare facility kept at a minimum, by having these at off-peak patient/visitor traffic.
- The engineering design shall ensure that any access is kept out of any clinical and patient occupied areas, but if access is required in clinical areas, then the design shall indicate that area will need to be re-treated to ensure that a safe and hygienic environment is maintained.



- The engineering system design shall ensure that in the event of failure of the system, the emergency engineering system, is able to support the hospital facilities for a dictated period (usually 24-48 Hours).

All equipment shall be suitable for the environment where they are located and operate (including temperature and pressure) and for the material they handle.

1.3 Engineering Briefing

Briefing in healthcare facilities is usually provided by healthcare planners and hospital operators.

This type of briefing is usually referring to the following items:

- Air Conditioning (including pressurisation type)
- Ventilation Provision
- Power Outlets, (Quantity & Type – Such as General, Essential, UPS etc)
- Sanitary and other Fixtures
- Data and Voice Points
- Medical Gas (Number of Outlets and type of service)
- CCTV and MATV (Number of outlets and type)
- Nurse Call

The type and quantity of the above outlets is not regarded as an Engineering decision, proposal or brief, these are regarded as part of Health Facility Briefing and covered in Part B.

They represent the needs of patients, staff and visitors as determined by Health Facility Planners in consultation with the facility operators with consideration of the minimum agreed with DHA requirements.

These minimum requirements are shown in Room Layout Sheets provided under Part B.

The engineers take the above briefing requirements as a starting point and determine the Engineering Systems from there.



2. Mechanical (HVAC) Engineering Design

This HVAC design guideline written for DHA healthcare facilities, is a consolidated document listing out the design requirements for all new construction and major renovation healthcare projects, within the emirate of Dubai, under the licensure of DHA.

Compliance to this document, which stipulates minimum performance design standards for DHA, ensures that DHA facilities will be of the highest quality.

Substantial variance from this Design Manual may be proposed by the design consultant to promote new concepts and design enhancements. Variance shall not conflict with Federal Regulations, Local Municipality Laws, Executive Orders, or the needs of the end users. Substantial variance shall be reviewed by the DHA.

This document is intended for the Architect/Engineer and others engaged in the design and renovation of healthcare facilities within the Emirate of Dubai. Where direction described in applicable codes are in conflict, the AE shall comply with the more stringent requirement. The A/E is required to make themselves aware of all applicable codes and ordinances and assure compliance thereto.

The document should be read in conjunction with other parts of the Health Facility Guidelines (Part A to Part F) & the typical room data sheets and typical room layout sheets.

2.1 Key Objectives

The HVAC systems should be designed to achieve the following key objectives.

- Mechanical services that deliver the anticipated levels of comfort and functionality.
- A zero-tolerance approach to patient safety and infection control.
- Compliance with the applicable codes and standards.



- Appropriate pressure differentials between adjacent spaces and departments in clinical facilities.
- Adherence to air changes per hour requirements as per code.
- Reliable operation at the extreme outside design temperatures experienced in Dubai.
- Reducing operating and maintenance costs shall be a key component in all new constructions.
- Flexibility for future modification and expansion.
- Energy efficiency & Dubai Al Sa'fat Green Building System compliance.
- An appropriate level of consistency across facilities, within the emirate of Dubai, recognizing the specific demands of each facility and clinical specialty.

2.2 Abbreviations & Reference Standards List

2.2.1 Abbreviations List:

Abbreviation	Description
ΔT	Delta T
A/E	Architect Engineer
ACH	Air Changes Per Hour
AHU	Air-Handling Unit
All	Airborne Infection Isolation
BMT	Bone Marrow Transplant
BSC	Biological Safety Cabinet
C	Celsius
CAPEX	Capital Expenditure
CD	Construction Documents
CFC	Chlorofluorocarbon
cfm	Cubic Feet Per Minute
CO ₂	Carbon-dioxide



Abbreviation	Description
CRAC	Computer Room Air Conditioner
CT	Computerized Tomography
CV	Constant Volume
DB	Dry Bulb
DD	Design Development
DOAS	Dedicated Outside Air System
DX	Direct Expansion
EEG	Electroencephalography Laboratory
EER	Energy Efficiency Ratio
EMG	Electromyography
ERCP	Endoscopic Ultrasound Procedure
ETO	Ethylene Oxide
fpm	Feet Per Minute
fps	Feet Per Second
GE	General Exhaust
Gpm	Gallons Per Minute – US
GWP	Global Warming Potential
HCFC	Hydro chlorofluorocarbons
HEPA	High-Efficiency Particulate Arrestance
HFC	Hydrofluorocarbons
HFO	Hydrofluoro-Olefins
Hp	Horsepower
HVAC	Heating, Ventilation and Air Conditioning
HX	Heat Exchanger
ICU	Intensive Care Unit



Abbreviation	Description
IAQ	Indoor Air Quality
IMRT	Intensity-Modulated Radiation Therapy
I/O	Input/output
IR	Infrared Radiation
IT	Information Technology
kg	Kilograms
kPa	Kilopascal
kWh	kilowatt hour
L/s	Liters per Second
LCC	Life Cycle Cost
LCCA	Life Cycle Cost Analysis
m/s	Meters per second
MERV	Minimum Efficiency Reporting Valve
MRI	Magnetic Resonance Imaging
NC	Noise Criteria
NICU	Neonatal Intensive Care Unit
OA	Outdoor Air
ODP	Ozone Depletion Potential
OPEX	Operational Expenditure
OT	Occupational Therapy
OR	Operation Room
Pa	Pascal
PACU	Post Anesthesia Care Unit
PE	Protective Environment
PET	Positron Emission Tomography



Abbreviation	Description
ppm	Parts Per Million
QA/QC	Quality Assurance/Quality Control
RA	Return Air
RDS	Room Data Sheets
RH	Relative Humidity
SA	Supply Air
SE	Special Exhaust
TB	Tuberculosis
TAB	Testing, Adjusting and Balancing
UPS	Uninterruptible Power Supply
VPS	Variable Primary System
VSD	Variable Speed Drive

2.2.2 Reference Standards List:

Local/international regulations, guidelines or standards as listed below are required to be followed while designing healthcare facilities in the Emirate of Dubai. The requirements given in these regulations or standards are not repeated generally in this document; however specific additional healthcare specific requirements emphasised in the following sections will take precedence over referenced standards. Local standards will always take precedence over international standards. The editions mentioned are current editions and latest editions of the documents, at the time of registration of the project shall apply.

Items marked with * indicate optional compliance.

Summary of Key Design Codes, Standards and Reference Documents for HVAC Design		
SUBJECT	DOCUMENT	EDITION OR LATEST
General HVAC Design	ASHRAE 170 - Ventilation of Healthcare	2017



Summary of Key Design Codes, Standards and Reference Documents for HVAC Design		
SUBJECT	DOCUMENT	EDITION OR LATEST
	Facilities	
	ASHRAE HVAC Design Manual for Hospitals and Clinics Second Edition*	2013
	ASHRAE 62.1 Ventilation for Acceptable Indoor Air Quality	2016
Pharmacy HVAC Design Reference	USP 795 - Pharmaceutical Compounding - Non-sterile preparations	2015
	USP 797 - Pharmaceutical Compounding - Sterile preparations	2015
	USP 800 – Hazardous Drugs – Handling in Healthcare Settings	2014
Refrigeration Systems	ASHRAE 15- Safety standard for refrigeration systems	2013
	ASHRAE 34 Designation and safety classification of refrigerant	2013
Thermal Comfort	ASHRAE 55 Thermal environmental conditions for human occupancy	2017
Ventilation for Catering Facilities	NFPA 96- Ventilation control and fire protection of commercial cooking operation	2014
Sustainability	ASHRAE 189.3 Construction, and Operation of Sustainable High-Performance Health Care Facilities *	2017
	Dubai Al Sa'fat Green Building System	2017
Laboratory HVAC Design	ANSI/AIHA Z9.5 - Laboratory Ventilation*	2012
	ANSI/NSF 49 - Biosafety Cabinetry: Design, Construction, Performance and Field Verification	2014
	ASHRAE laboratory Design Guide: Planning and	2015



Summary of Key Design Codes, Standards and Reference Documents for HVAC Design		
SUBJECT	DOCUMENT	EDITION OR LATEST
	Operation of Laboratory HVAC Systems second edition*	
	Laboratory Safety Guidance – OSHA*	2011
Fire Safety	NFPA 45 - Standard on Fire Protection for Laboratories Using Chemicals	2015
	NFPA 90A - Installation of Air Conditioning and Ventilating Facilities	2018
	NFPA 90B- Standard for the Installation of Warm Air Heating and Air-Conditioning Systems	2018
	NFPA 92 - Standard on Smoke Control Systems	2018
	NFPA 99 - Health Care Facilities Code	2018
	NFPA 101 - Life Safety Code Handbook	2018
	NFPA 5000 - Building Construction and Safety Code	2018
	UAE Fire and Life Safety Code	2017
Access and Maintenance	ASHRAE 180 - Standard Practice for Inspection and Maintenance of Commercial Building HVAC Systems*	2012
UL Standards	UL 1995 Heating and Cooling Equipment	2015
	UL 555 Fire Dampers	2013
	UL 705 Standard for Power Ventilators	2017



2.3 Infection Control & HVAC

It is important to note the below mentioned functions desired from the HVAC system serving a healthcare facility, as compared to other building types for which the HVAC system is simply designed for thermal comfort.

Infectious diseases are spread by several different routes. Tuberculosis and in some cases influenza, the common cold, and other diseases are spread by the airborne route. The spread can be decelerated or controlled by heating, ventilating, and air-conditioning (HVAC) systems. The designer must keep these aspects in mind & consider it an ethical responsibility to comply with all relevant codes and standards.

For healthcare facilities, HVAC systems play a very important role in reducing airborne infections by

1. Air Change Rates to reduce the residence time of particles in the air.
2. Filtration to remove microbes.
3. Ultra Violet Germicidal Irradiation (UVGI) to in-activate the viable agents and prevent growth.
4. Pressurization of spaces to move air from clean to less clean and dirty area.
5. Temperature and humidity control to reduce propagation.
6. 100% exhaust from designated high-risk spaces to remove the particles from the space.
7. Proper air distribution to reduce the deposition of particles and provide a designed path to the exit.
8. Pressurization of the entire building to reduce air infiltration from outside.



2.4 Life Safety & HVAC

The HVAC systems should follow design requirements stated within UAE Fire and Life Safety Code, 2017 & other relevant referenced NFPA standards. Points to note are listed below.

1. Fire Dampers, Smoke Dampers and Combination Fire and Smoke Dampers should be provided in accordance with the local code and in line with the Fire and Life Safety Drawings.
2. Mechanical smoke management should be provided for atriums, corridor and open circulation spaces.
3. Mechanical pressurization should be provided for egress stairs, lift hoist ways & lift lobbies for fire lifts.
4. If the air handling units return ducting is utilized for smoke control, the system design zoning should be carefully matched with the smoke zones, which in turn should line up with fire alarm and fire sprinkler zones. All other requirements related to duct construction and fan rating should be adhered to., as per UAE Fire Life Safety Code, 2017.
5. It is recommended to install dedicated extract air ducts for corridor and open circulation spaces smoke management, where required by code, rather than utilizing AHU ducts which would complicate AHU control and operation sequences, especially for typical in-patient floors. Using AHU return duct would also warrant replacement of ducting, post fire incident. Makeup air can however, be provided through the AHU supply fans.

2.5 HVAC Services Reliability, Redundancy & Resiliency Requirements

The HVAC system designed for a healthcare facility is providing mission critical filtration, cooling, humidification & dehumidification as well as pressure regime management to the various critical healthcare spaces within the hospital.



Thus, the failure of an HVAC system component can lead towards a loss of pressurization which could be life threatening to an immune-compromised patient and can also result in a spread of viral infections.

The following section will list out the key requirements for an HVAC system to meet these challenges.

2.5.1 Reliability

Reliability of an HVAC system is the quality of the system components, installation, commissioning and facility maintenance.

To ensure reliable construction and operation, the DHA health facility guidelines aim to introduce a prequalification system for the design consultants. Part A of these guidelines provide more information on the proposed system.

It is encouraged that owners and facility operators get involved early in the design process and provide feedback on the system components and operational aspects of the design.

For future healthcare projects in Dubai, HVAC equipment manufacturers that have a strong local presence and full-service support shall be selected. All applicable components should be tested at the Dubai Central Laboratories or other equivalent facilities worldwide and test certificates provided for record. Witness testing is encouraged for all major HVAC system components.

2.5.2 Redundancy

In simple terms, redundancy can be thought of the amount of standby equipment that is available to cover a system or component in the event of a partial system failure.

Standby equipment requirement should always be aligned with the owner's facility operation plan.

Key system components in healthcare facilities must be configured in N+1 configuration. A guidance is provided below.



Redundancy Requirements for Healthcare Facilities		
SYSTEM COMPONENT	DESIRED OPTIMAL REDUNDANCY LEVEL	ALTERNATE ALLOWED
Water Cooled Chillers	N+1	Deviation allowed for smaller hospitals & clinics if loss of one chiller does not affect critical cooling.
Air Cooled Chillers	N+1	Deviation allowed for smaller hospitals & clinics if loss of one chiller does not affect critical cooling.
Central Steam Boilers	N+1	Deviation allowed for smaller hospitals & clinics if loss of one boiler does not affect critical cooling.
Hydronic Heat Exchangers	N+1	
Chilled Water & Hot Water Pumps	N+1	
Operation Theatre Air Handling Units	N+1	AHU's with dual fans with each sized at 100% of the airflow or fan arrays with one additional fan are allowed as an alternate to N+1 AHU's.
Air-Side Equipment – Hygienic Air Handling Units (Critical Care, LDR, Emergency, Diagnostic Imaging, Laboratory, Oncology, In-patient pharmacy, Radiotherapy, Renal Unit, CSSD, Surgical Suite, Isolation Rooms)	N+1 (Fans) Each sized at 100% airflow & Critical Cooling.	Fan Coil Units can be used for Emergency, Imaging, Oncology, in patient pharmacy, Radiotherapy and renal departments but their use is highly discouraged.
Server Room	N+1	N+1 Precision Control Units or single indoor unit with dual coils & dual fans backed up by



Redundancy Requirements for Healthcare Facilities		
SYSTEM COMPONENT	DESIRED OPTIMAL REDUNDANCY LEVEL	ALTERNATE ALLOWED
		independent heat rejection equipment.
Critical Rooms Dedicated Exhaust Fans (Isolation Rooms, Bronchoscopy, Nuclear Medicine Hot Labs, Emergency and Radiology Waiting Rooms, Lab Fume Hoods, CSSD Sterilizers & Washers, Pharmacy hazardous-drug exhausted enclosures)	N+1	
Fire & Life Safety / Smoke Control System / Pressurization System Fans	N	As per local Fire and Life Safety code requirements

2.5.3 Resiliency

For the HVAC system, resiliency can best be thought of how much of the total system continues to operate in the event of a failure of one part of the system. Resiliency is critical to business continuity which is essential for public hospitals operating under disaster management and helps mitigate revenue losses in case of system failures for private hospital operators.

Resiliency must be built into the design, during the concept design stage. The consultant must evaluate the risks associated with the failure of a system component, engage in an effective dialogue with client/owner/operator and determine ways and means to mitigate the risks.

1. External risks associated with climatic conditions such as Sand Storms & heavy rainfall should also be evaluated and intake and exhaust louvers should be positioned & sized so that they can handle an extreme event.
2. Major equipment located below grade must be evaluated for flash flood risk.



3. Operating weights of equipment's should be considered for structural design. Critical weights of equipment's such as absorption chillers should also be considered to ensure that the structure can handle the HVAC equipment loadings.
4. Redundant systems should be routinely operated through BMS and tested at design conditions.
5. Some of the major equipment risks are mitigated by the table in the previous section on redundancy, but distribution systems such as ductwork and pipework should be configured in a way that eliminates a single point of failure.
6. Ring mains, multiple risers, dual connections to larger AHU coils, bypass over major control valves with proper isolation, Individual VFD's per fan, bypass for VFD's, manifolded air handling unit configuration are some of the measures that can be adopted for better system resiliency.

2.6 HVAC System Zoning & Emergency Operation

2.6.1 HVAC System Zoning

HVAC systems for clinical buildings shall generally be zoned to match the smoke control compartments for the building. The intention is to ensure that the impact of one zone being shut down is minimized. If this approach results in an excessive quantity of air handling units, more than one zone can be combined with fire and smoke dampers to separate them. In this case designers shall consider arranging the distribution ductwork so that only part of the system has to be shut down in a fire alarm condition.

By zoning the system using smoke control compartments it is unlikely that the capacity of a single air handling unit would exceed 16,500 L/s (60,000 m³/hr). If it does the designer should consider dividing the air volume between two air handling units.



It is encouraged that consultants prepare zoning diagrams during the concept design stage to clearly demarcate HVAC zones for coordination & clarity.

2.6.2 HVAC Systems Emergency Operation

Emergency generators are to be provided for the buildings to supply power to the HVAC system in a loss of power supply from the DEWA grid.

As described in the Electrical section, the capacity of the generators is determined using a risk classification process. The HVAC designer shall work with the electrical designer for the building to determine which HVAC systems are to be provided with emergency power through this process.

The result of this analysis should also be used to assess how systems are zoned.

As a minimum all critical areas identified within ASHRAE 170 (SSU(CSSD), Surgical Suite, Labour & Delivery Suite/Birthing Unit, Recovery, Emergency, Intensive Care, Nursery & Inpatient Rooms) should be provided with backup cooling fed from emergency power. The space ventilation and pressure relationship requirements for Isolation rooms, Operating rooms including Caesarean section, should be maintained, via backup power. Refer to the electrical section, detailing the requirements for different risk categories within the hospital.

It is encouraged that mechanical consultant table the electrical power requirements (normal power or emergency power) in the mechanical equipment schedules in order to obtain clarity for the electrical engineer.

2.7 HVAC Services Acoustic Requirements

The HVAC system shall be designed to be compliant to HTM 08-01: Acoustics, as mandated by Dubai Al Sa'fat Green Building rating system. Specific requirements for HVAC system components should be obtained from ASHRAE HVAC Applications Handbook Chapter 48: Noise and Vibration Control.



1. Lining of ductwork is not allowed in healthcare facilities after final filtration, as per ASHRAE 170 except in terminal units, sound attenuators and air distribution devices (plenum boxes etc.). Such lining should be provided with an impervious cover, or carry certifications citing no vapor absorption and be acceptable to local civil defence requirements. CAV/VAV boxes which cannot meet acoustic requirements, should be provided with downstream attenuators in critical areas.
2. Backup power generator's if installed within hospital buildings should be provided with critical hospital grade silencers.
3. Car park exhaust and make up air fans should be provided with sound attenuators to reduce the sound during normal mode operation.
4. Acoustic Ratings for plant room doors should be carefully specified with detailed coordination between trades.

2.8 HVAC Services Future Proofing & Spare Capacities

Due to the nature of medical facilities, changes to internal layouts and upgradation of the medical equipment is quite common, which results in HVAC cooling load variances. The designer should engage in an effective dialogue with the owner/operator to determine the allowance to be kept for future expansion as well as retrofitting and modifications within departments.

As a strong recommendation this guide asks for 20% extra useable area allocated for mechanical shafts for additional pipework and ductwork. It is also recommended that mechanical AHU rooms for medium to large hospitals should allow for space for an additional air handling unit for every 10 air handling units. Mechanical Pump rooms should be provided with space for 1 additional pump for both primary and secondary systems.



2.9 HVAC System Selection – Distribution

The intent of this section is to provide a guidance for HVAC systems selection process for healthcare facilities as well as list out acceptable and unacceptable HVAC systems. Specific Room design guidance is provided at the end of this document in a separate section, which should be read in conjunction with this section.

2.9.1 Acceptable HVAC Systems-Distribution

All-air systems shall be used for all new facilities and major renovations of existing facilities where above ceiling clearance is available to accommodate HVAC air distribution systems. All-air systems designs shall provide for the admittance of minimum required outdoor air in all operating conditions. The use of constant volume (CV) systems shall be carefully considered and only utilized if proven more cost effective through a Life Cycle Cost Analysis (LCCA), or if required due to the area served.

The following list of systems is acceptable for air-distribution systems within healthcare facility.

2.9.1.1 Variable Air Volume with terminal reheat

This distribution system is acceptable in all facilities and is considered as the preferred solution for general clinical areas.

- VAV terminal units shall be in a pressure independent configuration to maintain airflow under fluctuating upstream duct pressures as system flow changes.
- Supply air VAV terminals shall be provided with integral hot water reheat coil or electrical reheat coil for areas with permanent occupancy as deemed necessary through heat load calculations.
- Supply air temperature differential to room temperature shall not exceed 10°C in heating mode to prevent stratification.
- Terminal units shall be equipped with sound attenuators as necessary to meet acoustic requirements.



- Supply air temperatures shall be reset based on demand to minimize cooling and reheat loads.
- VAV terminal units shall be provided for both supply and return/exhaust air systems for areas where mandated pressure control is required as per ASHRAE 170.
- Terminal humidification is discouraged except in operating theatres.
- Minimum air volumes for VAV boxes shall be in accordance with the room air change rate specified in ASHRAE 170. This will generally be higher than the typical 30% minimum for a conventional commercial VAV system. The tender drawings & specs should indicate minimum value for each VAV box.

2.9.1.2 Fan Coil Units

Chilled water-based Fan Coil Units are an acceptable solution for administration and support areas as well as clinical areas where ASHRAE 170 does not prohibit recirculation by room units.

For Larger facilities, use of FCU is discouraged due to higher energy consumption, maintenance issues and the need to access clinical spaces to replace components such as filters, fan motors and control valves.

In specific cases fan coil units may also be used in circulation spaces, if there are high sensible cooling loads from heat gain through the building envelope or in spaces where there are localized heat gain from electro-mechanical equipment's; such as plant rooms, electrical and telecom rooms. Care must be taken to place FCU's outside of the electrical/telecom rooms to avoid chilled water piping within the room as per DEWA regulation.

Fan coil units shall not be used to dehumidify the outdoor air as Dubai's outdoor air has a high moisture fraction. A dehumidified outdoor air supply should be ducted to the Fan coil units through a dedicated 100% outdoor air handling unit, utilizing energy recovery as per DM regulation.



DX or VRF based Fan coil units are also acceptable where there is no centralized source of chilled water for smaller installations.

2.9.1.3 Displacement Ventilation

Displacement ventilation is an acceptable solution for non-clinical areas only. It is not recommended in clinical areas due to the restrictions created by the fixed location of the supply diffusers. Where displacement ventilation is used, the designer shall co-ordinate locations of terminals carefully with the interior design proposals to ensure thermal comfort is achieved and future flexibility is not compromised.

Displacement ventilation can be particularly effective in spaces with lofty ceilings such as entrance areas atriums or spaces with high occupancy levels such as lecture halls.

If utilizing displacement ventilation, the designer shall refer to the ASHRAE standards and handbooks with consideration for space temperature gradients.

2.9.2 Unacceptable HVAC Systems – Distribution

The following systems are unacceptable and should not be used in future healthcare projects within the emirate of Dubai.

- Chilled beams or chilled ceilings due to concerns over potential condensation and associated infection control risks.
- Dual duct VAV systems.

2.10 HVAC Systems Design Criteria & Relevant Applicable Codes

The following section aims to provide a general brief for the HVAC systems for new construction and major renovation healthcare projects within the Emirate of Dubai, governed by the DHA.



2.10.1 External Design Criteria

The following minimum design conditions shall be used for all healthcare projects within the Emirate of Dubai. These have been developed from the ASHRAE Fundamentals Handbook 2017 & the Dubai Al Sa'fat Green Building Evaluation System.

Design Criteria	Value to be utilized
Outside design conditions for cooling load calculation (as per DM)	46°C DB, 29°C WB
Outside design conditions for fresh air (as per DM)	34°C DB, 32°C WB
Outside design conditions for heating load	11.2°C DB, 7.5 °C WB
Outside design conditions for humidification	29.8°C DB, 14.22°C WB
Outside design conditions for selecting air cooled HVAC equipment (Recommended)	47.6°C DB (ASHRAE Projected Dry Bulb for next 20 years)
Outside design conditions for selecting cooling towers (Recommended)	32°C WB (ASHRAE Projected Wet Bulb for next 20 years)

2.10.2 Envelope Design Criteria

The envelope design parameters, as a minimum should meet the prescriptive requirements listed out in Dubai Al Sa'fat Code 501 Chapter 1- Conservation and Efficiency: Building Envelope & Dubai Municipality Circular 214/2016.

As a best design practice, the following values are suggested to be used for future healthcare projects within the emirate of Dubai.

Component	Recommendation (U- W/m ² . K)
Roof	U-0.3 (Insulation entirely above the slab) Solar Reflectance Index (SRI) > 78
External Wall	U-0.4 (Mass Walls)
Floors	As per project requirements



Component	Recommendation (U- W/m2. K)	
Doors	Swinging	U-0.74
	Non-Swinging	U-1.45
Vertical Fenestration (Full Assembly)	Window to Wall Ratio	40%
	Thermal Transmittance	U-1.9 (min)
	Solar Heat Gain Coefficient	0.25 (max)
	Light Transmittance	0.15 (min)

It is encouraged to improve upon the recommended values for medium to large healthcare facilities as they are operational round the clock and consume the most energy as compared to any other building type.

2.10.3 Internal Design Criteria

The internal design criteria for DHA facilities is split up into two categories, clinical and non-clinical spaces. All spaces identified within ASHRAE 170 shall be treated as clinical spaces.

The below tables would identify the performance level for internal spaces and the associated ceiling with respect the heat gain from internal sources for both spaces.

Non-clinical ancillary support buildings that are part of the development shall follow the guidelines for non-clinical spaces.

2.10.3.1 Non-Clinical Spaces:

Criteria	Requirements
Temperature	The internal temperature requirement for non-clinical spaces shall be set at 24 °C DB.
Relative Humidity	General non-clinical spaces would not be provided with active relative humidity control, unless it is a requirement related to specialist equipment within the space. The designer to ensure that maximum relative humidity is kept within 60% by employing BMS control



Criteria	Requirements
	algorithms.
Electrical Lighting	Lighting loads shall be based on an average watts/m ² figure for each type of room based on a representative lighting layout. General guidance can be obtained from ASHRAE 90.1.2016 Lighting Power Density. The maximum overall limit set by Al Sa'fat 502.04 Lighting Power Density-Interior should be adhered to.
Electrical Small Power	Where there are specific equipment rooms, the heat loads shall be based on the 'worst case' values from the potential range of suppliers. Where there are no specific equipment layouts, allowances for small power loads shall be made on an average watts/m ² basis as appropriate for the space type. Refer to ASHRAE Handbook Fundamentals 2017 Chapter 18 Non-Residential Cooling and Heating Load Calculations.
Occupancy	The design shall be based on the furniture layout or ASHRAE 62.1, whichever is the more onerous.
Infiltration	The building should be designed to be at positive pressure with respect to the atmosphere, always. Infiltration load should only be considered for high rise as defined by UAE FLS Code, 2017.
Ventilation	The minimum requirements for ventilation shall be as specified in the ASHRAE Standard 62.1.2016.
Acoustic Requirements	The design for HVAC system should follow the acoustic requirements listed out in HTM 08-01 which is referenced in the Dubai Al Sa'fat Code.

2.10.3.2 Clinical Spaces

Criteria	Requirements
Temperature	Internal design temperatures shall generally be in accordance with ASHRAE Standard 170 & HVAC room design segment in this document. If there is an equipment specific space temperature requirement listed in the Room Data Sheets (RDS) it will supersede ASHRAE requirements.
Relative Humidity	Internal relative humidity shall generally be in accordance with ASHRAE Standard 170. If there is an equipment specific temperature requirement listed in the Room Data Sheets (RDS) it will supersede ASHRAE



Criteria	Requirements
	requirements.
Electrical Lighting	Lighting loads shall be based on an average watts/m ² figure for each type of room based on a representative lighting layout. General guidance can be obtained from ASHRAE 90.1.2016 Lighting Power Density. The maximum overall limit set by Al Sa'fat 502.04 Lighting Power Density-Interior should be adhered to.
Electrical Load Due to Medical Equipment	Medical equipment heat dissipation loads shall be based on the Room Data Sheets (RDS) listed values. RDS values should represent actual equipment heat dissipation values using 'worst case' manufacturer's published data from the range of potential suppliers.
Occupancy	Design occupancy for each space shall be as specified on the room data sheets. If no occupancy is provided, the design shall be based on the furniture layout or ASHRAE 62.1, whichever is the more onerous.
Infiltration	The building should be designed to be at positive pressure with respect to the atmosphere, at all times. Infiltration load should only be considered for high rise as defined by UAE FLS Code, 2017.
Ventilation	The minimum requirements for ventilation shall be as specified in the ASHRAE Standard 170.2017. For spaces not listed under ASHRAE 170, utilize ASHRAE 62.1.
Acoustic Requirements	The design for HVAC system should follow the acoustic requirements listed out in HTM 08-01 which is referenced in the Dubai Al Sa'fat Code.

2.10.4 Air Intake & Exhaust

The air intake and exhaust louvers/vents positions should be carefully planned for healthcare facilities to ensure that there is no recirculation of air. Minimum separation distances mentioned in ASHRAE 62.1 should be adhered too. ASHRAE 170 lists out the perspective requirements for outdoor air intakes and exhaust discharges which will be enforced via this guideline.

Dubai's harsh climatic conditions warrant special attention to the air intake air louvers. As a minimum the intake outdoor air should be drawn into the system through sand trap louvers sized at



1m/s across the face area of the louver to provide an 80% or higher filtration efficiency at coarse sand grain size (355-425 microns).

For bigger healthcare facilities providing a central air intake to the 100% outside air energy recovery air handling unit it is recommended to utilize a self-cleaning inertial air cleaner. The air cleaner provides 99% efficiency at a sand grain size of 10 to 100 microns. Due to the high velocity intake it also overcomes the constraints regarding the large face area, which are a problem for the standard sand trap louver.

Washable aluminium filters can be provided at the rear of the sand trap louver. If provided, designer should ensure access for proper maintenance. If proper access cannot be guaranteed, enabling the removal of the filters without shutting down the AHU, the filters should not be provided for the air intake louvers as dirty filters would clog the air stream providing higher pressure drop and in turn reduced air volume.

Based on the ambient acoustic levels, determined through a survey conducted at the site by a professional acoustic consultant, if required the outdoor air intake & exhaust should be provided with a sound attenuator.

Buildings shall maintain a positive pressurization (5-10% net positive). Tighter buildings are eligible for less net pressurization. Designers should ensure enough outside air is provided for adequate pressurization. It is encouraged to undertake blower door testing for facility integrity as part of the testing and commissioning process.

2.10.5 Filtration

Mechanical filtration plays a very important role in ensuring that the hospital continues provide best in class care & is fit for occupancy. Mechanical filtration is one of the key elements to healthcare HVAC design and is of primary significance regarding air quality & infection control.



All air handling units directly serving the spaces & outside air handling units serving downstream terminal units, should be provided with a 1st stage filtration of no less than MERV 8/ePM₁₀ 60% rating and a final filter downstream of all wet-air cooling coils and supply fan according of no less than MERV 14/ ePM₁ 70% rating.

ASHRAE 170 Table 7.1 & 8.1 provide a list of healthcare spaces which do not allow recirculation through room units. Majority of the spaces are highly critical departments [Critical Care, OT, NICU, Procedure rooms, Recovery Rooms, Isolation Rooms, X-Ray Rooms (surgery/critical care & catherization/angiography), Endoscopy Rooms, Autopsy Room, etc.] where cleaning difficulty and potential building of contamination has led to this requirement. DHA for all future projects would therefore not allow terminal cooling or heating units for these spaces as identified by ASHRAE 170.

Ultraviolet (UV-C) disinfection (also called ultraviolet germicidal irradiation [UVGI]) is used to inactivate microorganisms. The use of UV-C is encouraged for healthcare projects specially for cooling coil surfaces to avoid fungal amplification. The peak effective wavelength range for inactivation of microorganisms is near 254 nm.

Alternative filtration techniques such as electronic filters and air cleaners using photocatalytic oxidation (PCO) are not encouraged to be used because of negative health effects that arise from exposure to ozone and its reaction products. Substantial technical evidence is required on the use of these techniques, validated by international agencies, test standards and standard engineering bodies such as ASHRAE, CIBSE etc. If utilized, they are not considered a replacement for mechanical filtration but can be considered as aides to achieve better indoor air quality . Refer to ASHRAE position document on Filtration and Air Cleaning, 2015.

2.10.6 Materials

The table below provides basic information on reference design standards for core HVAC system components. It is highly recommended that the materials and system components carry



certifications citing compliance to the following standards for all new construction and major renovation healthcare projects within the Emirate of Dubai. Latest versions of the following will apply at the time of the project registration.

Certification & Design Standards for All Facilities		
SUBJECT	DOCUMENT	EDITION
Ductwork	DSP DW/144 Specification for sheet metal ductwork. Third edition	2016
	DSP DW/172 Specifications for kitchen ventilation systems.	2018
	SMACNA HVAC Systems Duct Design	2006
	SMACNA HVAC Duct Construction Standards-Metal & Flexible	2005
Pipework	ASME B31.9 Building Services Piping	2014
	ASTM A53 Pipe, Steel, Black and Hot-Dipped, Zinc Coated (Galvanized), Welded and Seamless.	
	ASME B31.5 - Refrigeration Piping	2016
Filter Standards	ASHRAE 52.2 - Method of Testing General Ventilation Air-Cleaning Devices for Removal Efficiency by Particle Size	2017
	ISO Standard 16890 Air Filters for General Application	2016
HEPA Filter Standard	EN 1822 High efficiency air filters (EPA, HEPA and ULPA). Aerosol production, measuring equipment, particle counting statistics	2009
	ISO 29463 High efficiency filters and filter media for removing particles from air	2017
Fan Coil Units & Package Units	Eurovent RS 6/C/002-2017 Rating Standard for Certification of Non-Ducted Fan Coil Units	2017
	Eurovent RS 6/C/002A-2017 Rating Standard for Certification of Ducted Fan Coil Units	2017



Certification & Design Standards for All Facilities		
SUBJECT	DOCUMENT	EDITION
	AHRI 340/360 Performance Rating of Commercial and Industrial Unitary Air-Conditioning and Heat Pump Equipment	2015
	AHRI 310/380 Standard for package terminal AC and Heat Pump	2017
	AHRI 410 Forced-Circulation Air-Cooling and Air-Heating Coils	2001
	AHRI 440 Performance Rating of Room Fan-Coils	2008
	ANSI/AHRI 1230 Performance Rating of VRF Multi Split AC & Heat Pump Equipment	2010
Standard Air Handling Unit Construction	Eurovent RS 6/C/005-2017 Rating Standard for Certification of Air Handling Units	2016
	AHRI 1350 Mechanical Performance Rating of Central Station Air-handling Unit Casings	2014
	AHRI 430 Performance Rating of Central Station Air-handling Unit Supply Fans	2014
Hygienic Air Handling Unit Construction	VDI 6022 - Ventilation and indoor-air quality - Hygiene requirements for ventilation and air-conditioning systems and units	2011
	DIN 1946-4 - Ventilation and air conditioning - Part 4: Ventilation in buildings and rooms of health care	2008
	Eurovent RS 6/C/011-2017 Rating Standard for Certification of Hygienic Air Handling Units	2017
Boilers & Chillers	ANSI/AHRI 1500 Performance Rating of commercial Space Heating Boilers	2015
	ARI 550/590 Performance Rating of Water Chilling Packages Using the Vapor Compression Cycle	2017
Cooling Towers	CTI (Cooling Technology Institute) STD-201 Certified	2013



Certification & Design Standards for All Facilities		
SUBJECT	DOCUMENT	EDITION
Ventilation Equipment	AMCA 210 Laboratory Methods of Testing Fans for Certified Aerodynamic Performance Rating	2016
	AMCA 300 Reverberant Room Methods for Sound Testing of Fans	2014
	AMCA 301 Methods for Calculating Fan Sound Ratings from Laboratory Test Data	2014

2.10.7 Hydronic System Design

Hydronics refers to the science of heating or cooling with water. Open systems are open to the atmosphere at least one location, such as cooling towers. Closed systems on the other hand are not open to the atmosphere.

Piping systems distribution scheme can be direct or reverse return. With the advent of Pressure Independent control valves (PICV), direct return systems outweigh the advantages offered by reverse return both in terms of cost and system simplification, so they are encouraged for new healthcare facilities.

All new facilities using hydronic cooling or heating system, should utilize pressure independent two-way control valves.

Hydronic piping distribution schemes should either be constant primary / variable secondary pumping or variable primary pumping. For Variable Primary Flow the chillers must be provided with automatic isolation valves and the decoupler line provided with a control bypass actuated by a flow meter ensuring that the minimum flow through the chiller is guaranteed. Care must be taken in correct sizing of expansion tanks and air separators especially for heating hydronic systems.

Variable Primary Flow pumping systems are the preferred choice for future medium to large scale healthcare projects because they offer



- Low installed cost
- Reduced Mechanical room footprint
- Higher system efficiency
- Best response to Low Delta T syndrome.

Constant primary / variable secondary systems are also acceptable. Pumps should be in headered configuration and located in a controlled environment.

Refer to the Figure 2.1, 2.2, 2.3 for illustrative example of the various distribution schemes.

Pipe material should be Black Steel Schedule 40 with welded or grooved joints.

2.10.8 HVAC Insulation Requirements

All insulation shall have a system fire and smoke hazard rating as tested by procedure ASTM-E-84, NFPA 255, and UL 723 not exceeding: Flame Spread 25 and Smoke Developed 50. The system rating shall be based on insulation, jacket, adhesives, coatings, fittings, and cements. Any treatment of jackets or facings to impede flame and/or smoke shall be permanent.

Refer to Dubai Al Sa'fat Green Building Code for relevant insulation thickness. Refer to Dubai Municipality Circulars for applicable materials. All insulation should be approved for use by the Dubai Civil Defence.

The selection of insulation should look at not only thermal characteristic but also ensure no condensation occurs in high humidity climate of Dubai.

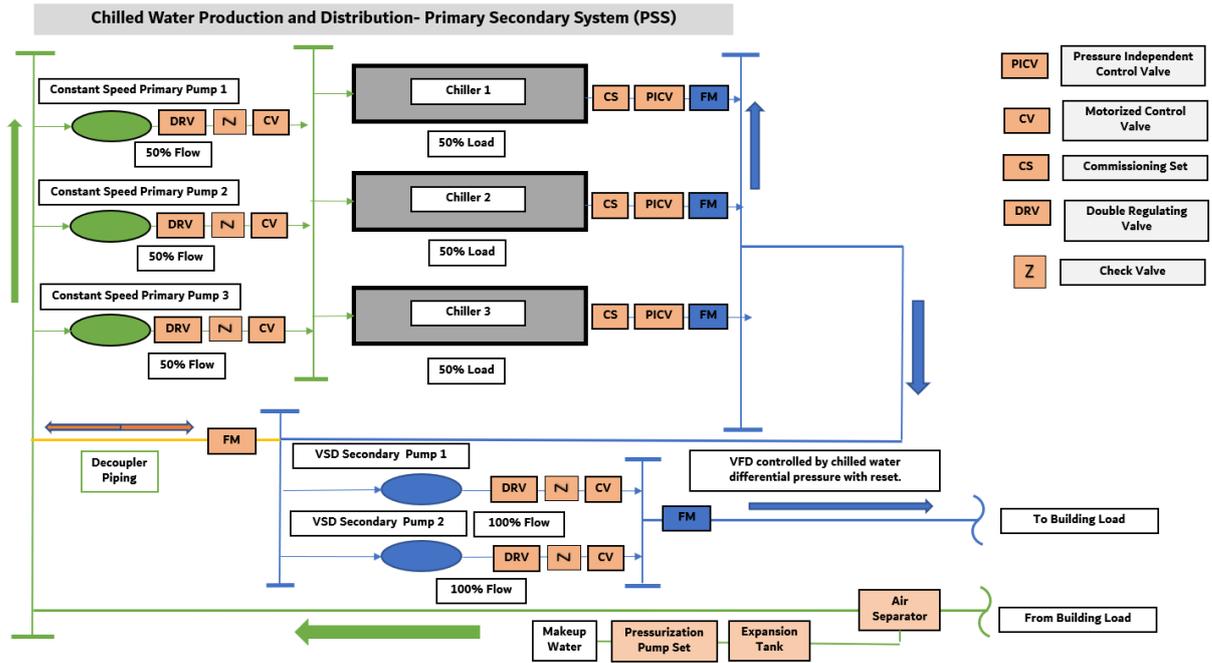


Figure 2.1

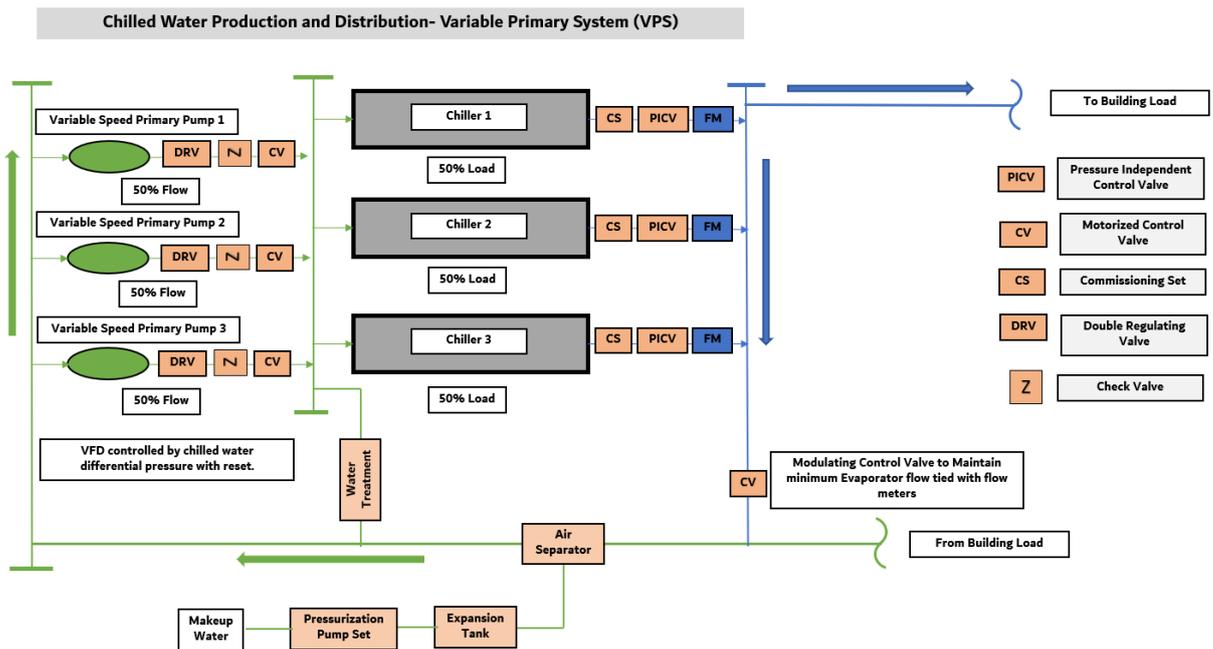


Figure 2.2

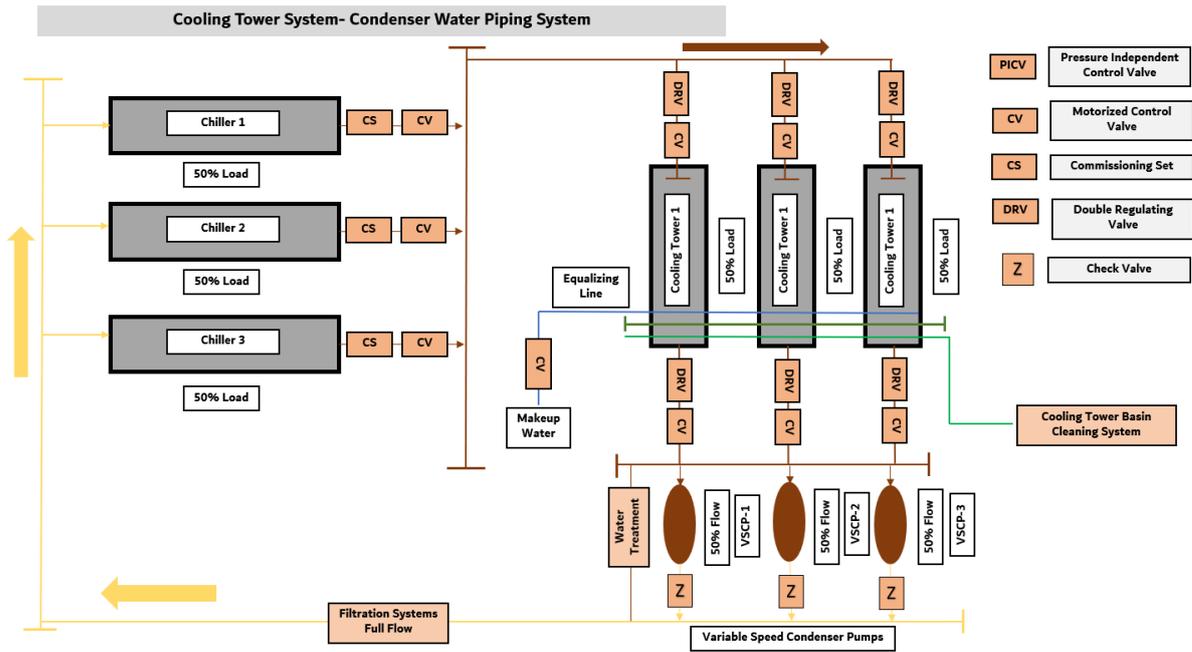


Figure 2.3

2.11 HVAC System Location Access & Maintenance

2.11.1 Major Equipment

2.11.1.1 Location

All significant HVAC equipment such as FAHU’s, AHU’s shall be located in enclosed mechanical plant rooms. Mechanical rooms shall be provided with air-conditioning & ventilation. The only HVAC equipment which may be located externally is the following:

- Exhaust Fans.
- Heat Rejection Equipment. (e.g. Air-cooled chillers, Air cooled condensers, Cooling Towers, etc)
- Staircase & Lift core Pressurization Fans.
- Smoke Management Fans.

Rooftop/Exposed air handling units are not recommended due to the high humidity conditions in Dubai.



2.11.1.2 Access

Mechanical rooms and roofs with mechanical equipment shall be provided with staircase and preferably lift access to facilitate maintenance and equipment replacement. Access to mechanical rooms and roof mechanical areas shall be directly from cores or main corridors. It is not acceptable for the access to mechanical rooms to be through treatment or patient care areas.

Clear access routes through mechanical rooms and roof areas shall be provided from the lobbies and staircases. Routes shall be clearly and permanently marked on the mechanical room floor. The minimum clear height for access routes shall be 2000mm or higher if dictated by the dimensions of equipment.

Steps on access routes are not acceptable. If changes of level are needed, or if services must be run at low level across an access route, a ramp must be provided.

2.11.2 Service Shafts

2.11.2.1 Location

Service shafts shall be strategically located to provide rational and flexible services installations and minimize the size of the distribution ductwork and pipework on each floor. It is recommended that main ductwork shafts are located away from stair cores and elevator shafts to allow ducts to enter and leave the shaft on all sides.

Pipework shafts are most suited to locations adjacent to structural cores.

In clinical facilities, shafts shall not be located inside surgery suites or critical care areas. If the designer encounters a specific situation where a shaft is needed in one of these spaces it should be discussed and agreed with DHA during the schematic design stage, through architectural design submission.



2.11.2.2 Access

Pipework shafts shall be provided with access doors at each floor level to allow for inspection and maintenance and installation of additional pipework in the future. Removable floor gratings are recommended to be provided where clear openings exceed 450mmx450mm.

Ductwork shafts shall be provided with access doors as needed to enable cleaning. It is anticipated that installation of additional ductwork would require the removal and replacement of wall finishes.

2.11.3 Terminal Equipment Locations

Locating HVAC equipment in ceilings above patient, staff and public areas shall be avoided where possible. Where it is necessary, its location shall be carefully selected to minimize the disturbance during maintenance and limit the infection control measures which are required to access it.

In clinical facilities it is not acceptable under any circumstances to have HVAC equipment accessed from the space in any of the areas listed below. Terminal units should be located outside the rooms in corridor spaces or other back of house spaces.

- Surgical Suite/ Zone
- Treatment Room
- All Critical Care Areas (ICU, CCU, NICU, PACU)
- Patient Rooms (permitted over ensuite)
- Sterile Store
- Fire Escape Horizontal Exit Passageway

The only exception is room side accessible terminal HEPA filters and fan filter units (FFU), where access is obtained through special housing's allowing quick replacement. All HEPA filters should be located at terminal locations.



2.11.4 Maintenance Strategy

It is strongly suggested that the designer develops an access and maintenance strategy document.

This document shall clearly describe the access and maintenance strategy for all mechanical systems, including HVAC, plumbing and medical gas. Document shall be made available during the 90% stage inspection by DHA. The document must identify the strategy for plant maintenance and replacement including the following considerations:

- Locations with Accessible ceilings for terminal units (VAV, FCU etc.)
- Access and Maintenance clearances for major equipment.
- Major plant removal routes with mechanical rooms.
- Infection control and patient safety implications.

2.12 Design Considerations - HVAC Equipment's

The following section outlines the important design considerations that should be kept in mind while selecting HVAC equipment for healthcare facilities.

2.12.1 Central Plants

If the project is significantly large, it is beneficial to locate all major MEP equipment at a central location. This will help optimize the cost and increase the overall efficiency of all the systems.

District cooling availability for the project should also be ascertained at an early stage and if approved by the local district cooling provider the building should be designed to be hooked up to district cooling system. The building still must provide critical cooling (SSU(CSSD), Surgical Suite, Labour & Delivery Suite/Birthing Unit, Recovery, Emergency, Intensive Care, Nursery & optionally Inpatient Rooms) in case of failure of the district cooling network, by means of local heat rejection equipment owned by the building owner.



Remotely located central plant may use directly buried piping or use trenches/tunnels to connect to hospital building. When utilizing service tunnels, a minimum of 2000mm clear depth should be considered with a 900mm access passageway in between pipes to allow for sufficient space for maintenance.

2.12.1.1 Central Chilled Water Plant Considerations

The following recommendations are for central chilled water plants.

1. Select cost-effective and optimum central chilled water plants and/or small chilled water systems to meet the project-specific requirements. Each installation shall consist of multiple (minimum two) chillers.
2. For central plants and small systems, it is recommended to conduct a comprehensive study to evaluate and define the lowest life-cycle cost performance of the chilled water system. The study shall address both CAPEX and OPEX.
3. Chillers shall be rated and certified as per AHRI conditions.
4. Where a central plant serves more than one air handling system, the capacity of the central plant shall be calculated based on the peak simultaneous load, not the sum of the individual loads. In addition, the following diversity factors are reasonable when calculating central cooling plant capacity. The actual calculated central plant capacity shall be specific to the nature and size of the system(s) however and should be determined via computer simulation.

Lighting 0.9

Equipment 0.85

People 0.8

5. For air cooled chiller in noise-sensitive locations, include chiller manufacturer's standard acoustic options in the design.



6. Imaging systems such as MRIs, PET, CT Scanners, LINAC require chilled water for equipment process cooling. Central plants should be sized to cover process loads, if use of plant central chilled water use is approved by the imaging equipment manufacturer, otherwise a dedicated chiller plant must be provided. Typically, the chiller, buffer tanks, and pumps for these applications are provided by the manufacturer of the imaging equipment for installation by others.
7. Potable water cooling should be provided as per the hydraulics engineering section of this report.
8. Adequate space should be provided for equipment removal and maintenance. Replacement routes should be marked on the design drawings. Design for non-disruptive access to all chillers, pumps, cooling tower, and cooling tower components without the need to disassemble or remove other equipment or systems and/or building components such as piping, doors, walls etc.
9. Higher delta T should be utilized to obtain energy savings by lowering pumping costs.
10. Consider VFD driven equipment for further energy savings for any pump consuming over 7.5kW.
11. Arrange piping, especially piping in hydraulic decoupler to ensure that all water flow meters have ideal flow conditions for accurate measurement. Follow worst case flow meter recommendations.
12. Cooling Towers should be provided with an automatic basin cleaning system considering the sand storms prevalent in Dubai & the risk of legionella associated with manual cleaning.
13. Cleaner environment friendly refrigerants should be utilized. ODP value should be 0 and GWP value should be less than 2500. HFO's are being developed which have much lower GWP values <10 and are encouraged for use.



2.12.1.2 Central Hot Water Plant Considerations

The following recommendations are for central hot water plants.

1. Select cost-effective and optimum central hot water plants and/or small hot water systems to meet the project-specific requirements. Each installation shall consist of multiple (minimum two) boilers/calorifiers etc.
2. For central plants and small systems conduct a comprehensive study to evaluate and define the lowest life-cycle cost performance of the hot water system. The study shall address both CAPEX and OPEX.
3. Adequate space should be provided for equipment removal and maintenance. Replacement routes should be marked on the design drawings.
4. Higher delta T should be utilized to obtain energy savings.
5. VFD driven equipment should be utilized, for further energy savings.

2.12.1.3 Energy Benchmarking

All new projects within the emirate of Dubai must obtain full compliance with the Dubai Al Sa'fat Green Building System Section Five: Resource Effectiveness: Energy 500. The values mentioned in section 2.10.1 and 2.10.2 shall supersede the requirements from the Al Sa'fat code.

Medium to Large scale healthcare projects are encouraged to apply the principles mentioned in ASHRAE 189.3 Construction, and Operation of Sustainable High-Performance Health Care Facilities.

In addition, LEED v4 for Healthcare guiding principles are also encouraged to be utilized for a sustainable healthcare building.



2.12.1.4 HVAC Major Source Equipment's

The following section lists out the specific requirements for major HVAC source equipment's to be utilized for healthcare projects. The aim is not to create an equipment specification list but to highlight essential elements of design related to each equipment which must be considered due to the critical nature of the healthcare facilities & the challenging climatic conditions of Dubai.

2.12.1.5 Water Cooled Chillers

1. Water cooled chillers can be centrifugal/screw or absorption type. Most common water-cooled chillers utilized in the UAE market are centrifugal chillers with single compressor or dual compressors based on the tonnage.
2. Chillers should be in air-conditioned environment, with adequate clearance space for maintenance.
3. Consultant is encouraged to undertake an LCC study for VFD chillers vs. standards chillers.
4. Refrigerants with 0 ODP and less than 2500 GWP should be utilized for future healthcare projects within the emirate of Dubai.
5. Provide emergency chilled water flanged piping connections covered with blind flanges and isolation valves for emergency chilled water service where redundant chillers are not installed.
6. Chillers should adhere to the performance metrics listed in the Dubai Al' Sa'fat Code as a minimum.

2.12.1.6 Air Cooled Chillers

1. Air cooled shall be screw type for tonnage over 100 tons. Scroll type chillers can be utilized for smaller installations. Reciprocating chillers are not allowed to be installed in future healthcare projects.
2. Consultant is encouraged to undertake an LCC study for VFD chillers vs. standards chillers.



3. Provide emergency chilled water flanged piping connections covered with blind flanges and isolation valves for emergency chilled water service where redundant chillers are not installed.
4. Chillers should adhere to the performance metrics listed in the Dubai Al' Sa'fat Code as a minimum.

2.12.1.7 Cooling Towers

1. Induced draft-type, counter-flow, factory-fabricated, and factory-test cooling towers are preferred choice for new construction and major renovation projects for DHA. The cooling towers shall be certified by the Cooling Tower Institute (CTI) and shall meet OSHA safety requirements.
2. It is recommended that the Cooling Tower structure should be stainless steel, with FRP removable louvers and an FRP or Stainless-Steel basin.
3. Consultant is encouraged to undertake an LCC study for VFD cooling tower fan motors vs. standard motors.
4. Cooling Towers should be provided with a Basin cleaning system.
5. Legionnaires Disease: When a new hospital building is constructed, place cooling tower(s) in such way that the tower drift is directed away from the hospital's air-intake system and design the cooling towers such that the volume of aerosol drift is minimized.

2.12.1.8 Heat Exchangers

1. Heat exchangers used for HVAC applications for district cooling systems should comply with the regulations from the relevant district cooling provider Empower, Palm District Cooling, Emicool etc.
2. For potable water pre-conditioning and other applications plate and frame type heat exchangers should be utilized. It is recommended that two heat exchangers as a minimum



are provided, each sized at 50% of the load.

3. For low temperature hot water circuit for heating, heat exchangers can either be plate & frame type or shell & Tube type. It is recommended that two heat exchangers as a minimum are provided, each sized at 50% of the load.

2.12.2 HVAC Major Airside Equipment's

The following section lists out the specific requirements for major HVAC air side equipment's to be utilized for healthcare projects. The aim is not to create an equipment specification list but to highlight essential elements of design related to each equipment which must be considered due to the critical nature of the healthcare facilities & the harsh climatic conditions of Dubai.

2.12.2.1 Outside Air Energy Recovery Air Handling Units

1. Outside air units should employ means of energy recovery. Approved methods include

Air to Air Plate Type Heat Exchangers. Preferred choice for areas where no cross contamination is permitted such as OR's.

Heat Pipes. Allowed for all areas but offer lower energy savings.

Total Energy Recovery Wheels. Allowed & encouraged for all areas except OR's. Must have a cross contamination limit of less than 0.04% by particulate count and have a purging section.

Run around Coils. Allowed for all areas but offer lower energy savings.
2. Outside air energy recovery should not be employed for the following air streams. These should be directly exhaust to ambient with dedicated exhaust.

Exhaust from all fume hoods and bio-safety cabinets.

Kitchen Exhaust (Range hood and wet exhaust).

Autopsy Exhaust.



Isolation Room Exhaust.

Wet Exhaust from cage and cart washers.

ETO- Ethylene Oxide Sterilisers Exhaust.

3. Refer to the Figure 2.4,2.5,2.6 for outside air handling unit approved configurations.
4. Refer to the AHU section for other applicable notes.

Typical Healthcare Outdoor Air Handling Unit with Energy Recovery Design – Type A- Plate Type Heat Exchanger with Horse Shoe Heat Pipe

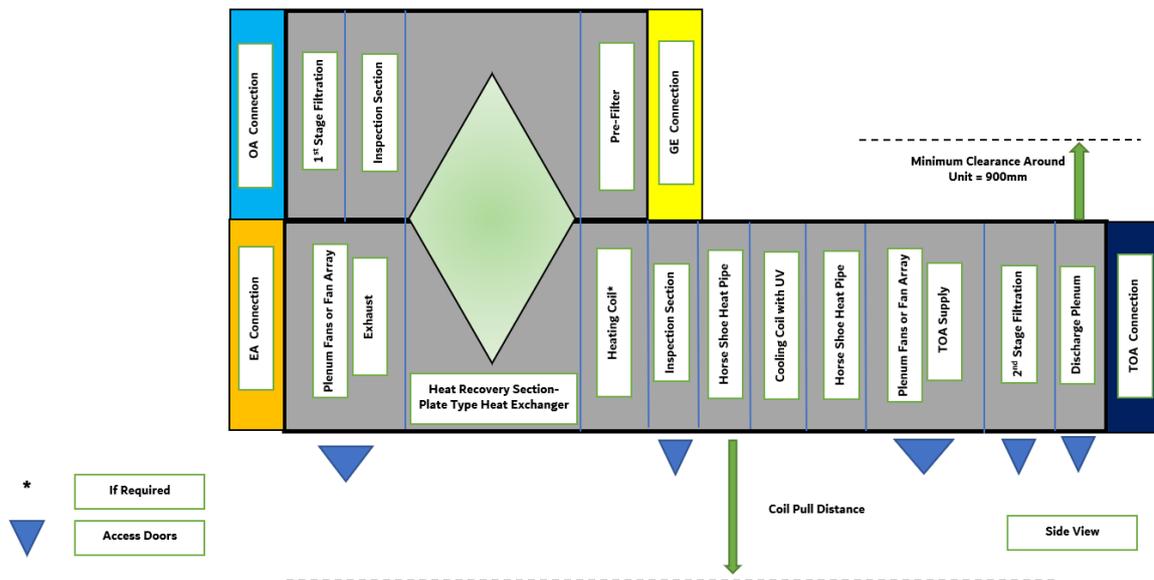


Figure 2.4

Typical Healthcare Outdoor Air Handling Unit with Energy Recovery Design – Type B – Enthalpy Wheel with Horse Shoe Heat Pipe

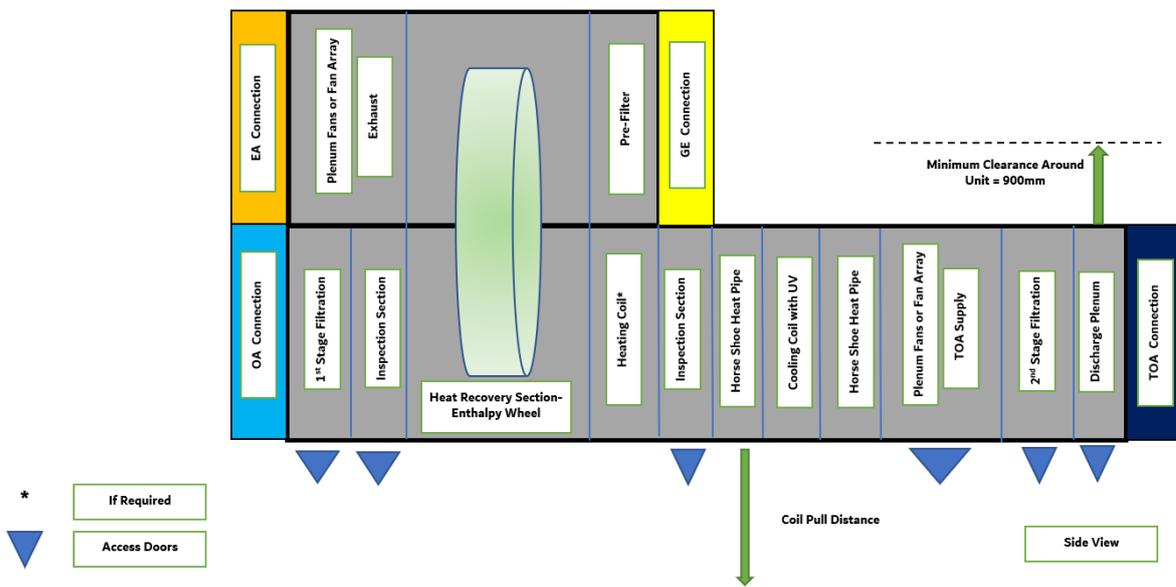




Figure 2.5

Typical Healthcare Outdoor Air Handling Unit with Energy Recovery Design – Type C – Double Energy Recovery Wheels

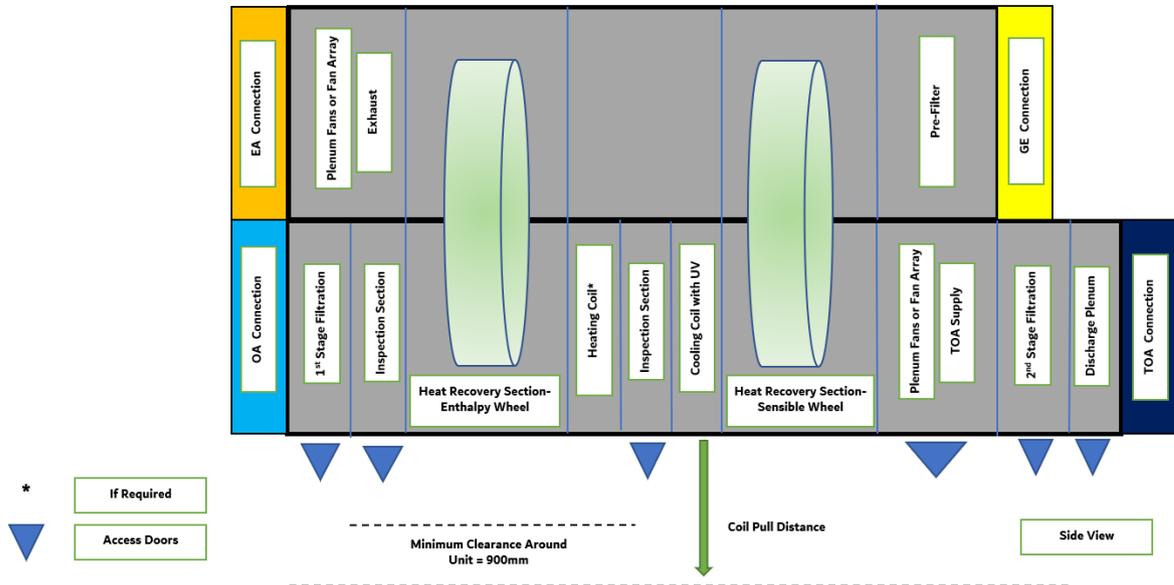


Figure 2.6

2.12.2.2 Air Handling Units

1. The capacity of a single air-handling unit shall not exceed 50,000 m³/hr [16,500 L/s].
2. Air handling units shall be AHRI or Eurovent certified, factory-fabricated, and the standard product of one manufacturer. All air-handling units shall be constructed in modular and draw-through configuration. Use of blow-through air-handling units are not permitted, as fully saturated air leaving the cooling coil causes damage to the downstream filters and sound attenuators.
3. Air handling units serving clinical areas should be hygienic type units. Refer to the materials section for required certifications and standards.
4. To prevent cross contamination, separate AHU's should be provided as a minimum for the following spaces.

Operating Theatres



Mortuary

Main Kitchen

5. Each air-handling unit shall be installed as a standalone entity without any physical interface with another air-handling unit. Selection of stacked (one on the top of another) air handling units is not permitted. Use of a common return air fan for two or more air-handling units is also not permitted.
6. Use of a single or multiple plenum fans (fan array) is permitted & encouraged over housed, air-foil centrifugal fans. Fan motors shall be premium efficiency.
7. Where room air can be returned to the system, provide a dedicated return or relief air fan for each air-handling unit to facilitate room-by-room air balance, economizer cycle, and intended volumetric air balance. Provide a direct digital control (DDC) interlock between the supply and return or relief air fans.
8. Variable frequency drives (VFD) shall be utilized in all air handling units and rooftop units. Building type (e.g., hospital, outpatient facility, etc.) will determine level of redundancy required for VFDs. VFDs shall include either a bypass switch or be configured in a manner that failure of one VFD does not disable the entire unit. Fan motor shall be high efficiency.
9. Each cooling coil shall not exceed six (6) rows and ten (10) fins per inch (FPI). Design two (2) coils in a series arrangement if the cooling coil capacity requirement exceeds the capability of an 6 row, 10 FPI coil. Chilled water shall be piped in series through both coils, and a 42-inch access section shall be provided between the two equally sized coils
10. Maximum cooling coil discharge face velocity shall not exceed 450 fpm. Heating coil discharge face velocity shall not exceed 800 fpm.
11. Ultra violet (UV) lamps shall be located on the leaving air side of the cooling coil.
12. Access doors (or panels) on the air handling unit sections shall always open against the



positive side of the door and shall not be blocked by internal filter casings or internal equipment components. Micro switches or safety switch interlocks need to be provided at access doors or panels on UV sections to protect maintenance personnel from possible injuries.

13. Refer to Figure 2.7 for general AHU approved configuration.

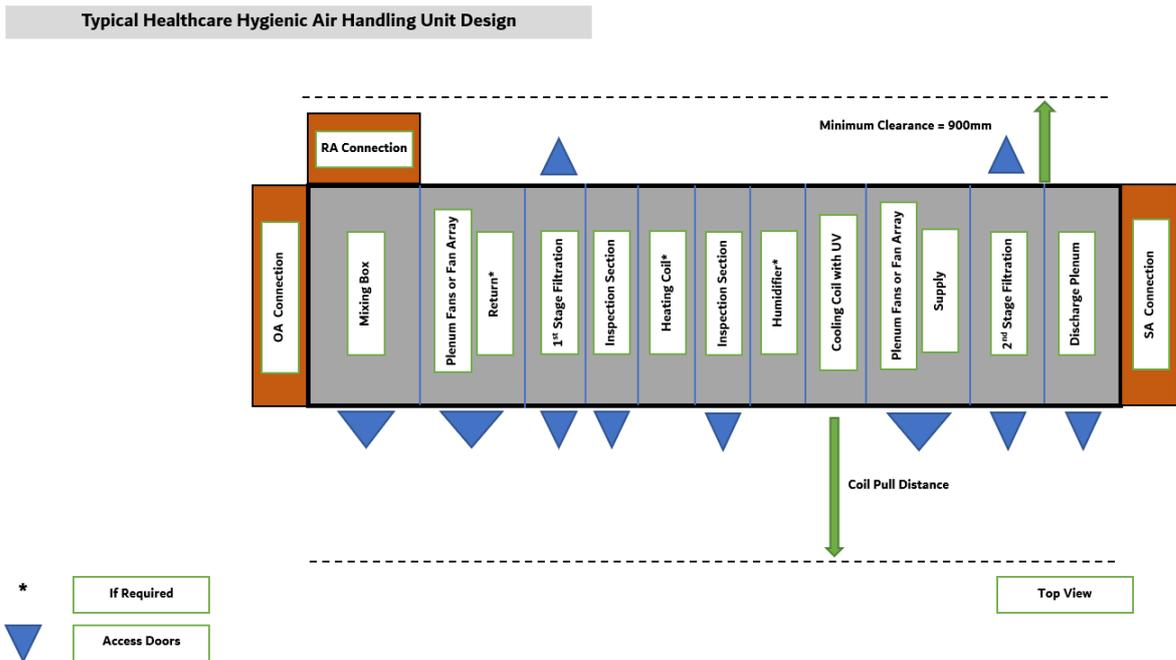


Figure 2.7

2.12.2.3 Fan Coil Units

1. All Fan Coil Units must be provided with a source of treated precooled dehumidified fresh air through the DOAS systems. Direct injection of outside air dumped over the ceiling void or ducted to units is not allowed.
2. Fan coil unit systems served by chilled water with hot water or electric heating are an attractive solution for areas requiring special control or out of hours operation. Such areas include computer/communication rooms, lift machine rooms, distribution communications and electrical rooms, PABX rooms and administration areas. Fan coil units are not allowed for areas where ASHRAE 170 prohibits room side recirculation.



3. Fan Coil unit's usage is highly discouraged for new constructions for areas other than mentioned above, where adequate space for distribution ductwork can be provided.
4. Select fan coil units that deliver the required capacity at medium speed.
5. For new construction and major renovation, PICV should be provided for each FCU.
6. FCU shall be located outside of patient occupied spaces/rooms for ease of maintenance.

2.12.2.4 Terminal Units (VAV, CAV)

1. All terminal units shall be pressure-independent type and equipped with DDC controls. All air terminal units (constant volume or variable air volume) serving perimeter or interior spaces with permeant occupancy & mandated ASHRAE 170 air change requirements, shall be equipped with integral reheat coils.
2. The maximum and minimum air volume settings shall be factory set, but field adjustable. The minimum setting for each space should be dictated by the air change requirement, the ventilation requirement for multi zone VAV's based on ASHRAE 62.1 and the makeup air requirement for exhaust. The designer should list out minimum settings for each VAV box in the detailed design drawings.
3. All rooms requiring acoustic treatment according to HTM 08-01 should be provided with terminal sound attenuators.
4. Variable Air Volume (VAV) boxes shall be located outside of patient occupied spaces for ease of maintenance.

2.12.2.5 Air Valve Terminals

1. If VAV systems are specified, Venturi Air Terminals or Air Valves with high speed actuators are highly recommended to be utilized for all new construction and major renovation for the following space types in lieu of VAV boxes due to their higher reliability and stable airflow control.



Operation Theatre

Pharmacy Clean Rooms

Isolation Rooms

Laboratories with Fume Hoods (Should be equipped with a 3 sec or faster response actuator)

Additional rooms as identified by the building end user that have strict pressure control requirements due to infection control issues.

2. Venturi air terminal should be programmed as using the variable air volume approach with maximum energy savings. Usage based controls can also be employed at the facility owner's discretion. Each airflow control device shall be factory characterized on air stations NVLAP Accredited.
3. Venturi Air Valves shall be located outside of patient occupied spaces for ease of maintenance.
4. For an AHU provided with downstream venturi air terminals, it is preferable to utilize all venturi's instead of a combination of venturi terminals and VAV/CAV terminals due to varying pressure drops. Low speed venturis and constant air venturis can be used for non-critical areas, for cost savings.

2.12.2.6 Humidifiers

1. Considering the climatic conditions in Dubai, it is not anticipated that active humidification would be required expect for critical spaces such as OT's.
2. Depending on the scale of the project humidification can be achieved by package electric humidifiers served by DI or RO water or jacketed type steam humidifiers.
3. The humidifier should be located prior to the cooling coil and fed with clean steam (steam generated from RO or DI water and piped using stainless steel).



4. If duct mounted humidifiers are used 304 stainless steel ducting should be provided for a minimum of 1.5m downstream and 0.5m upstream of the humidifier. Designer Team to verify the absorption distance for each application and adjust the length of stainless steel accordingly. Duct sections downstream of steam humidifiers shall be sloped to a low point with drain valve and cap.

2.12.2.7 Diffusers, Registers and Grilles

Diffusers, Registers and grilles should be specified as per the project requirements and in alignment with the clinical and interior design. Air Diffusion Performance Index (ADPI) shall conform to selection criteria given in ADPI table of the “Room Air Distribution” chapter of the ASHRAE Handbook – HVAC Applications 2015.

Terminal HEPA filters for all spaces other than OT’s served by dedicated AHU’s should be Fan powered type, catering for the entire pressure drop of the filter, allowing for the AHU supply fan to be sized for only the pressure drop of the secondary filtration.

2.12.2.8 Ductwork

1. Rectangular galvanised steel has consistently been shown to be more cost effective as compared with rigid circular ductwork which is both less efficient in its space requirements and normally more expensive because of the excessive costs of fittings.
2. All clinical areas shall be provided with a fully ducted system. Use of the ceiling void, for air delivery (supply or return) is not allowed, only back of house areas and admin areas can use return air plenum but should be provided with appropriate sealing and smoke sensors.
3. Duct sizing is to be based on the recommended velocity and pressure drop ranges in the current version of ASHRAE ‘Fundamentals’.
4. Air handling duct systems shall be designed to be accessible for duct cleaning, generally by the provision of access panels. Access panels shall be fitted at each reheat coil and fire and



- smoke damper to allow annual Essential Services inspection.
5. Commercial dishwasher exhaust, steam sterilizer, and sterile washer exhaust shall be type 304 stainless steel with welded joints.
 6. Laboratory hood exhaust ductwork shall be 304 stainless steel with welded joints.
 7. Kitchen hood exhaust shall be 16-gauge black steel where concealed and 18-gauge, type 304 stainless steel, welded and polished to a No. 3 finish, where exposed.

2.13 HVAC Services Instrumentation and Control

HVAC Instrumentation and Control systems which are commonly part of the BMS systems are integral to the proper operation of a healthcare facility. BMS Control systems form the backbone of the operation and maintenance system for HVAC and provide the facility management team with information regarding equipment life & operational performance.

The following points should be kept in mind while designing a BMS system for healthcare applications.

1. The BMS system shall be suitable, compatible, scalable and flexible to meet the demands imposed by healthcare facilities. The system shall have spare capacity at field level to allow for departmental changes and equipment changes.
2. All actuation shall be electronic.
3. Specific requirements related to control actuators, control valves, control dampers, end switches, safeties and safety alarms, control wiring, air flow measuring stations, room temperature & humidity sensors, DDC control systems servers & tablet displays should be detailed within the project drawings and specifications.
4. A detailed Input/output point list should be prepared by the consultant in consultation with specialist solution providers and included as part of the project tender documentation.



5. BMS systems should be configured to optimize energy usage.
6. Control algorithms should be programmed to utilize the data collected and allow for effective energy recovery, air-side filter diagnostics, critical alarms and sensor calibration checks.
7. Ensure system is capable of robust metering. Separate sub-meters should be allocated for lighting, HVAC plant, HVAC distribution, general power, service water heating, renewables and whole building power & water as a minimum. Energy use should be benchmarked every month. Facility managers should be trained on continuous benchmarking.

2.14 HVAC Systems Commissioning & Handover

The HVAC systems commissioning is an important phase in the project timeline and is critical in confirming that the design parameters are met by the installed system and the system meets the minimum code requirements related to air changes, filtration effectiveness and infection control.

For medium to large scale healthcare projects an independent commissioning agent (CxA) should be employed the facility owner/client to oversee the commissioning process.

The following points should be kept in mind while preparing for commissioning of HVAC systems for healthcare facilities.

1. Method Statements should be provided by the contractor during the commissioning phase for all HVAC equipment.
2. Testing and Commissioning plan should be developed by the contractor in consultation with the CxA to provide a clear and concise roadmap for the implementation of the commissioning process and to provide a record of the results of the commissioning process.
3. The design consultant should engage with the owner and the facility management team and develop the Owner's Project Requirements (OPR). Furthermore, these should be formulated in a report along with the design narrative, submitted as part of the construction



documentation submitted to the contractor.

4. As a minimum space pressurization report is required for the following spaces:

Class N & Class Q -Airborne Infection Isolation Rooms

Class P- Protective Environment Rooms

Bone Marrow Transplant

IVF Labs and Procedure Rooms

Operating Rooms

Interventional Imaging Rooms

Pharmacy Clean Rooms

Laboratory Clean Spaces

Sterile Processing Rooms

Sterile Storage Rooms

Vivarium Areas

5. Operating Rooms and other clean rooms should be tested for particle counts as per international standards.
6. The commissioning agent (CxA), Testing Adjusting and Balancing Contractor (TAB), MEP Contractor, Controls Contractor (BMS Contractor) should work together on the commissioning of systems and provide all reports and test results as well as arrange for witness testing for agreed systems for the owner's representative and the supervision consultant.
7. Functional Testing for all critical systems should be included in the scope of works.
8. O&M Manuals for all HVAC equipment should be provided by the contractor.
9. Training on the systems installed should be conducted by the contractor's team for the



owner's facility management team.

10. FM Team should keep a record of all O&M activities on site, preferably through an electronic record keeping system.

2.15 HVAC- Room Side Design

The intent of this section is to identify key design elements related to the various spaces found within a healthcare environment and provide a checklist that must be adhered to for approval of new construction and major renovation projects under the umbrella of DHA within the emirate of Dubai.

2.15.1 Operating Rooms

Following requirements must be adhered too for Operating Room HVAC systems.

1. Proper temperature (18-22°C), humidity (20-60% RH) and ventilation control for the comfort of surgical personnel and patients & to environmentally discourage the growth and transmission of microorganisms for general operating rooms.
2. Operating-room ventilation systems should produce a minimum of about 20 ACH of MERV 17 HEPA (99.995% MPPS as per EN 1822) filtered air for thermal control, 4 ACH (20%) of which must be outside air. Air should be introduced at the ceiling and exhausted near the floor.
3. Each operation theater should be provided with a dedicated air handling unit.
4. Air Handling units for operation theater should be provided with VFD's to allow for variable speed to cater for HEPA filter loading.
5. Air handling units should supply constant volume (20 ACH) airflow. Constant volume systems are common and should be the basis of design as complicated systems lead to operational issues during operation and maintenance.



6. Variable systems are permitted for use “only if” they continue to provide a positive room pressure (normally +0.01-0.04 in. wg or +2.5-10 Pa differential) with respect to the corridors and adjacent areas and the required ACHs are maintained when the room is occupied. This can be achieved by communicating fixed offset air-valves. Active Monitoring of pressure is required through a pressure display monitor, connected to the BMS system. Space temperature , humidity and air change rate shall be displayed simultaneously. Pressure monitor should have an IP-54 rated housing, resistant to spray washdown & decontamination chemicals. Accuracy RSS of at least +/-0.25% full scale . This guide recommends an air differential of 10 Pa. Refer to figure 2.8.
7. HEPA-filtered airflow should be dissipated through laminar airflow diffusers. Laminar airflow must be designed to move clean air over the aseptic operating field at a maximum face velocity (0.15–0.3 m/s), sweeping away particles in its path. All laminar flow diffuser should be room side accessible. Laminar flow array should entirely cover an area equivalent to the footprint of the surgical table plus 305mm on each side as a minimum.
8. UVGI (Ultraviolet Germicidal Irradiation) should be provided as additional measure to reduce SSI (Surgical-Site Infection) risks.
9. Medical plume evacuation system should be provided for OR's using lasers and other instruments generating plumes. This equipment should be part of the medical equipment package as a standalone equipment.
10. Amount of reheat should be minimized, through supply air temperature reset, if humidity conditions can be met, and through reduced airflow when the operating room is not occupied.
11. Special low temperature requirements, related to heart and orthopedic surgery should be ascertained early in the design process and a corresponding low temperature chilled water circuit be provided to meet the surgeon's desired temperature (if required). It is to be noted



that temperatures as low as 16 C DB can be required in operating rooms. Special elevated temperature requirements related to burn and pediatric units should also be ascertained, and systems designed to suit with space heating & humidification.

12. Surgeons should only be allowed to set the dry bulb temperature. Humidity display should be provided.
13. Humidity and temperature sensors should be provided in the return air duct for system control.
14. In general, operating room air handling units should be designed at 2 m/s air velocity at the coil to allow for lower leaving air temperatures.
15. In general, operating room chilled water pipes to the AHU should be designed at higher velocities in the range of 1.8 m/s to 2 m/s to allow for better heat transfer.
16. Refer to Figure 2.8 for operating room airflow configuration and pressure relationship.

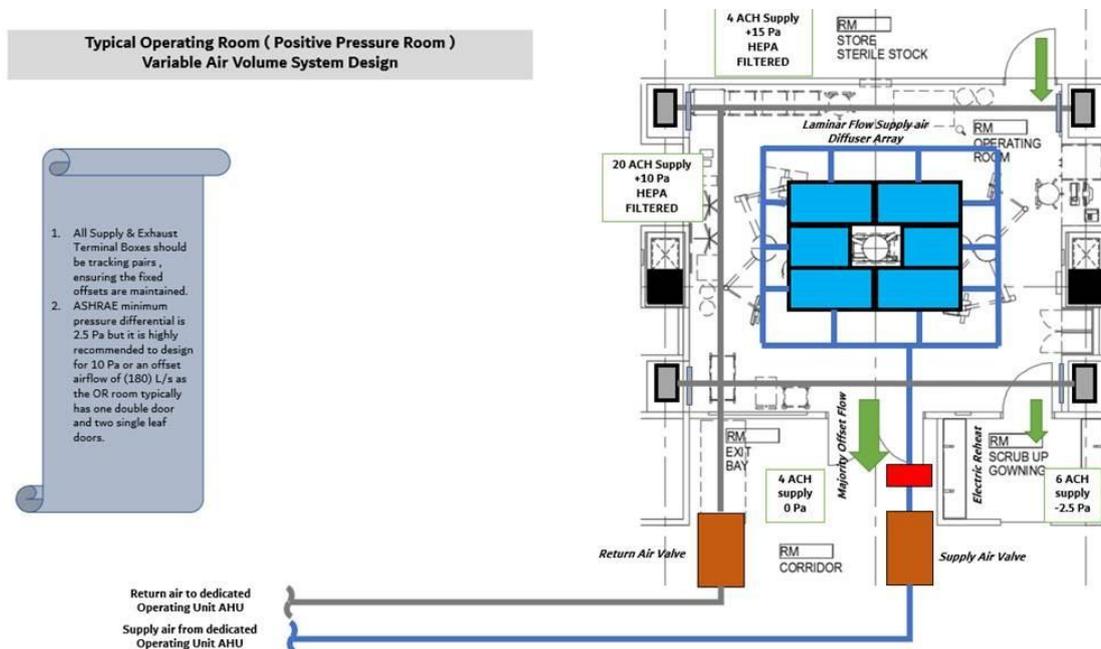


Figure 2.8

2.15.2 Imaging Rooms

Following requirements must be adhered too for Imaging Room HVAC systems.



1. Imaging rooms can be grouped into 4 types as mentioned below, each having their respective requirements.

X-Ray (CT, Radiography, Fluoroscopy)

Ultrasound (Diagnostic Treatment)

Magnetic (MRI)

Nuclear (PET Scan, Linear Accelerator LINAC, Nuclear Camera, Gamma Knife)

2. In general Imaging rooms fall under diagnostics which according to ASHRAE require 6 ACH of supply air with 2 ACH of outside air & a Temperature requirement (21-24°C), humidity (<60% RH).
3. Imaging rooms do not require dedicated air handling units and can be served from the same air handling unit serving the rest of the radiology suite.
4. Imaging rooms designed for treatments such as fluoroscopy (e.g. vascular, cardiac catheterization, interventional lab, cystoscopy, electrophoresis(EP)) carry a prescriptive requirement for treatment rooms 15 ACH of supply air with 3 ACH of outside air but are recommended to be designed to operating rooms standard as mentioned in section 2.15 for future flexibility. All relevant clauses applicable should be adhered to.
5. Data should be obtained from Room Data sheets for the control room, procedure room and equipment room heat dissipation.
6. Wherever possible water cooled medical equipment should be preferred. Process water cooling can be provided via dedicated medical grade chillers backed up by central chilled water system or with the central chilled water system backed up by chilled potable water. Discussion on the system and its criticality should be brought up by the designer to the facility owner during concept design.
7. MRI rooms must be designed to cater for the heat load produced by the equipment. As a



minimum 6 ACH of supply air and 2 ACH of outside air should be provided. Following key considerations should be accounted for.

All materials in the room should be nonferrous.

No rotating equipment (motors, fans) should be placed within the 1 gauss field.

Chilled water requirements as per point 6 above.

Provide an insulated stainless-steel quench pipe with proper thrust restraints sized as per manufacturer guidelines and vented to outside with the exclusion zone clearly marked.

Provide an emergency exhaust fan sized at 12ACH to exhaust helium. This can also be used to purge clean agents in case of fire.

Provide an overpressure relief grille.

8. PET & SPECT Scan rooms are diagnostic rooms requiring 6 ACH SA/2 ACH OA. All air should be exhausted via the general exhaust system from the scanning rooms. Chilled water requirements as per point 6. Hot labs, Radio pharmacies provided with PET and SPECT scan rooms normally house BSC II Hoods and should be provided with dedicated hood exhaust with bag-in bag-out filtration for isotopes and general exhaust from the space.
9. LINAC rooms are also diagnostic rooms with no invasive procedures being carried out. Regular requirements of 6AC SA/ 2 ACH OA will suffice. Humidity should be kept less than 50%. Chilled water requirements as per point 6. Modern day LINAC's are often coupled with MRI's within the same suite. Care should be taken to accurately calculate the heat dissipation and cater for all requirements of MRI room as per point 7.

2.15.3 Laboratories

Following requirements must be adhered too for Laboratories HVAC systems.

1. Proper temperature control (21-24°C), maximum 60% RH with 6 ACH SA/ 2 ACH OA



- should be provided for all labs.
2. All Laboratory work areas should be 100% exhausted to outside through general exhaust passed through heat recovery.
 3. Fume hoods and Bio Safety cabinets located within the labs should be exhausted to the ambient through high plume dilution fans through proper filtration. Exhaust from BSC cabinets can be combined into a single manifold, provided they carry the same class of air and exhausted through N+1 exhaust fans. Similar approach can be adopted for Fume cupboards. Engineer should minimize the number of fans for operational efficiency and maintainability of the system.
 4. Labs containing Fume Hoods or BSC cabinets should be provided with laminar flow diffusers located at appropriate locations.
 5. Flammable cabinets should be provided with ventilation with dedicated exhaust fan and discharge.
 6. Variable systems are permitted for use “only if” they continue to provide a negative room pressure (normally -0.01-0.04 in. wg or -2.5-10 Pa differential) with respect to the corridors and adjacent areas and the required ACHs are maintained when the room is occupied. This can be achieved by communicating fixed offset air-valves for the supply, general exhaust and hood exhaust (one per BSC). Active Monitoring of pressure is required through a pressure display monitor, connected to the BMS system. Space temperature , humidity and air change rate shall be displayed simultaneously. Pressure monitor should have an IP-54 rated housing, resistant to spray washdown & decontamination chemicals. Accuracy RSS of at least +/- 0.25% full scale.
 7. Laboratory sterilizing areas should be provided with 10 ACH SA/ 2 ACH OA.



2.15.4 Pharmacy

Following requirements must be adhered too for Pharmacy HVAC systems.

1. As a minimum Pharmacy spaces should be provided with temperature control (21-24°C), maximum 60% RH with a 4 ACH SA/ 2 ACH OA.
2. Pharmacy should be kept at positive pressure. VAV systems are permitted without compromising on the pressure requirement.
3. In-patient pharmacy providing compounding facilities should be designed according to USP 797.
4. Vault, if designed for controlled substances should be provided with cooling with supply and return air.
5. Pharmacy clean rooms (if required by clinical planning) should be designed to ISO Class 7 Standard according to ISO 14644, unless stated otherwise for the project by the operator , providing a minimum of 40 ACH of HEPA filtered air , with a ceiling coverage between 30%-40%, keeping the maximum face velocity under 0.15 m/s and providing low level return. These should be provided with an ISO Class 8 ante room , providing a minimum of 20 ACH of HEPA filtered air.
6. HEPA filters modules should be fan filter type to reduce central fan size.
7. Clean rooms should be kept at positive pressure except when used for hazardous drugs which should be negative pressure with associated ante room at positive pressure. Clean rooms should be certified to ISO 14644 standard.
8. Hazardous drugs compounding clean rooms are provided with BSC cabinets. The exhaust from these cabinets should be filtered with a carbon filter and a hepa filter before being discharged through a high plume dilution fan or an exhaust stack.
9. Clean room personal are wearing heavy protective clothing so lower temperature should be



considered as a design requirement, 20 C.

2.15.5 Patient Rooms

Following requirements must be adhered too for Patient Room HVAC systems.

1. As a minimum Patient rooms should be provided with temperature control (21-24°C), maximum 60% RH, with a 6 ACH SA/ 2 ACH OA.
2. Each patient room should be provided with a thermostat linked with the BMS system (if available).

2.15.6 Intensive Care Rooms- Critical Care Rooms

Following requirements must be adhered too for Intensive Care Room HVAC systems.

1. Intensive Care rooms include specialized rooms such as Surgical Intensive Care (SICU), Medical Intensive Care (MICU), Cardiac Care Unit (CCU), Paediatric Intensive Care Unit (PICU), Neonatal Intensive Care Unit (NICU), High Dependency Unit (HDU) etc. All these rooms require a minimum of 6 ACH SA/2 ACH OA with temperature range of 21- 24°C, and 30-60% RH.
2. ICU areas should not be served with recirculating type units such as FCU's.
3. Reheat should be provided to each ICU room/bay. Thermostat should be linked with the BMS system (if available).

2.15.7 Morgue & Autopsy

Following requirements must be adhered too for Morgue & Autopsy HVAC systems.

1. As a minimum Morgue & Autopsy spaces should be provided with temperature control (20-24°C), maximum 60% RH with a 12 ACH SA/ 2 ACH OA.
2. Air should be supplied via uni-directional flow diffusers.
3. Exhaust grilles should be located at both high level and low level.



4. All air should be exhausted outside through dedicated ductwork.
5. Direct exhaust connection to the autopsy table should be provided. Exhaust air should be HEPA filtered, UV treated, and carbon filtered for odours and discharged at a high velocity, preferably using a stack. Since autopsy is normally not carried out at private facilities, this requirement will not apply.
6. Body Holding refrigerators should be designed by the specialist manufacturer. Designer to take the heat dissipated for the refrigerators into account while designing the HVAC system.
7. Negative room pressure (normally -0.01-0.04 in. wg or -2.5-10 Pa differential) with respect to the corridors and adjacent areas is required. Active Monitoring of pressure is required through a pressure display monitor, connected to the BMS system.

2.15.8 Isolation Rooms

Isolation rooms can be classified into 3 categories.

1. Class N- Airborne Infection Isolation Rooms (AIIR) – Negative Pressure Isolation Room
2. Class Q – Quarantine Isolation – Negative Pressure Isolation Room with Clean and Dirty Utility.
3. Class P- Protective Environment Isolation Rooms (PE)- Positive Pressure Isolation Room.
4. Class S- Standard Isolation Room - Contact Isolation Room- Neutral Isolation Room.
5. Switchable Pressure Isolation Rooms – No longer allowed by FGI/ASHRAE.

2.15.8.1 Class N- Negative Isolation Room

1. Proper temperature (21-24°C), humidity (<60% RH) and ventilation control, minimum 12 ACH SA/ 2 ACH OA, anteroom 10 ACH SA.
2. Use of negative pressure rooms with close monitoring and control of airflow direction (normally -0.01 to -0.03 in. wg or -2.5 to -8 Pa differential). Negative pressure to be



maintained during un-occupied mode by communicating Air Valves. Provide differential pressure monitor with alarm points to building automation system. Space temperature, humidity and air change rate shall be displayed simultaneously. Pressure monitor should have an IP-54 rated housing, resistant to spray washdown & decontamination chemicals. Accuracy RSS of at least $\pm 0.25\%$ full scale. This guide recommends a negative pressure of 10 Pa for the class N room. Refer to figure 2.9.

3. Seal room below 0.5 ft²(465 cm²) of air leakage (called Effective Leakage Area under 4 Pa pressures differential test)
4. Exhaust air grille should be placed over the patient head or at low level near the head. Air from negative pressure rooms is to be HEPA-filtered with a bag in bag out filter and exhausted directly to the outside with dedicated N+1 high plume dilution exhaust fans discharged 10 feet above roof level. Recirculation is not allowed. Air from other AIIR rooms can be mixed provided each room is provide with a VAV or Air Valves prior to connection.
5. UVGI fixtures may be placed in upper room, or inside the ducts as an additional measure, but are not a mandatory requirement.
6. Pressure relationship should be negative with respect to the ante room with the ante room negative with respect to the corridor.
7. Refer to Figure 2.9 for AIIR room airflow configuration. Room exhaust and supply air valves should be VAV type while the remaining valves for ante room and toilet can be CAV types.

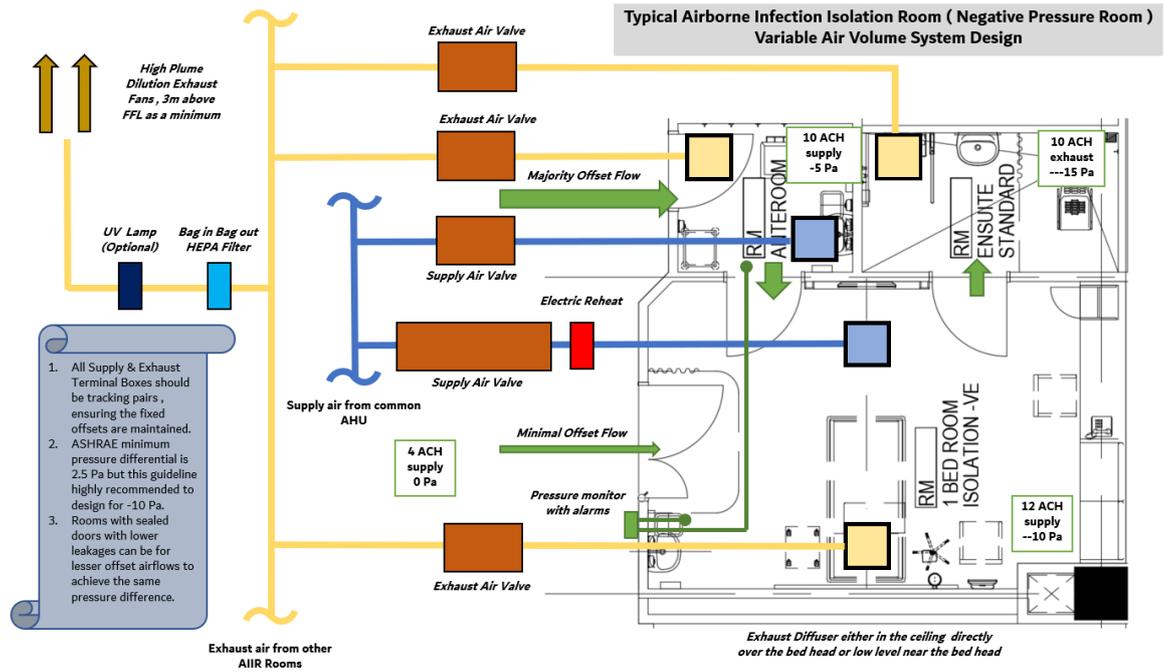


Figure 2.9

2.15.8.2 Class Q- Negative Isolation Room

1. All the requirements for Class N rooms must be adhered too for Class Q rooms.
2. In addition, supply should be provided with HEPA filters similar to Class P rooms.
3. Class Q isolation suite will contain a dirty utility as well. That should also be exhausted to outside, similar to the bed room, ante room and toilet.

2.15.8.3 Class P-Positive Isolation Room

1. These rooms are to be designed for high-risk, immuno-compromised patients (BMT, organ transplant, leukemia, burn, late-stage HIV) and to minimize fungal spore counts in air.
2. Proper temperature (21-24°C), humidity (<60% RH) and ventilation control, minimum 12 ACH SA/ 2 ACH OA, anteroom 10 ACH SA.
3. Incoming air through HEPA filters or fan powered HEPA filters mounted in laminar flow diffusers, supply air on top of the patient bed and exhaust out through the opposite side of the room, preferably at low level.
4. Pressure of +2.5 Pa (0.01" w.g.) relative to the corridor as a minimum. Provide differential



pressure monitor with alarm points to building automation system. Space temperature , humidity and air change rate shall be displayed simultaneously. Pressure monitor should have an IP-54 rated housing, resistant to spray washdown & decontamination chemicals. Accuracy RSS of at least +/-0.25% full scale. This guide recommends a positive pressure of 10 Pa for the isolation room. Refer to figure 2.10. Room return and supply air valves should be VAV type while the remaining valves for ante room and toilet can be CAV types.

5. Seal room below 0.5 ft²(465 cm²) of air leakage (called Effective Leakage Area under 4 Pa pressures differential test)
6. UVGI fixtures can be placed in upper room, or inside the ducts as an additional measure.
7. Pressure relationship should be positive with respect to the ante room with the ante room positive with respect to the corridor.
8. Refer to Figure 2.10 for PE room airflow configuration.

2.15.8.4 Class S-Contact Isolation Room

1. These isolation rooms are used to provide physical isolation for patients having a communicable disease which is not airborne as chicken pox, etc. Requirements for regular patient rooms apply.

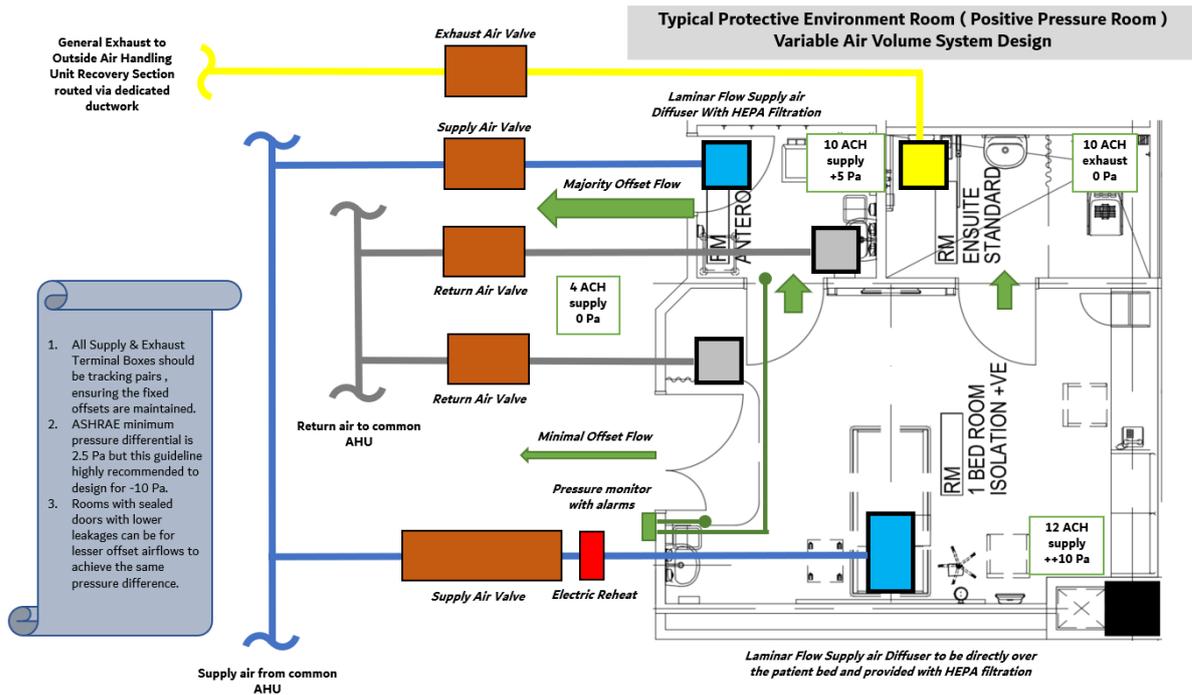


Figure 2.10

2.15.9 SSU(CSSD)

Following requirements must be adhered too for SSU(CSSD) HVAC systems.

- SSU(CSSD) can be broken down into 3 areas.
 - Dirty Area – 6 ACH SA/2ACH OA with 100% dedicated exhaust and negative pressure. Temperature 16-23°C
 - Clean Area- 4 ACH SA/2 ACH OA with positive pressure. Temperature 20-23°C
 - Sterile Store – 4 ACH HEPA filtered SA/ 2 ACH OA with positive pressure. Temperature 24°C
- Means of recording daily temperature and humidity should be provided via the BMS system for all spaces.
- Exhaust ductwork should be stainless steel for durability.
- Direct exhaust from washers, disinfectors and sterilisers should be provided as per the Room Data Sheets.



5. Where ethylene oxide (ETO) sterilizers are used and ETO is stored system shall be designed to provide 100% dedicated exhaust to outside. Upon loss of exhaust system airflow, an audible and visual alarm shall activate in the steriliser work area, and at a location that is continually staffed.

2.15.10 Renal Dialysis & Chemotherapy

Following requirements must be adhered too for Renal Dialysis Patient Bays systems.

1. Room/Bay can be considered as having the same requirements as standard patient room.
2. Consider radiant heating panels directly over the patient chair/bed for radiant heating as dialysis/chemo patients are frequently cold & anaemic & immobile for the duration of the treatment.
3. Consider low design velocities of below 0.25 m/s at the treatment bed/chair, preferably through laminar flow diffusers.

2.15.11 Recovery (Post Anaesthesia Care Unit)

Following requirements must be adhered too for PACU Recovery area HVAC systems.

1. As a minimum PACU rooms should be provided with temperature control (21-24°C), 30-60% RH, with a 6 ACH SA/ 2 ACH OA.
2. Low level return should be provided with stainless steel grilles to capture the anaesthetic gasses being exhaled by the patients and allow for better flushing of the space.
3. Each room/bay should be provided with a thermostat linked with the BMS system (if available).

2.15.12 Emergency

Following requirements must be adhered too for Emergency area HVAC systems.

1. Decontamination Room: Temperature control (21-24°C), with a 12 ACH SA/ 2 ACH OA,



- negative pressure. All air should be 100% exhaust with dedicated ducting.
2. Exam/Treatment Room: Temperature control (21-24°C), maximum 60% RH, with a 6 ACH SA/ 2 ACH OA, positive pressure.
 3. Resuscitation (Trauma) Room: Temperature control (21-24°C), 20-60% RH, with a 15 ACH SA/ 3 ACH OA, positive pressure. If Trauma is to be utilized as emergency Operating room under the hospitals disaster management scheme, operating room requirements should be imposed.
 4. Triage: Temperature control (21-24°C), maximum 60% RH, with a 12 ACH SA/ 2 ACH OA, negative pressure. All air should be 100% exhaust with dedicated ducting.
 5. Emergency Department Public Waiting Area: Temperature control (21-24°C), maximum 60% RH, with a 6 ACH SA/ 2 ACH OA, negative pressure. All air should be 100% exhaust with dedicated ducting.

2.15.13 Burn Units

Following requirements must be adhered too for Burn Unit Room HVAC systems.

1. As a minimum Burn Units rooms should be provided with temperature control (21-32°C), 40-60% RH, with a 6 ACH SA HEPA Filtered with laminar flow diffusers / 2 ACH OA. Room should be at positive pressure.
2. Each patient room should be provided with a thermostat linked with the BMS system (if available).
3. Each patient room should be provided with an individual humidifier and a humidistat to control the humidity level in the room.
4. Each patient room should be provided with reheat sized to raise the temperature to 32°C inside the room.



2.15.14 Bone Marrow Transplant Rooms

Requirements for Protective Environment PE Isolation rooms should be applied for Bone Marrow Transplant rooms.

2.15.15 Hydrotherapy & Therapeutic Pools

Following requirements must be adhered too for Hydro-Therapy Pool HVAC systems.

1. Should be provided with temperature control (26-28°C), with the ability to reheat up to 32°C, with a minimum of 10 ACH SA / 100% exhaust from the space. Space should be at negative pressure.
2. Provide a dedicated or common wet exhaust system with welded stainless-steel ductwork. To allow for energy saving, VAV system can be employed via supply and exhaust terminal during unoccupied mode.
3. The Spinal cord injury patient requires 33°C (92°F) water temperature, while the patient with multiple sclerosis requires 28°C(84°F) water temperature. The pool equipment should be designed to accommodate rapid water temperature change, where both patient types can use the same pool on a given day based on schedule. Humidity control should be appropriately designed to cater for the water evaporation from the pool surface.

2.15.16 Psychiatric Rooms

Requirements for standard patient rooms apply, in addition

1. Care must be taken that all grilles/diffusers and other HVAC devices must be suicide and vandal resistant.
2. Use duct mounted sensors and allow for heavy-gage construction to resist damage and vandalism and reduce injury.
3. Special Anti-Ligature devices should be used.



2.15.17 Procedure Rooms

Following requirements must be adhered too for Procedure Room HVAC systems.

1. As a minimum procedure rooms should be provided with temperature control (21-24°C), 20-60% RH, with a 15 ACH SA with laminar flow diffusers / 3 ACH OA. Room should be at positive pressure.
2. If aesthetic gasses are administered all requirements related to operating rooms should be applicable.

2.15.18 Endoscopy Procedure Rooms

Following requirements must be adhered too for Endoscopy Procedure Room HVAC systems.

1. Gastrointestinal Endoscopy procedure room:

As a minimum should be provided with temperature control (21-23°C), 20-60% RH, with a 6 ACH SA with laminar flow diffusers / 2 ACH OA. Room shall have no mandated pressure requirement, but its preferable to be under negative pressure.

2. Endoscopy/Bronchoscopy:

As a minimum should be provided with temperature control (20-23°C), 20-60% RH, with a 12 ACH SA with laminar flow diffusers / 2 ACH OA. Room shall be negative pressure with dedicated 100% exhaust ducting to outside.

This is more common scenario and endoscopy rooms should be designed as a worse case to this requirement, unless noted otherwise by the operator.

3. Endoscopy ERCP procedure room:

If specifically designed by the clinical planning team as a dedicated ERCP (Endoscopic Retrograde Cholangio-Pancreatography) room the following requirements shall supersede the previous requirements.



As a minimum should be provided with temperature control (20-23°C), 20-60% RH, with a 15 ACH SA with laminar flow diffusers / 3 ACH OA. Room shall have positive pressure requirement.

4. Endoscope Cleaning Rooms:

As a minimum should be provided with temperature control (21-24°C), 20-60% RH, with a 10 ACH SA / 2 ACH OA. Room shall have negative pressure requirement. All air should be exhausted to outside with dedicated ducting.

2.15.19 Outpatient Clinics & Support Spaces

The HVAC systems for outpatient clinics & support functions are often not designed to the same level of redundancy as in-patient facilities. It is encouraged that the consultant engages with the owner/facility manager early in the design process to figure out the requirements for the clinics and day surgery units, endoscopy & imaging procedures if present.

Any particular low temperature requirements for day surgery units should be advised by the owner's representatives and the consultant should undergo an analysis of whether the requirements are achievable by the proposed system design.

2.15.20 IVF Clinics/ Fertilization Centres

Following requirements must be adhered too for IVF HVAC systems.

1. IVF Clinics typically contain the following spaces.

Procedure Room & Embryo Transfer Room: The procedure room & embryo transfer room should be treated as an OR and all requirements for operating room should be complied.

Recovery Room/Bays: Recovery bays should be treated as PACU rooms and all requirements should be taken for PACU rooms.

Laboratories (Embryology, Andrology, Cryo etc.): Labs for IVF centre represent ultra clean



labs. In addition to the requirement for laboratory mentioned in the previous section all air should be HEPA filtered with laminar flow diffusers. Pressure requirement should be positive pressure (+0.01-0.02 in. wg or +2.5+5 Pa differential). ISO Class 7 certification testing is highly recommended.

Infectious Labs: Infectious labs should be provided with the same systems as other IVF labs, but the air pressure regime should be negative. (-0.01-0.02 in. wg or -2.5-5 Pa differential)

Sample Collection Rooms: Sample collection rooms should be kept at negative pressure via the adjoining shower area exhaust.

2. HVAC air handling units serving the laboratories, procedure and embryo transfer rooms should be provided with carbon filters, with activated alumina impregnated with potassium permanganate & HEPA filters in the air handling unit. HEPA filters can also be installed at the terminal locations instead of the air handling units if dedicated air handling units are not used.

2.15.21 Data Centre

Following requirements must be adhered too for Data Centre/Server Room HVAC systems.

1. As a minimum Server rooms should be provided with temperature control (19-22°C), 30-60% RH, with supply air governed by the heat load for the servers but not less air required to cool 0.5 kW/m² of data hall of heat load, to cover for future expansion.
2. Server Room should be cooled by precision ac units or close control ac units, providing cooling and humidity control, located within the server room with adequate clearance space or preferably adjacent to the server room in a dedicated mechanical room.
3. A minimum of two close control units should be provided for each server room in N+1 arrangement, one fed from the central chilled water circuit and one fed from a dedicated DX



machine for medium to large scale healthcare facilities. For smaller facilities and outpatient facilities one close control unit can be provided with dual coil arrangement and dual fans. Close control units shall be fed from emergency power.

4. Server Rooms rack should be arranged in hot aisle and hot cold arrangement, where applicable.
5. Server Rooms should be conditioned through raised floor arrangement, with perforated floor tiles provided for up to 6kW rack load and fan powered tiles or rack containment provided for higher heat loads.
6. Use of Fan coils to provide backup cooling is not permitted



3. Electrical Services

This document is intended for the Architect/Engineer (A/E) and others engaged in the design and renovation of DHA facilities. Where direction described in applicable codes are in conflict, the A/E shall comply with the more stringent requirement. The A/E is required to make themselves aware of all applicable codes.

The document should be read in conjunction with other parts of the Health Facility Guidelines (Part A to Part F) & the typical room data sheets and typical room layout sheets.

3.1 Introduction

This section of DHA health facility design guideline provides, Healthcare Planners and Designers guidance on the acceptable level of standards to be achieved for all fixed electrical wiring installation within healthcare facilities in The Emirate of Dubai. This applies to all new installations and modifications to existing facilities within the framework of Part A of this document.

It is not the intention of this document to unnecessarily repeat national, international or industry standards. Where appropriate, these standards are referenced, and additional specific requirements are described in the following sections.

In addition, guidance is also given on ELV and ICT systems.

3.2 Abbreviations, Standards and References

Abbreviation	Description
BMS	Building Management System
CIBSE	Chartered Institute of Building Services
CCTV	Closed-Circuit Television
CE	European Conformity



Abbreviation	Description
CT	Current Transformer
DEWA	Dubai Electricity and Water Authority
EBB	Equipotential Bonding Bar
ELCB	Earth Leakage Circuit Breaker
ELV	Extra Low Voltage
EMC	Electromagnetic Compatibility
EMR	Electronic Medical Records
EMR	Electronic Health Record
EPS	Emergency Power Supply (Also referred as Secondary Power Supply)
FL	Full Load
HIS	Hospital Information System
ICU	Critical Care Unit
IEC	International Electrotechnical Commission
IEE	Institute of Electrical Engineering
IGBT	Insulated Gate Bipolar Transistor
IPS	Isolated Power Supply (also referred as Medical IT)
ISO	International Standards Organisation
IT	Impedance Terra Earthed (Derived from an Isolated Power Supply)
ICT	Information and Communication Technology
LAN	Local Area Network
LPS	Lightning Protection System
LSOH	Low Smoke Zero Halogen
LV	Low Voltage
MV	Medium Voltage
NTP	Network Time Protocol



Abbreviation	Description
PACS	Picture Archiving and Communication System
PEC	Protective Earth Conductor
PPS	Primary Power Supply
PTZ	Pan Tilt and Zoom
RCBO	Residual Current Breaker with Overcurrent
RCD	Residual Current Device
RDS	Room Data Sheet
SPS	Secondary Power Supply (Also referred as Emergency Power Supply)
TPS	Tertiary Power Supply (Also referred as UPS Power Supply)
TRA	Telecom Regulatory Authority
UPS	Uninterruptible Power Supplies
VRLA	Valve Regulated Lead Acid Battery

3.3 Risk assessment

1. Electrical power distribution systems are inherently designed to isolate power supplies to parts of the installation where an electrical fault is detected for safety and reliability of electrical distribution in general.
2. In any electrical installation the power supply may fail at some point and contingency needs to be in place to mitigate the impact of the power failure by providing redundancy in power source and distribution.
3. The level of redundancy to be contusive for the type of healthcare premises and level of care rendered. A power failure in an outpatient care facility may not have much detrimental effect on the patient safety while a power failure in an acute care facility could have disastrous



consequences.

4. Depending on the level of care provided in the healthcare facility, the stake holders should carefully consider the risks involved due to a power failure for clinical, non-clinical and engineering applications and come up with an optimum arrangement that will minimize the risk to the patient safety and healthcare facility operation in general.
5. The risk assessment can be a simple or complex approach depending on size and nature of the medical services being provided in the healthcare facility. This guideline recommends the risk assessment approach described in HTM 06-01 2017 edition, chapter 4 be followed for determining the risks; business continuity risks are graded from Grade 1 to Grade 4 (Grade 1 being highest risk) while clinical risks are graded from Grade A to Grade E (Grade A being highest risk).
6. Specific requirements given in this guideline takes precedence over HTM or any other Standard or regulation.
7. Within an outpatient department in a large healthcare facility or in a clinic, it may be determined as acceptable to have single points of failure in a system, since ambulant patients are likely to be more mobile than patients in critical care areas and staff will be able to move them away from the affected area in the event of a power failure. On the other hand, in critical care areas or operating theatres, the consequence of a prolonged, or even a very short, power failure could result in serious health disabilities or, in the worst cases, fatality. In this instance, a more resilient infrastructure with additional levels of secondary and/or tertiary power supplies are appropriate. Also, the eventual stakeholder's (hospital owner/end user) vision with respect to management of business continuity risks to be considered while finalizing the risk levels (clinical and business continuity).



3.4 Design considerations

1. It is important to access the requirements of a healthcare facility project in terms of power supply requirement for equipment, small power outlet, lighting etc.; it is particularly important to identify those areas or functions that will require special consideration, for example Group 2 Medical Locations (HD 60364-7-710:2012, IET Guidance Note 7) in healthcare facilities.
2. Local/international regulations or standards as listed below are required to be considered while designing healthcare facilities in the Emirate of Dubai.

Sl. No.	Standard/Guideline
1	Dubai Electricity and Water Authority - Regulations for Electrical Installations 2017 Edition or later edition.
2	UAE fire code.
3	Al Sa'fat Green Building Evaluation System.
4	Local Telecom Company Regulations as applicable.
5	HD 60364-7-710:2012 (or later) Electrical installations of buildings - Part 7-710: Requirements for special installations or locations - Medical locations.
6	CIBSE Lighting Guide 2: Hospitals and healthcare buildings,2008, by The Society of Light and Lighting.
7	IEC 60079 - Electrical apparatus for explosive gas atmospheres.
8	IEEE 519 - IEEE Recommended practices and requirements for harmonic control in electrical power systems.
9	HTM 06-01 - Electrical service supply and distribution, 2017 or later edition.
10	NFPA 99 – Health Care Facilities, Chapter 6, Section 6.4.2.2 (Edition 2012 or later).
11	Equipment and installation material standards/listing: IEC, EU Declaration of Conformity, or UL Listed.

3. The requirements given in the above regulations or standards are not repeated generally in



this document; however specific additional healthcare specific requirements emphasised in the following section will take precedence over the referenced standards above.

4. It is important to note that, the services outlet (power, data etc.) quantities and their types provided in the various medical locations shall be based on the guidance provided as per the RDS (Room Data Sheets) included under Part B of this guideline.
5. Non-medical equipment should not be used in a patient environment unless it meets the electrical safety requirements of IEC 60601-1, particularly with respect to touch and leakage currents.
6. Primary Power Supply (PPS): - Primary Power Supply is the electricity supply provided by the local utility company, Dubai Electricity and Water Authority (DEWA). Power supply from DEWA is generally reliable, however, while power supply allocation requests are made to the local utility company, level of care provided by the proposed healthcare facility should be conveyed to the utility company so that appropriate level of redundancy could be considered by the utility supply company for power intake provisions.
7. Secondary Power Supply (SPS): - Secondary Power Supply is the electricity supply provided from an on-site power source such as a Diesel Generator Set (s). The secondary power source shall be suitably supplemented by appropriate secondary distribution system to reduce the risk of single point failure. Single point of failure to be as close as practically possible to the load. Secondary power supply shall be available to the associated loads in 15 seconds or less from the PPS interruption. Power outlets fed from the SPS are also referred as Emergency Power Supply (EPS) outlets.
8. In the event of a primary power supply failure the secondary power supply should be available to the associated emergency loads in 15 seconds or less.
9. Providing a resilient secondary power source is only one part of the solution while providing



a redundant secondary distribution network is equally important. Refer to section 3.8.

10. Tertiary Power Supply (TPS): - Tertiary Power Supply (with less than 0.5 Sec break) is required to provide additional (in addition to PPS and SPS) power source in clinical risk Grade A and B areas where loss of power supply could have disastrous consequences. Static double conversion Uninterruptible Power Supplies shall be provided as TPS sources. Refer to section 3.9.
11. Isolated Power Supplies (IPS): Isolated power supplies incorporating an isolation transformer, distribution arrangement and Isolation monitoring system are used to deliver power supplies to power outlets intended for relevant critical medical equipment in critical medical locations where enhanced level of resilience is required. Refer to section 3.9.
12. Following clinical risk grading and associated recommendation on power supply types are provided based on the interpretation of HTM 06-01 and HD 60364-7-710:2012 in the context of Emirate of Dubai where quality and reliability of primary power supply is generally excellent. Therefore, this clinical risk grading may not be applicable for other geographic locations.

Clinical Risk Grade (Interpretation of HTM 06-01: 2017)	Medical Location (Interpretation of HD 60364-7-710:2015)	Area Description	Power Supply Types
Grade A	Group 2	These are areas where treatment and patient safety will be compromised and endangered by any minor interruption of electrical supply; such areas include but not limited to the following;	SPS: Required TPS: Required IPS: Required (Note: PPS is also recommended in these areas to serve power outlets intended for non-clinical



Clinical Risk Grade (Interpretation of HTM 06-01: 2017)	Medical Location (Interpretation of HD 60364-7-710:2015)	Area Description	Power Supply Types
		Operating Rooms Anaesthetic Induction rooms Recovery Bays (Stage 1) Critical Care Angiography and Cath labs Emergency resuscitation bays IVF Procedure rooms High dependency units Neo-Natal Intensive Care Units Brachytherapy rooms Chemo embolization rooms	applications such as cleaning. Power supply for support systems such as HVAC, hot & cold water, and medical gas alarms shall be connected to SPS)
Grade B	Group 1	These are areas where treatment and patient safety may be compromised (but not endangered) by any minor interruption of electrical supply; such areas include but not limited to the following areas; Delivery rooms Endoscopy Procedure Rooms Emergency treatment areas. Haemodialysis bays Urology treatment rooms Radiation therapy rooms Imaging equipment Procedure rooms Triage	SPS: Required TPS: Generally, not required. However, TPS may be required for specific medical equipment. IPS: Not Required (Note: A few power outlets connected from TPS is recommended at Nurse stations serving critical care areas, PPS is recommended in these areas to serve power outlets intended for non-clinical applications such as cleaning Power supply for support systems such as HVAC, hot &



Clinical Risk Grade (Interpretation of HTM 06-01: 2017)	Medical Location (Interpretation of HD 60364-7-710:2015)	Area Description	Power Supply Types
		Staff stations.	cold water, and medical gas alarm shall be connected to SPS) SPS backup for imaging equipment are optional depending upon the level of care provided in the facility. If the healthcare facility is having interventional procedures at least one of each type of imaging system to be connected to SPS.
Grade C	Group 1	These are areas where treatment and patient safety will not be immediately compromised by an interruption of electrical power; such areas include but not limited to the following areas; Outpatient Treatment rooms Consult/Exam rooms Pharmacy Patient bed room Recovery – Stage II Observation bays	PPS: Required SPS: Required TPS: Not Required IPS: Not Required (Note: Power supply for support systems such as HVAC, hot & cold water, and medical gas alarms shall be connected to SPS)
Grade D	Group 0	These are areas where loss of power supply may give rise to disruption, inconvenience and a reduced environmental quality	PPS: Required SPS: Optional TPS: Not Required



Clinical Risk Grade (Interpretation of HTM 06-01: 2017)	Medical Location (Interpretation of HD 60364-7-710:2015)	Area Description	Power Supply Types
		<p>but would not directly compromise clinical treatment and safety; such areas include but not limited to the following areas; Consult rooms Waiting areas Sterile Supply Unit (SSU)</p>	<p>IPS: Not Required (Note: SPS for small power outlets in these areas are optional; the designer may provide SPS to mitigate business continuity risk, if required by the end user. It is recommended that 50% of lighting circuits are connected to SPS. SPS backup is highly recommended for at least one of each type of sterilizing and cleaning equipment in Sterile Supply Unit (SSU) as a minimum)</p>
Grade E	-	<p>These are areas where loss of the electrical supply does not have an immediate effect on the clinical treatment or safety of patients; such areas include but not limited to the following areas. General circulation areas Offices Other Non-clinical areas</p>	<p>PPS: Required SPS: Optional TPS: Not Required IPS: Not Required (Optional: SPS and TPS for areas such as offices are optional; the designer may provide SPS and TPS to mitigate business continuity risk, if required by the end user)</p>

**TABLE: E.3.1 Clinical Risk Grading**

13. Notwithstanding the guidance provided above, there may be situations where enhanced level of power supply resilience is required based on the specific medical treatment envisaged. The designer is required to assess the risks involved and shall include further enhancements in the design as necessary. In addition, power supplies for building's life safety system shall be supplied from SPS as per the local fire code.

3.5 Power quality

1. Electrical disturbances may affect the reliability of high-tech medical equipment. As medical equipment is often connected to vulnerable patients, such a malfunction may result in fatal consequences. To mitigate this problem careful consideration shall be made in terms of the design of the electrical distribution system as well as selection of electrical distribution equipment. The following approaches shall be considered.

Power supply feeders for sensitive medical equipment such as X-Rays, CT, MRI and Linac. etc, shall be directly sourced from the Main Distribution Boards (MDB) rather than from shared sub-distribution panels. Alternatively, dedicated appropriately sized submain distribution board (SMDB) located in the MDB room to serve a group of imaging equipment will also suffice.

Providing surge protection devices.

Providing active harmonic filters: Power system harmonics of order 3rd, 5th, 7th, 9th, 11th and 15th order can create significant problems such as over current and overheating of cables, busbars and transformers. since it is not practical to accurately estimate the rating of active harmonic filters required for any project in advance, provision such as breakers shall be made in the Main Distribution Boards to install harmonic filters when actual harmonics can be measured at the earliest. Spare breakers designated for this



application shall be labels as “ For Harmonic Filter Only”.

Harmonics to be measured once the majority of the mechanical, electrical and medical equipment are in operation. This guideline recommends that this measurement be made within 6 months following the opening of the facility. Suitably rated harmonic filters shall be installed to limit the harmonics stipulated as per IEEE 519 (Recommended practices and requirements for harmonic control in electrical power systems).

Power factor correction meeting DEWA requirement; Power factor correction equipment can also contribute to the harmonic generation; unless properly designed detuning reactors are incorporated into the design of the power factor correction capacitor banks. Power factor correction capacitor banks shall be with detuning reactors. Capacitor banks employing Thyristor based capacitor switching is recommended.

Special attention is drawn to DEWA regulation clause 1.10 and 8.2 with respect to under voltage release and auto-reclosing for feeders serving air conditioning units or similar equipment employing compressors drawing large inrush current at start-up.

Facility to display power quality parameters such as THD is recommended to be provided in the Main Distribution Boards.

3.6 Power supply and distribution resilience

1. The resilience of power supply and distribution shall be as per the type of health care facility and level of care provided in that part of the facility.
2. When designing the strategy for the electrical distribution, it is important to take an all-inclusive approach.
3. All Main Distribution Boards serving non-critical applications shall have temporary generator connection provision to connect temporary generator in case of any prolonged



utility power supply outage.

4. Refer to Fig. E.3.1 for a diagrammatic representation of a typical Hospital high-level power distribution arrangement. The number of Automatic Transfer Switches indicated in this diagram may have to be increased or decreased based on the layout of the hospital, load considerations and distribution arrangement.
5. All automatic transfer switches serving critical areas shall be bypass isolation type to enable ATS maintenance or fault rectification without loss of power supply to critical services.

3.7 Primary (Normal) power supply and distribution

1. Primary power supply shall be sourced from local utility provider DEWA, based on the standard procedures and approval process mandated by the local power supply authority.
2. Main power supply intake rooms (RMU, Transformer and MDB) shall be provided as per DEWA regulations.
3. With fast evolving advancements in the medical treatment field there is an ever-increasing need for electrical power for healthcare facilities and this trend is likely to continue. Considering this spare capacity may be allowed in the power distribution equipment such as transformers.
4. Typically, in healthcare facilities, large number of small power sockets are provided at patient locations on service panels and pendants for redundancy and convenience than simultaneous use. As such, suitable diversity shall be worked out by a qualified and experienced designer to avoid ending up with an inappropriately expensive overdesigned electrical system.
5. For critical care facilities separate, dedicated Main Distribution Board rooms shall be provided for primary and secondary power supplies to segregate primary and secondary Main Distribution Boards.



6. Figure E.3.1 below indicates a typical primary and secondary distribution arrangement for a hospital. Note that this is a typical high-level arrangement and the number of different equipment and connection arrangement may vary depending upon the size of the facility, associated loads and relative location of loads.

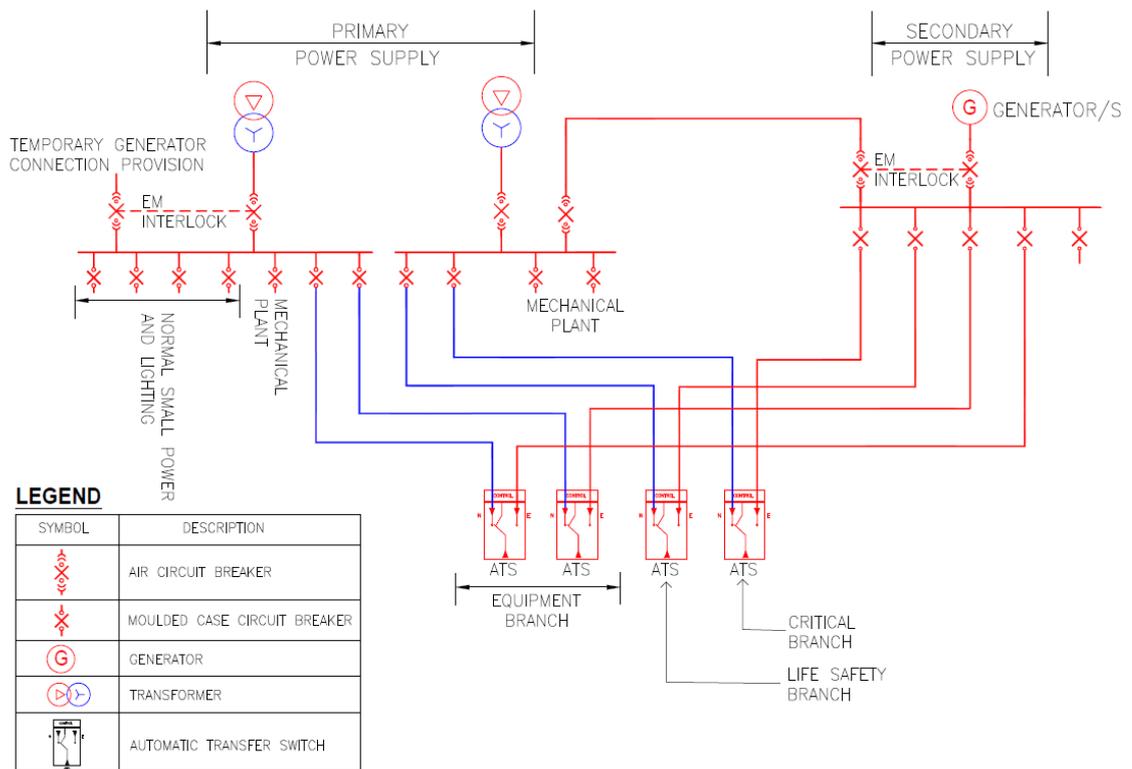


Figure E.3.1 Typical high-level power distribution arrangement schematic for a Hospital

3.8 Secondary (Emergency) power source and distribution

1. Onsite secondary power supply source (Diesel Generator Set) and associated distribution shall be provided for Healthcare facilities. Coverage of the secondary power supply shall be as per the level of care provided in the facility.
2. Location of the Generator Set shall optimise the secondary distribution by reducing the amount of power distribution elements between the critical load and the power source. The location of the generator room shall also be protected from general flooding levels.
3. It is recommended that Diesel Generator Sets serving healthcare facilities are not located



below the grade level.

4. It is recommended that Diesel Generator Sets serving healthcare facilities are prime rated (ISO 8528-1) and not standby rated.
5. Where multiple Diesel Generator Sets are forming the Secondary Power Supply source and is only supporting critical loads in Grade A, B and C medical locations, N+1 source redundancy shall be provided.
6. Where the secondary power source is providing power backup for the entire facility, in addition to clinical risk grade A, B and C locations, N+1 redundancy may not be required. However, in the event of one Generator failure, the remaining arrangement shall be capable of supporting the entire Grade A, B and C medical locations.
7. For healthcare facilities where, the total capacity of the Secondary Power Source requirement is within the limit of a single generator set, it is acceptable to have one diesel generator set.
8. This guideline does not recognize an alternate power supply (in addition to PPS) from the local utility company or a Solar PV/Concentrated plant as a means of secondary power source.
9. Special consideration shall be given to the choice of starting batteries and battery chargers for diesel generator sets. The diesel generator plant is highly dependent upon the availability of the batteries for cranking the engine when required. The batteries shall be either VRLA or Ni-Cd type; However, Ni-Cd batteries are highly recommended.
10. Battery status to be monitored and alarmed through the building management system or any other separate monitoring system.
11. Onsite fuel storage shall be provided for diesel generator sets. The fuel storage quantity requirements shall be carefully determined considering the level of care provided in the



facility; it is recommended that healthcare facilities providing inpatient and critical care functions are provided with a minimum of 24 Hours of fuel storage at 70% average loading of the respective diesel generator sets. This can be reduced to 4 hours in case of outpatient clinics.

12. The diesel fuel storage within the generator room shall not exceed 2400 litres.
13. Separate, dedicated Main Distribution Board rooms shall be provided for secondary Main Distribution Boards serving emergency functions of the facility.
14. Secondary power supply outlets in clinical areas shall be logically grouped in distribution branches with segregated distribution. Automatic change over between PPS and SPS shall be as close as practically possible to the point of utilization depending upon the criticality of the application.
15. Feeder cables for radiology equipment incorporating high voltage generators drawing pulse currents for a short duration (not exceeding 5 Sec.) need not be sized considering the peak current as continuous current. The following general guideline may be followed while determining the demand load and associated feeder cable sizes for medical equipment drawing short duration impulse current.

One imaging equipment: Demand load and cable size shall be designed based on 50% of the short time peak rating of such equipment or 100% of the continuous rating of the equipment; whichever is higher.

Two imaging equipment: Demand load and cable size for an upstream feeder serving two such imaging equipment shall be designed based on the sum of (50% of the short time peak rating of the first equipment or 100% of the continuous rating of the first equipment; whichever is higher) and (50% of the short time peak rating of the second equipment or 100% of the continuous rating of the second equipment; whichever is



higher).

More than two imaging equipment: Demand load and cable size for an upstream feeder serving more than two such imaging equipment shall be designed based on the sum of the (demand load for largest of the two imaging equipment based on “b” above) and 20% of the sum of peak current of the all the remaining imaging equipment.

16. Note that the above criteria is a general guideline for the design stage, final section of the cable shall be verified against manufacturer’s certified requirement once the final selection of the equipment has been made.

17. The secondary power supply distribution shall be logically organized in separate change over (ATS) and distribution branches. Refer to table E.3.2 as example of grouping of circuits for secondary power distribution.

Secondary Power Distribution Branch	Connected Equipment/systems
Life Safety Branch	<ol style="list-style-type: none"> 1. Fire pumps 2. Emergency lighting 3. Fire detection and signalling 4. Smoke management systems 5. Firefighting lifts 6. Other fire and life safety equipment as per local fire code. 7. (Building life safety systems in general)
Critical branch	<ol style="list-style-type: none"> 1. Socket outlets in Grade A clinical risk areas 2. Socket outlets in Grade B clinical risk areas 3. Socket outlets in Grade C clinical risk areas 4. Critical medical equipment power supplies 5. Medical gas power supplies 6. Critical area illumination



Secondary Power Distribution Branch	Connected Equipment/systems
	7. UPSs serving ICT Systems 8. UPSs serving IPSs and medical locations
Equipment branch	1. Domestic water pumps 2. Pneumatic tube system blowers 3. HVAC system equipment as applicable (part/full) as per design. 4. Lifts 5. Drainage sump pumps 6. Water treatment plants 7. Applicable loads in Kitchen 8. Laundry equipment 9. Standby lighting

TABLE: E.3.2 Secondary Power distribution branches

18. 100% Power supply backup for chilled water generating plant for space cooling is not mandatory but desirable. However, SPS shall have enough capacity to serve chilled water for space cooling in clinical risk grade areas A and B as a minimum. In cases where the primary cooling for the healthcare facility is provided by remote district cooling plant, power backup should be provided for backup cooling plant as described in Part E, section 2.12.2 of this guideline.

19. SPS backup shall be provided for HVAC air plant such that loss of PPS will not compromise the pressure differential regime mandated by the HVAC section of this guideline.

3.9 Tertiary (UPS) power source and distribution

1. Tertiary power supply source in the form of Uninterruptable Power supplies (UPS) shall be provided for Healthcare facilities to serve critical applications in clinical risk areas Grade A and Grade B defined in HD 60364-7-710:2012. In addition, tertiary power supplies may be provided for sensitive equipment in other areas such as laboratories, pharmacy, critical care



supervision stations, PACS and HIS workstations etc.

2. In some cases, sensitive medical equipment are provided with individual UPS units provided adjacent to the respective equipment. In such cases, secondary power supply would suffice.
3. In consideration of mitigating business continuity risks, the designer may provide UPS power outlets in non-clinical areas such as the finance department and receptions desks if required by the end user.
4. The UPS units shall be static double conversion type either monolithic or modular type.
5. Long life (10 Years) VRLA type batteries meeting IEC 60896 connected in dual string arrangement is recommended for UPS units. Multiple string battery connection assists in maintaining the batteries without completely eliminating the backup capacity of the UPS while in operation.
6. Since the battery life is closely related to the ambient room temperature it is critical that the UPS/battery rooms temperature is maintained within a temperature range of 20 to 22°C. Alarm systems may be considered to monitor the UPS room temperature and raise local and remote alarm when the temperature exceeds the limit.
7. In general, it is recommended that UPS units are not shared between building services (IT, Security system etc) and clinical applications. However, in case of healthcare facilities such as outpatient clinics it may be more feasible to have combined UPS units to serve clinical and nonclinical applications.
8. Careful consideration shall be given to the UPS connection arrangement and redundancy. An appropriate number of central UPS systems connected in N+1 redundancy, closer to the critical loads, are recommended, rather than one single large UPS plant serving the entire facility. On one hand the single large UPS plant increases the risk of single point failure while on the other hand having large number of UPS units to monitor and maintain would become



an operational challenge; thus, careful consideration shall be made by the designer to have an optimum number of UPS units based on the nature of the healthcare facility. Refer to HTM 06-01, 2017 figure 22 as an example of recommended secondary power source and distribution arrangement for a group 2 medical location.

9. A parallel synchronous redundant UPS arrangement is recommended for serving non-clinical applications such as building IT systems. Refer to HTM 06-01, 2017 figure 25 as an example. N+1 modular UPS arrangement is also acceptable.
10. An autonomy time of 60 minutes shall be provided for UPS units serving clinical services in critical care areas while the input power to the UPS units are sourced from secondary power supply.
11. This guideline does not recognise rotary UPS units as tertiary power source (TPS) for Healthcare facilities due to the following reasons.

Autonomy time provided by the Rotary UPS systems are not comparable to autonomy times that can be achieved with Static UPS systems.

Rotary UPS units are normally installed together with Diesel Generator Sets, making it not suitable for installation closer to sensitive medical locations such as Operating Theatres.
12. UPS units of 20kVA and larger or serving clinical risk grade A areas shall be provided with external by pass panel. Ability to by-pass the UPS unit in the event of a total failure of the UPS unit is a critical last option that should be available to the operator to maintain the power supply.
13. Separate UPS rooms are recommended for UPS units larger than 20kVA, than housing the UPS units in sub-electrical rooms.
14. UPS status and alarms shall be available in the Operating Theatres through the Surgeons' control panels or other annunciator units.



15. In general imaging equipment such as X-Rays, CTSs, MRI do not require power backup for the entire equipment from a central UPS, but a smaller local UPS to power the respective control console (not x-ray generator and magnet) would be sufficient.
16. If the imaging equipment is forming part of an interventional operating theatre suite, UPS unit serving such imaging equipment shall be specially designed to power the entire imaging equipment including x-ray generator or magnet to avoid the UPS units switching to bypass in case of transient overload and to ensure power quality.
17. If the designer opts for backing up the entire imaging equipment such as CT including the X-Ray generator, individual UPS units specially designed to handle transient currents should be provided. It is recommended that this UPS is not shared to serve other medical locations. Autonomy time for UPS serving noninterventional imaging only and fed from SPS can be limited to 10 Minutes.
18. Power outlets intended for connecting critical medical equipment in clinical risk grade A locations shall be fed from proprietary Isolated Power Supply (IPS) panel meeting relevant IEC standard or UL listed.
19. It is recommended that IPS panels serving operating theatres are provided with integral automatic transfer switch for additional resilience. Power sources for the ATS shall be primarily from the tertiary power source while alternate power supply can be from the secondary power source.
20. Isolated power panels shall be located closer (within 30m) to the area of application to minimise the leakage currents due to conductor capacitance.
21. Maximum capacity of the IPS panels shall be limited to 10kVA, with single phase input.
22. It is recommended that at least two IPS circuits are provided for each patient care location in clinical risk grade A locations where critical medical equipment are likely to be connected



- to the patient.
23. Where multiple IPS panels are provided to serve multiple Operating Theatres or critical care areas it is recommended that the IPS final circuits are interleaved between the different rooms so that failure of one IPS unit will not render all IPS outlets in any given patient location without power simultaneously.
 24. IPS panels are not recommended to be located within operating theatres; rather these shall be located in suitably designed ventilated spaces to facilitate cooling and maintenance access.
 25. This guideline recommends that a maximum of 4 Nos. 13A sockets outlets are connected to any given IPS final circuit. No ring circuits are not permitted for IPS final circuits.
 26. IPS final circuits shall not be protected with RCD or RCBOs.
 27. Due to the inherent nature of isolated power supply final circuits, both conductors of the final circuit will be live and will be at a higher potential with respect to the ground; considering this both conductors of IPS final circuits shall be wired with same phase colour as that of primary power supply input to the IPS and should be ferruled as L1 and L2.
 28. The IPS sockets shall be double pole unswitched, with blue colour face plate with engraving “For Medical Equipment Only”.
 29. Luminaires including operating theatre surgical lights are not required to be connected to IPS panels
 30. Remote Alarm Annunciator Unit for the IPS panel shall be located in the respective Operating Theatre and associated nurse stations.
 31. In case of IPS panels serving critical care areas other than operating theatres, the Remote Alarm Annunciator unit shall be located at the respective supervision (nurse) station.
 32. It is recommended that the IPS Remote Alarm Annunciator Unit in the operating theatres



have the following parameters displayed.

IPS insulation status/Leakage current

IPS load information

IPS temperature

Input ATS status (if applicable)

UPS Alarm

33. Isolated circuit fault locator system in conjunction with IPS leakage monitoring system is desirable but not mandatory.
34. Socket outlets supplied from IPS panels are also referred as “Cardiac Protected” outlets elsewhere in these guidelines.

3.10 Protection and switchgear

1. Since it is critical to ensure availability of critical healthcare facilities during any natural calamities it is important that the main intake switchgear (both LV and MV) are not placed below grade level. Potential flooding risks are to be assessed carefully before finalizing the location of main electrical intake rooms.
2. Main 11kV intake switchgear and its arrangement shall be as per DEWA standard.
3. Main Intake LV switchgear (MDB) serving the critical care facility shall be a minimum of Form 4b assembly meeting IEC 61439-2 and relevant sections of DEWA regulations.
4. All Motor Control Centres (MCC) shall be a minimum of Form 4a or 4b type tested assembly meeting IEC 61439-2 and relevant sections DEWA regulations.
5. Final circuit distribution boards shall be factory-built assemblies meeting IEC 61439. To reduce the impact of cumulative natural earth leakages of medical equipment on the protective device, that may cause nuisance tripping, it is recommended that final circuits



serving clinical areas are protected with RCBOs, rather than RCDs covering multiple MCB circuits.

6. RCBOs and RCDs serving small power circuits in Group 0, Group1 and Group 2 (as per HD 60364-7-710) medical locations shall have a tripping characteristic of Type A or Type B with a maximum tripping current of 30mA: Type AC, RCBOs or RCDs shall not be used in Group1 and Group 2 medical locations.
7. Socket outlets protected for earth leakage is also referred as “Body Protection” elsewhere in these guidelines.

3.11 Electromagnetic Compatibility

1. In general, all electrical and electronic equipment used in healthcare facilities shall be CE (or Equivalent) marked or certified. Careful consideration shall be given to power distribution induced electromagnetic interferences on sensitive medical equipment.
2. Where non-CE marked or equivalent non-certified, equipment has to be used in the facility the original equipment manufacturer shall confirm that the proposed equipment use in the facility will not have any adverse effect on other sensitive equipment in the facility.
3. The following are recommended for healthcare facilities for EMC.

Cable containment (conduits and cable trays) used shall be metallic rather than plastic.

Conduits recessed in concrete, masonry or cement plaster can be plastic.

Cable trays with slots longitudinal to the length of the cable trays are recommended for carrying communication cables rather than caged or basket type cable containment.

Where screened or armoured cables are used the screen shall be earthed at both ends of the cable.

Follow IEC 61000-5-2 with respect to electromagnetic compatibility.



Follow IEC 60364-5-54 with respect to earthing and bonding.

Follow EN 50310:2016 Application of equipotential bonding and earthing in buildings with information technology equipment.

Follow IEC 60364-5-52 with respect to segregation of cables at various voltages from one another.

Total harmonic distortion shall be limited below 5%.

Single core power cables emanating from the secondary side of the transformers shall be armoured and armouring to be earthed at both ends to reduce magnetic coupling of the cables with structural steel reinforcement of the building.

Communication or Extra-Low voltage system cable shall not be run in the same cable tray or trunking as power cables

3.12 Earthing and bonding

1. High voltage and Low Voltage system earthing to be as per DEWA practice. In addition, safety requirements given below shall be met.
2. Equipotential bonding to be provided for all Group 1 and Group 2 Medical locations by providing equipotential bonding to all fixed medical equipment including service panels, pendants and bedhead units by bonding the metal frames or metal bodies of these equipment with the Earth Bonding bar (EBB). Refer to DEWA regulation Appendix 9 for the applicable conductor sizes for supplementary bonding.
3. Critical medical locations such as Operating Theatres shall have dedicated EBBs located near the Operating Theatre. For other areas EBB shall be in the respective sub-electrical rooms, where the final distribution boards are located.
4. Medical imaging and treatment locations requiring multiple supplementary bonding such as



CT Room, MRI Room and Radio Therapy Bunkers shall be provided with dedicated EBB.

5. Connections to the EBBs shall be carefully labelled and easy to inspect.
6. When earth mats are provided in Operating Theatres, the mat to be made continuous and should be connected to EBB.
7. Dedicated earthing jacks may be provided in critical care areas such as Operating Theatres, however these are not mandatory. (IEEE Std. 241)
8. IPS panels shall have a dedicated earthing as illustrated in the typical operating theatre earthing as illustrated in diagram E.3.2

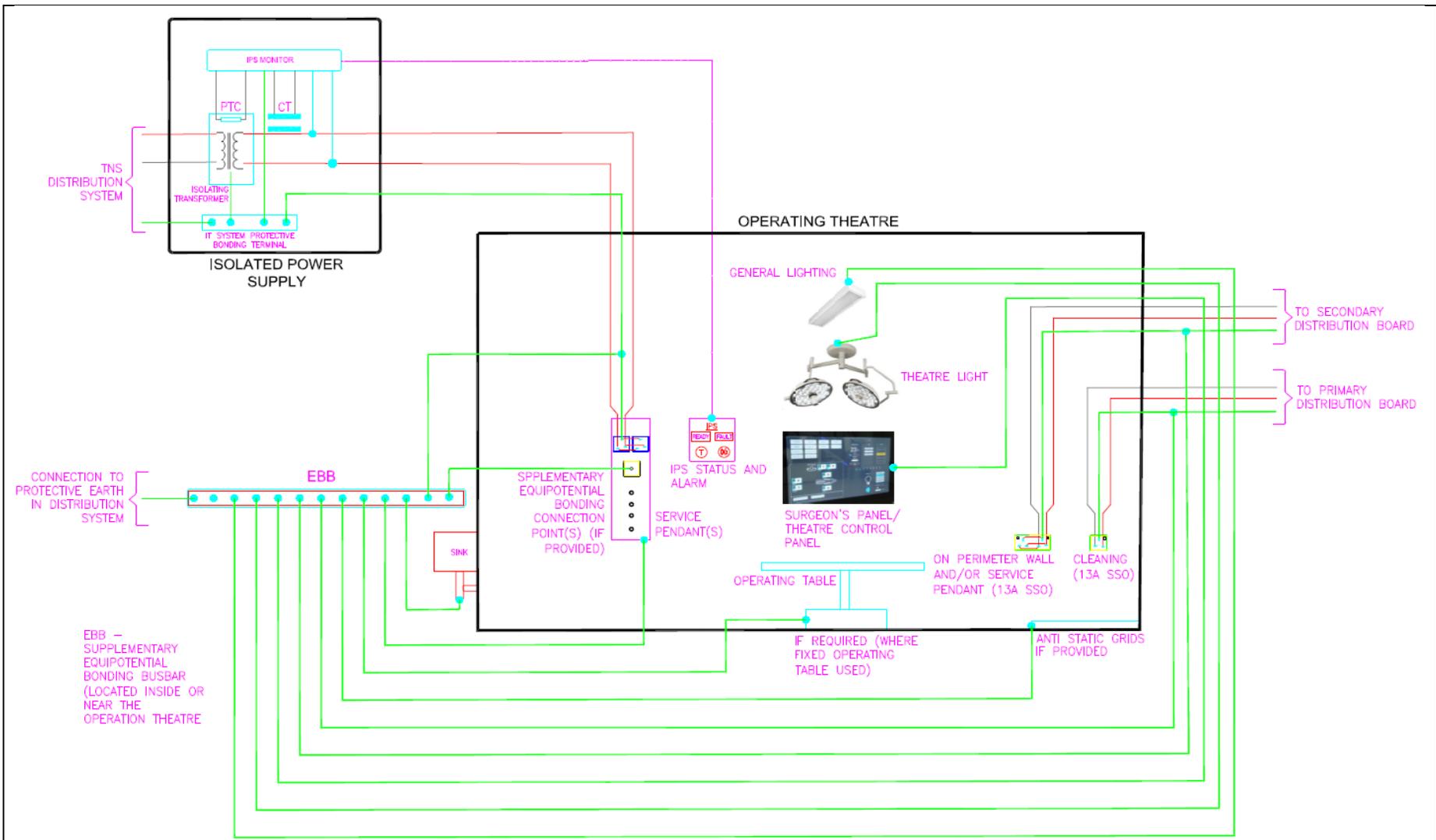


Figure E.3.2 Typical earthing arrangement for an operating theatre

3.13 Lightning protection

1. Lightning protection system for healthcare facilities to be designed based on IEC 62305.
2. The class of lightning protection required for the facility to be determined by the designer based on IEC 62305 Part 2.
3. Surge protection devices to be provided at the incoming of each main distribution boards (MDB).
4. Special consideration to be given for protection of electronic devices and medical equipment within healthcare facilities for damages from lightning strike. Surge protection devices (SPDs) shall be provided for submain electrical branch circuits serving critical medical and communication equipment. The surge protection device to be carefully selected based on the surge protection environment (defined in IEC 62305) in which it is located.

3.14 Containment and cables

1. Power supply distribution cables serving life safety equipment such as fire pumps, firefighting lifts and smoke management systems shall be fire proof as per local civil defence requirement, while SPS cables serving medical equipment other than life safety systems shall be same type of cables as used for PPS.
2. Wiring cables and power cables used in healthcare facilities shall be with LSOH insulation. Armoured power cables installed outdoor or buried underground shall be with PVC outer sheath.
3. Separate cable containment for PPS, SPS and TPS distribution is required for clinical risk grade A and B areas.
4. Isolated power supply (IPS) final circuits shall be provided with separate cable trunking and conduits.

5. Conduits used in clinical risk grade A and B areas are highly recommended to be of galvanized steel, while galvanized steel conduits are desirable in clinical grade areas C, D and E.
6. Separate containment to be provided for emergency lighting circuits.
7. Containment to be labelled suitably for ease of identification of services it carries.

3.15 Final circuits

1. Using of floor power outlet boxes in healthcare facilities shall be minimized due to housekeeping considerations. Where floor boxes are used in open public spaces, it shall be with stainless steel lid and suitable for wet mopping with lid in closed position.
2. Use of multi-plug extension cords are not permitted in healthcare facilities, as extension cords are prime cause for overloading of circuits and safety risks associated with it.
3. Primary (Normal) power supply sockets (13A) shall be identified with white rocker switches. Faceplate shall be either plastic or metal. Plastic faceplates shall be white coloured with white rocker switch. Where metal face plates are used, the rocker switch to be of similar colour as that of faceplate.
4. Secondary (Emergency) power supply sockets (13A) shall be identified with red rocker switches. Faceplate shall be either plastic or metal. Plastic faceplate shall be white coloured with red rocker switch. Where metal face plates are used, the rocker switch to be red.
5. UPS power supply sockets (13A) shall be identified with blue rocker switches. Faceplate shall be either plastic or metal. Plastic faceplate shall be white coloured with blue rocker switch. Where metal face plates are used the rocker switch to be blue.
6. Edges of Light switches and socket outlets shall be suitability spaced away from the medical gas outlets at any location so that medical gas outlet accessories do not obstruct the socket outlets.

7. USB charging sockets integrated with 13A socket outlets shall not be used in healthcare facilities. Where USB charging points are to be provided in public areas it shall be separate charging stations plugged into standard 13A sockets.
8. 13A Socket outlets indented for mobile x-ray machines in operating theatre shall not be fed from IPS, but from the primary or secondary power supply branch.
9. UPS backup shall be provided for operating theatre surgical lights.
10. UPS backup shall be provided for Operating Theatre IT equipment and Theatre Control Panel.
11. Socket outlets intended for highly sensitive medical equipment such as automated medication cabinets shall be provided with dedicated circuits.
12. All power outlets to be clearly labelled with respective final circuit reference.

3.16 Lighting

1. While designing healthcare lighting, follow detailed recommendations given in CIBSE Lighting Guide 2: Hospitals and healthcare buildings, 2008 or later version, by The Society of Light and Lighting.
2. It is recommended that lighting circuits serving Group 2 medical locations are protected by RCD or RCBOs with an earth leakage sensitivity of 30mA.
3. Lighting circuits shall not be connected to IPS circuits.
4. Night time orientation lights, mounted low level on wall, are recommended in patient bed rooms. These lights should be operable from patient location and from main door to the patient bed room.
5. In many clinical locations varying levels of lighting is required. Careful consideration shall be given to proposed clinical function of the area while determining the lighting control

approach and design of the switching circuits. It is always advisable to employ two switching circuits in any rooms having more than two light fixtures.

6. Follow CIBSE LG2 Table 1 for recommendations on lighting levels, colour rendering index, lighting control and standby lighting requirement.
7. Standby lighting (normal lighting backed up by SPS) shall be provided for all clinical risk grade areas A, B and C.
8. Clinical risk area Grade A shall be provided with Grade A standby lighting. (100% Luminaires supplied from SPS branch)
9. Clinical risk area Grade B and C shall be provided with Grade B standby lighting. (Around 50% Luminaires supplied from SPS branch)
10. Luminaire selections to be complementing the ceiling integrity in relation to infection control; detailed recommendations given under CIBSE Lighting Guide 2 to be adhered with.
11. Life safety emergency lighting to be provided based on local fire code.
12. Recommended illumination levels, colour rendering index, method of lighting control and grade of backup lighting is summarised in table

Room/Function	Illuminance (Lux)	Colour Rendering Index (%)	Recommended Lighting Control Method*	Lighting Grade (Section 3.16.8,9)
Emergency Unit				
Admissions/Reception	300	80	N	B
Stores	300	80	N/AL	A
Treatment Area	500	80	N	B
Minor Operation	500(15000 / 30000 Local)	90	N	B

Room/Function	Illuminance (Lux)	Colour Rendering Index (%)	Recommended Lighting Control Method*	Lighting Grade (Section 3.16.8,9)
Triage	500	90	N	A
Plaster Room	500	80	N	B
Procedure Room	500 (15000 / 30000 Local)	90	N	A
Resuscitation Room/Bay	500	80	N	B
Common and Circulation Areas				
Corridors (General)	200	80	S/AL	B
Entrance Canopy	50 (Min)	80	S/AL	B
Entrance Lobby	200 (Min)	80	S/AL	B
Library	300	80	S/AL	—
Lift Car	150	80	-	—
Lift Lobby	200 (Min)	80	S/AL	B
Loading Bay	100	80	S/AL	—
Reception Area	300	80	S/AL	B
Overnight Stay	150	80	S/AL	—
Lounge	150	80	S/AL	—
Shop/Kiosk	300	80	S/AL	—
Storage (General)	200	80	N/AL	—
Toilets	200	80	N/AL	—
Changing Room, Lockers	100–150	80	N/AL	—
Prayer Rooms	75-100	80	N/AL	—
Tutorial Room	300	80	N/AL	—

Room/Function	Illuminance (Lux)	Colour Rendering Index (%)	Recommended Lighting Control Method*	Lighting Grade (Section 3.16.8,9)
Consult/Exam Room	300	80	N	B
Disposal (Clinical, Domestic Waste)	200	80	N/AL	—
Doctor's Office	500	80	N/AL	B
Medication Room	500	80	N/AL	B
General Office	300	80	N/AL	B
Seminar Room	300	80	S/AL	B
Staff Change	100	80	N/AL	—
Staff Room	50/200	90	N/AL	—
Clean Utility	150	80	N	B
Dirty Utility	200	80	N	B
Critical Care				
Critical Care (Night)	5 (Max)	80	N/S	B
Observation/Night Watch	20	80	N/S	B
High Dependency Unit (HDU)	100	80	N/S	A
Intensive Care Unit (ICU)	100	80	N/S	A
Night Light	5 To 10	80	N	A
Simple Observation /Examination	300	80	N/S	A
Examination	1000 (Local)	90	N	A
Sterile Supply Unit (SSU)				
Decontamination and	500 (Local)	80	N	A/B

Room/Function	Illuminance (Lux)	Colour Rendering Index (%)	Recommended Lighting Control Method*	Lighting Grade (Section 3.16.8,9)
loading				
Maintenance (Including Rear of Cleaning Units)	200	80	N	—
Sterile Storage	150	80	N	—
Packing Area	500	80	N	B
Dental Unit				
Laboratories	500	80	N	B
Reception/Administration Areas	300	80	N/S	B
Dental Surgeries	8000 To 20000	90	N/S	A
White Teeth Matching	5000	90	N	B
Laboratory				
Aseptic Laboratory	300	80	N	B
Blood Bank	300	80	N	A
Colour Inspection	1000 (Local)	90	N/V	A
Cold Rooms	200	80	N	B
Inspection	500 (Local)	80	N	A/B
Laboratories	500	80	N	A/B
Relatives' Waiting Room	300	80	N/S	B
Seminar Room	300	80	N/S/V	B
General Treatment Areas				
Dialysis	500	80	N/V	B
General Storage Areas	200	80	N/AL	—

Room/Function	Illuminance (Lux)	Colour Rendering Index (%)	Recommended Lighting Control Method*	Lighting Grade (Section 3.16.8,9)
Teaching Areas	300	80	N	—
Administration (Medical Records)	500	80	N	—
Pharmacy	500	80	N	A/B
Morgue				
Autopsy Table	5000	90	N	—
Autopsy Rooms General	500	90	N	—
Body Holding Room	200	80	N	B
General	300	80	Sp	—
Staff Change	100 To 150	80	N	B
Store Room	150	80	N	—
Viewing Room	50/100	80	S/V	B
Waiting Room	200 (Min)	80	N/S	B
Linen Holding Unit				
Linen Store (Linen Department)	100	80	N	—
Pack and Dispatch	300	80	N	A
Pressing	300	80	N	A
Sewing Room	500 (Local)	80	N	A
Laundry	300	80	N	A
Delivery Unit				
Applying Sutures	1000 (Local)	90	N	A
Circulation Space (Day)	100	80	N	B

Room/Function	Illuminance (Lux)	Colour Rendering Index (%)	Recommended Lighting Control Method*	Lighting Grade (Section 3.16.8,9)
Delivery	500	80	N/S	A
Circulation Space (Day)	100	80	N	B
Day	50 To 100	80	N	A
Night	5	80	N	A
Nurseries (Day)	100	80	N	B
Nurseries (Night)	5	80	N	B
Formula Room	300	80	N	B
Special Care Baby Unit	1000 Local	80	N	A
Staff Station				
Day	300	80	N/S	A
Night	30/200	80	N/S	A
Interview	300	80	N	B
Operating Rooms				
Anaesthesia Induction Room	1000 (Local)	80	N	A
Anaesthesia Induction Room	500	80	S	A
Angiography Procedure Room	500	80	S/V	A
Endoscopy Procedure Room	300	80	S/V	B
Operating Room	1000	90	S/V	A
Operating Table/Cavity	10000 to 100000	90	S/V	A

Room/Function	Illuminance (Lux)	Colour Rendering Index (%)	Recommended Lighting Control Method*	Lighting Grade (Section 3.16.8,9)
Recovery – Stage 1	500	90	N/S	A
Scrub	500	80	N	B
Clean Utility	100 To 150	80	N	B
Dirty Utility	100 To 150	80	N	B
Allied Health				
Gymnasium	300	80	N/S	—
Hydrotherapy Pool	200	80	N	A
Physiotherapy	200	80	N/S	—
Rehabilitation	200	80	N/S	B
Ophthalmology				
Consult Room	300	80	S/V	B
Examination of Outer Eye	1000 Local	80	N	—
Reading/Colour Vision Test Screen	300	90	N	—
Vision Test Area	100 (Max)	80	S	—
Outpatient Unit				
Consult/Exam Room	300	80	N	B
Treatment Room	500	80	N	B
Medical Imaging / Interventional Cardiology / Nuclear Medicine				
Angiography	300	80	N/V	A
CT/MRI Scanning Rooms	300	80	N/V	A
ECG	300	80	N/S	A
Electro-Medical	300	80	N/S	A

Room/Function	Illuminance (Lux)	Colour Rendering Index (%)	Recommended Lighting Control Method*	Lighting Grade (Section 3.16.8,9)
Screening - Fluoroscopy	300	80	N/S	A
Isotope Store	300	80	N/S	B
Radiotherapy	100	80	N/V	A
Ultrasound	300	80	N/S	A
Mammography	500	80	N/V	A
X-Ray	300	80	N/S	B
Inpatient Unit				
Children's Play Area	300	80	N/AL	B
Circulation Space	100	80	N/S	B
Circulation Space (Night)	5	80	N/S	B
Treatment Room	1000 (Local)	90	S/V	A
Treatment Room	500 (General)	80	N/S	B
Staff Station				
Day	300	80	N/S	A
Night	30/200	80	N/S	A
Observation/Night Watch	20	80	N/S	B
Observation/Night	1 To 5	80	N/S	B
Mental Health Units	200	80	N/S	B
Patient Bed	300	80	N	B
Corridors (Day)	200	80	N/S/AL	B
Corridors (Night)	50	80	N/S/AL	B

Room/Function	Illuminance (Lux)	Colour Rendering Index (%)	Recommended Lighting Control Method*	Lighting Grade (Section 3.16.8,9)
* LIGHTING CONTROL				
N – Conventional On/Off Switching				
S – Multilevel switching with ability to control the lighting level in the room by selective On / Off switching of groups of luminaires				
V – Variable lighting output from luminaires				
AL – Automatic lighting control for energy saving				

Table E.3.3 Recommended Illumination Levels

3.17 System Testing, Commissioning and Operation

Equipment commissioning is an important phase in the project timeline and is critical in confirming that the design parameters are met by the installed system and the system meets the minimum code requirements and commissioned as per manufacturer recommendations.

For medium to large scale healthcare facilities an independent commissioning agent should be employed by the facility owner/client to oversee and integrate the commissioning process.

The following points should be kept in mind while preparing for commissioning of the systems for healthcare facilities.

1. Method Statements
2. Testing and Commissioning plan
3. Testing and commission shall be carried out by respective system manufacture's trained and authorized represented.
4. All testing and commissioning records to be included in the O&M documents. It is highly recommended that an online solution is deployed for O&M documentation for ease of retrieval and reference.

5. Routine testing of backup generators and UPS to be conducted at every 30 days or recommended by the manufacturer (whichever is shorter), and results recorded for verification during DHA inspections.
6. Training on the equipment installed should be conducted by the authorized representatives of original equipment manufacturer.
7. Routine maintained activities shall be carried out as per the respective system manufacturer's recommendation and easily retrievable records are maintained in the facility. Deployment of online software-based facility management solutions incorporating necessary maintenance modules are highly recommended, depending upon the nature of the facility.
8. Refer to DEWA regulation section 1.13 with respect to detailed requirement on routine inspection and maintenance of electrical distribution equipment. These requirements to be strictly adhered to and records shall be available in the facility for routine verification by DHA.
9. All critical system malfunctions to be monitored and all such events to be recorded and archived.

4. ELV and ICT systems

This document is intended for the Architect/Engineer (A/E) and others engaged in the design and renovation of DHA facilities. Where direction described in applicable codes are in conflict, the A/E shall comply with the more stringent requirement. The A/E is required to make themselves aware of all applicable codes.

The document should be read in conjunction with other parts of the Health Facility Guidelines (Part A to Part F) & the typical room data sheets and typical room layout sheets.

4.1 Introduction

ELV and ICT systems play a key role in efficient and safe operation of any Healthcare facility. With the advent of multitude of systems and approaches and fast evolving technologies it is not prudent to mandate specific design criteria in this guideline for ELV and ICT systems. The following section provides general guidance to the designer during the design of various ELV and ICT system in healthcare facilities from a functional point of view.

The LAN Infrastructure shall provide IP connectivity for several services, which may require being isolated from one another from an application point of view while sharing the same physical network. The applications include but not limited to Voice, Data, CCTV, Video, Public Address, Digital Signage, Nurse call, Central Clock, queuing systems, HIS, PACS and others. The IT infrastructure shall be flexible high capacity network capable of providing virtualized services to IP unicast and multicast applications. The IT network must be highly dependable and provide sub-second recovery in the event of any component, node or link failure.

4.2 ICT Network

The following key objectives to be considered for the Medical Grade Network (MGN) design and its implementation for healthcare facilities. Follow standard ISO/IEC 11801 – “Information technology, Generic cabling for customer premises”; with respect to structured cabling.

1. **High Availability & Resiliency:** Due to the mission critical nature of many of the systems that will run on the IT network, fault tolerance and resiliency are mandatory requirements in all aspects of Design. The solution must be designed with No Single Points of Failure: link redundancy, power redundancy and core switch redundancy are essential. The network should be available at all times and should not be severely affected in the cases of component failures. LAN switches must support state of the art and latest LAN technologies.
2. **Security:** The network design shall have capability for virtualizing and segregating users and services in isolated zones over the same physical network. In addition, the proposed solution should be capable of protecting network from traditional IP hacking and IP exposure. IT security to be considered during the design and implementation and to be verified as part of completion sign-off.
3. **High Performance:** The Network should be able to support latency sensitive applications by using low latency switches that can support optimal topologies to reduce number of hops through the network. In addition, the proposed network should be fully active-active load sharing with no idle hardware or links.
4. **Convergence:** It is recommended that a highly resilient converged Network Infrastructure is planned for healthcare facilities than several individual semi-resilient networks. Each virtual network shall have own firewalls to avoid hopping from one virtual network to another.
5. **Scalability:** The network shall be designed in a way that allows for smooth future growth and scalability. Scalability is required to guarantee the support for future applications, users,

traffic, technologies, etc. without the need for major upgrades, or restructuring. Future technologies such as 40G & 100G may be considered.

6. **Simplicity:** The network design solution shall provide automated end to end configuration of services with minimal human intervention. SDN (Software Defined Networking) and configuration automation technologies shall be capable to expand to the campus and remote sites where users and network devices exist.
7. **Manageability:** Manageability is an essential requirement. All aspects of the solution should provide a method of Centralized Control via SNMP Management as well as the normal switches management features through console interface, web-interface. All management features should be integrated in the switches whether on the backbone or the edge switches. Simplicity of the design is an important advantage. Intelligent patch panels are recommended for large facilities with over 3000 network points.
8. **Open Standards:** The network design and technology shall be based on open Standards and only use IEEE or IETF certified protocols to allow interoperability with other vendors supporting the same standards such as HL7 and DICOM. Proprietary protocols and mechanisms are not desirable.
9. **Product & Technology Reliability and Maturity** is a critical factor that should be considered during the implementation. Vendor's technologies and approaches must be proven in live implementations prior to their deployment in any healthcare facilities.
10. **Multicast Enabled Architecture:** The IT network shall support multiple virtual IP multicast routed domains with complete traffic separation between them.
11. **Medical Devices security and tracking:** The network shall be capable of providing security and ease of mobility and tracking for expensive medical equipment that may need to be relocated across the healthcare facility, and to provide automated SDN based deployment

to centrally manage, configure, and secure those devices.

12. Bandwidth requirements to be carefully considered when determining the topology of the network and data storage requirements. Bandwidth and data storage requirement to be calculated based on the systems and number of modalities anticipated in the facility. Systems such as PACS require high amount of bandwidth requirement while systems such as Laboratory Information Systems or Central Clocks may require only limited bandwidth.
13. Fully redundant and resilient converged network is preferred over a number of individual networks supporting different systems. However, high bandwidth systems such as CCTV together with access control may be in a separate network.
14. All ICT and ELV equipment located in the clinical areas shall be specifically designed for the intended application especially with respect to safety and infection control.
15. Data storage capacity shall be planned for a minimum of 6 years operation of the facility during the initial build. Additional off site storage is also recommended.
16. The main data storage and server room for the facility shall not be located below grade level.
17. A typical network topology that will provide enhanced level of availability and network redundancy is illustrated below.
18. When public WIFI access is provided in the facility, this should be implimented though Captive Portals.
19. Where cloud storage is considred it should be compiant to TRA information security policies.

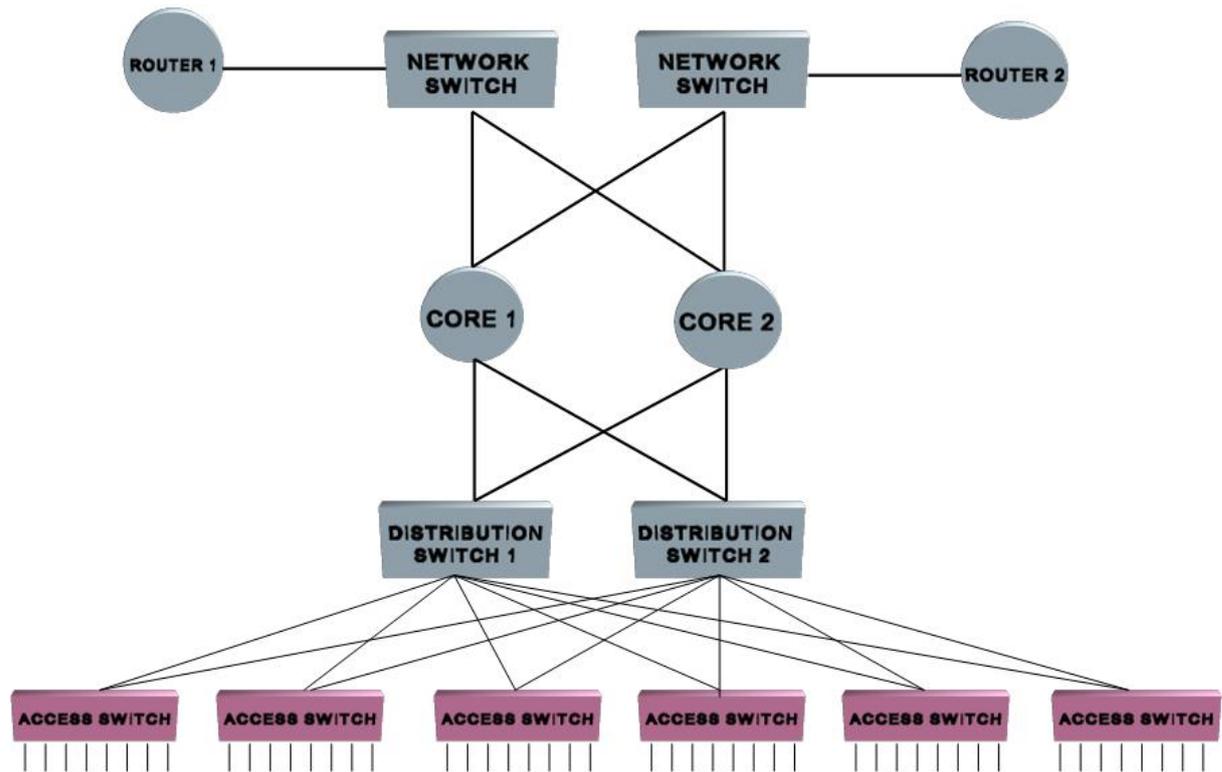


Figure E.4.1 - Typical IT Network Topology

4.3 Nurse Call Systems

1. Nurse call system shall be provided in all healthcare facilities to suite the level of care provided in the facility. This guideline recommend that the component terminologies and its basic functions are standardised as follows.

Annunciator - Desktop Console (AN-DC): This unit is intended to be located at the nurse stations for receiving calls and alarms from different patient and staff locations. This unit is recommended to have bi-direction speech capability with patient privacy in mind.

Annunciator - Room Lights (AN-RL): These are colour coded lights above or beside each main entrance to the area/room where the Nurse Calling devise is located, to assist the responder to reach the originator of the call quickly and efficiently.

Annunciator - Corridor Display (AN-CD): Corridor displays, alphanumerically indicating the origin and nature of a call from the patient or other staff member greatly help in

efficiently responding to an emergency call. Depending up on the specific configuration of the clinical department corridor displays may be required. This can be either dedicated linear LED displays or can be integrated into strategically positioned IPTV screens if seamless integration of the two systems are implemented.

Patient call with handset (PC-H): These devices shall be located in in all patient locations where the patients are likely not attended by a staff member continuously. This unit shall comprise of a fixed unit at the bed head with Staff Assist button, Speaker, Microphone and Emergency Call buttons in addition to the jack for plugging the patient handset. The patient handset shall have a minimum of easily identifiable nurse call button to originate a call to the associate nurse station, speaker and microphone for bi-direction communication with nurse and reading light control. The handset to be durable, simple and easy to use and disinfect.

Patient call without handset (PC): These units shall be used in areas where all functioning of PC-H (above) is desired other than the function of the handset. This will be a wall mounted unit.

Patient call – En-suite [Toilet] (PC-E): These units are used to initiate an emergency alarm call from the patient toilets to the associated nurse station. These call buttons are to be easily visible and recommended to be located at low level in the patient toilets reachable from shower area as well as from WC. One or two buttons shall be provided depending up on the configuration of the toilet. These units shall be water proof and designed to be located at wet locations. Ceiling mounted call units with pull cords are not recommended.

Staff Assist Call (SAC): These devices are intended for staff at a patient location to seek additional help from other staff members. This button may be integrated with a common

face plate providing other functions or can be on a separate face plate depending up on the product design by the manufacturer.

Staff Presence (SP): This is an optional device that can be provided at the entrance to a patient bed room for activation by a staff member to indicate someone is already attending to the patient. The annunciator room light above the door shall indicate the nurse presence. This module can be either an independent button or can be integrated to other modules forming part of any workflow solution the end user may optionally include for efficient functioning of the facility.

Emergency Call (EC): Emergency Call buttons are intended for clinical staff to escalate an emergency by alerting other relevant staff members for additional help. Activation of the emergency call (EC) button shall generate an audible tone-based alarm, at the associated staff station and other designated mobile devices, along with alphanumeric display indicating the nature and location of the call. The emergency call button can be a separate unit or integrated into a console including buttons for other nurse call system functions. Emergency calls should only be cancellable from the patient location where the call was originated.

Wireless Handset (WH): Wireless handsets to receive nurse call system audio calls and alert text messages are recommended for use of staff members on the move within departments. A minimum of two wireless units are recommended at each supervision station; this quantity to be increased based on the number of anticipated staff members on the move within the department.

2. Refer to the RDS (Room Data Sheets) included under Part B of this guideline for the recommended Nurse Call System devices for various clinical locations.
3. Additional optional functions to facilitate workflows and patient monitoring may be provided

as part of the nurse call systems.

4. There shall be interface between the fire alarm system and nurse call system to discretely alert the respective Nurse Stations of any fire detection events.
5. Where IP based communication is used by the Nurse Call system, the Nurse Call System may share the facilities' hospital grade IT backbone network.
6. It is recommended that the nurse call system has the capability to relay alarm text messages from the Nurse Call system to mobile devices such as IP Phones in the facility or over mobile phone data networks and over facility WIFI network.

4.4 Central Clock Systems

1. Central Clock Systems are recommended in critical care and relevant public areas of the hospital for unified time referencing. The system comprises the following components in general.

Master Clock Unit: The function of this unit to accept time references inputs over GPS and NTP and relay time reference signals to time display clocks located at various locations in the facility.

Clock Displays: These devices will display the unified time based on the input received from the master clock unit. The clock display can be either analogue or numerical. This guideline recommends clocks with numerical displays where medical procedures takes place, while analogue displays in public areas (where provided).

Due to reliability considerations it is recommended that clocks are wired type powered using POE. Where POE facility is not available local power supplies or battery cells may be considered.

Clocks with additional functions such as elapsed time displays are required in operating

theatres. The reset button for these elapsed clock function to be located at an accessible height.

2. Refer to the RDS (Room Data Sheets) included under Part B of this guideline for the recommended locations of clock displays.

4.5 CCTV and Access Control

Healthcare premises pose unique challenges to ensure security due to the presence of people under mental stress, high value equipment and sensitivity of medical data. To mitigate this risk a carefully designed and implemented CCTV and Access Control system to be provided for healthcare facilities. The coverage and complexity of the system will depend up on the type of facility. The following section provides a brief on general considerations to be made while designing CCTV and Access Control Systems for healthcare facilities.

1. CCTV system design and installations shall meet the requirements of local law enforcement agencies with respect to equipment standards, coverage, monitoring and data storage requirements. In addition, the requirements given hereunder shall be considered during the design.
2. Patient privacy to be considered while deciding the location of CCTV cameras. Cameras shall not be installed in areas where patient privacy may be compromised.
3. CCTV coverage shall include the following areas but not limited to;
 - Inside medication rooms.
 - Outside medication rooms covering entrance door.
 - Inside laboratories
 - Inside blood storage rooms
 - Common corridors

- All entry and exits
- Emergency Room waiting areas and reception
- Pharmacy, medication dispensing areas
- Loading dock and receiving areas
- Cash counters
- Waiting areas
- Nursery
- Body storage areas
- Individual department main entrance doors
- Staff/Nurse stations
- Staff rooms
- Inside enclosed fire exit stairs
- Outside public toilet main entrances
- Inside Hot Labs
- Nursery
- Entrance to technical rooms
- Inside main MEP plant rooms
- In lift lobbies and inside lifts
- Sterile Supply Unit
- Also refer to RDSs provided under Part B of the this HFG.

4. In addition to the CCTV system cameras provided for the general security surveillance, there may be CCTV real time monitoring required in imaging and radiotherapy areas from the respective treatment control rooms. Such monitoring systems are not required to be

connected to the central CCTV system. These monitoring systems are recommended to be provided as part of medical equipment scope of supply and be positioned as per respective medical equipment manufacturer's recommendation.

5. All security system equipment including cameras shall be provided with UPS backup. CCTV cameras may be powered using POE. Associated network switches shall be provided with UPS power backup.
6. Primary CCTV surveillance for any required area shall be provide by means of fixed cameras, where additional secondary means of surveillance is required, such as main entrance hall, shall utilize PTZ cameras.
7. Electronically access controlled doors in the fire escape route shall be interlocked with the fire alarm system through normally closed contacts in the fire alarm interface units.
8. It is recommended that the security management system software have the capability for real time integration of the CCTV, access control, asset management and infant protection systems.
9. It is advisable that the CCTV system covering outpatient waiting areas have the capability to display live video from the waiting areas on the consultant's computer workstation in a web browser to provide the Consultant Doctor a visual reference to the waiting areas when required.
10. Access control system employing RFID cards/tags and readers that use encrypted message transfer are recommended. Finger print biometric readers requiring touch to scan the finger prints are not recommended in healthcare facilities due to infection control reasons.
11. The access card reader or door open switch for electrically operated swing doors located in the circulation corridors shall be placed 2400mm before the door to facilitate ease of operation while transferring patients on stretchers or beds.

12. Separate IT network may be considered for the IP CCTV network and access control due to operational and security authority requirements.
13. Where RFID based or RTLS asset management systems are provided, it is recommended that asset management system is interfaced with access control system to avoid items moving out of designated areas.
14. Infant Protection System employing trackable tags shall be implemented for maternity wards and nursery. Such system shall be interfaced with access control system to lock down in case of any security breach.
15. Electronic access control is recommended for the following areas. However, the exact provisioning of the access control to be based on the specific security strategy and work flow employed for the project based on the proposed layout of the facility. The following list act only as a general guide.
 - Fire exist doors leading to fire exit staircases.
 - Medication rooms
 - Clean utility
 - Dirty utility
 - Electrical, mechanical and ICT rooms
 - IT server room/data centre
 - Imaging rooms
 - Department entrances
 - Staff only corridors
 - All entries and exits to outside
 - Pharmacy

- Cash counters
- Entrances to back offices, insurance offices
- MRI Zones
- Radiotherapy areas
- Entrances to staff only areas
- Medical records
- Isolation rooms
- Nursery
- Air lock area between dirty and clean areas in Sterile Supply Unit (SSU) (with interlock so that only one door can be opened at a time)

16. Discrete Panic Alarms to be considered, as a minimum, at cash counters, emergency department reception and main reception. Expanse of the panic alarm coverage should be reviewed based on the security assessment for the facility and further alarms to be provided based on the assessment.

17. Where electronic access control is provided in fire escape routes suitable failsafe interlock to be provided to ensure the locks are released or lock overriding facility is available in case of any emergency. Such doors to be alarmed and monitored from the main security room.

4.6 Patient/Medical Equipment Monitoring

Many of medical equipment used these days are having the facility to transmit alarms and monitoring data over IP networks for clinical use and for equipment maintenance purposes. For safe and efficient operation of healthcare facilities such monitoring information should be efficiently managed and should be readily retrievable. To facilitate this, data outlets to be provided throughout the facility near to all locations where such medical equipment are intended to be used. In addition,

wireless LAN coverage to be available throughout the facility for connecting mobile monitoring equipment likely to be hooked to patients. Refer to the RDS (Room Data Sheets) included under Part B of this guideline for the recommended number of Data Outlets at various locations.

1. It is recommended that medical equipment requiring monitoring including fridges and freezers are provided with wired data appoints for connection to centralized medical fridge/freezer monitoring system than a wireless monitoring system.
2. It is highly recommended that patient tagging system employing trackable tags (RFID / RTLS) are implemented for psychiatry and geriatric wards. Such system shall be interfaced with access control system to lock down in case of any security breach.

4.7 Intercom Systems

Audio or Audio/Video intercom system to be provided as required to suite the workflow and security strategy employed by the designer. IP based solutions are recommended for better operational flexibility. The intercoms functioning in conjunction with the access control system shall have facility to unlock the associated doors.

Intercoms are recommended for;

1. Entry doors normally locked by electronic access control system and required to be occasionally accessible for persons without valid access cards. (Between unsecure side and designated door operator)
2. Radio therapy rooms. (Between control room and patient in treatment position)
3. Computed Tomography (CT), rooms (Between control room and patient in imaging position)
4. Magnetic Resonance Imaging (MRI) rooms (Between control room and patient in imaging position)
5. Isolation rooms (Between outside the entry door and patient position)

6. Loading docks
7. SSU (Sterile Supply Unit), between dirty and sterile area

4.8 Patient Infotainment Systems

Suitable patient entertainment facilities are recommended in patient bedrooms and at locations patients are likely to be stationed for extended period.

1. The patient infotainment provisions may include but not limited to facility to view main stream television channels, video on demand, patient education videos, hospital department information, dietary menus, Audio/Video Communication etc., based on the type of the facility.
2. The interface to access the infotainment information can be suitably positioned medical grade Smart Television Screen connected to IPTV network. In addition, optional medical grade PDA, networked over wireless LAN, of suitable size may be provided. When portable PDAs are provided appropriate docking, station incorporating charger and security lock is recommended. The docking station to be fixed adjacent to the patient location. The PDAs may be tagged with asset management system for additional asset tracking. When PDAs are provided it should not be shared with staff for accessing clinical data due to infection control reasons. Where wireless PDAs are opted for patient infotainment, the wireless access coverage and bandwidth requirements to be carefully coordinated to ensure a seamless user experience. A suitable mounting mechanism to be provided, preferably mounted on the bedside table.
3. Use of mobile phones to be carefully regulated in healthcare environment. A total ban on mobile phone throughout the entire healthcare facility may not be practical nor required. However, use of mobile phones should not be allowed near critical life support medical

equipment and critical care areas. Healthcare facilities shall develop their own mobile phone usage policies considering the above and display necessary signages at mobile phone restricted areas.

4.9 Queue Management System

Queue management systems are recommended be provided in areas such as outpatient waiting, pharmacy and other areas where visitors / patients are having to wait for their turn. The queue management system shall be a consolidated solution integrating different waiting areas of the hospital so that tokens can be transferred from one system to other. The proposed solution may have the following components and functions.

1. Token dispensing station shall be either standalone or at suitable location attended by the staff members for better efficient utilization of the system and work flow.
2. Waiting area display: This can be a suitably sized LED panel screens to display the token number along with associated counter or room number. These screens are recommended to be integrated with IPTV system of the facility to play television or patient education content. Sufficient number of waiting area displays shall be provided for ease of viewing. Auditable automatic token number announcements could be avoided for maintaining a quieter ambiance.
3. Counter/room number display: This can be suitably sized displays conveniently placed near the individual locations such as pharmacy counters to display the counter number and attending token number. Individual electronic counter displays may be provided for areas such as pharmacy or registration counters, however electronic counter displays may not be suitable for areas such as consulting rooms; in such cases normal (passive) alpha-numeric room number signage can be provided near the entry doors.

4. It is recommended that the calling station used by the staff are software based, and can be operated from computer workstation screens, rather than dedicated hardware with keypad. Standalone calling station units shall be used at locations where computer workstations are not used.
5. The system management software should have capabilities such as real time monitoring dashboards, overall performance reports, individual employee performance reports, service quality levels, SMS alerts etc.
6. It is recommended that the Queue management system also have the facility to accept and record customer experience feedbacks by incorporating suitable hardware and software.

4.10 Asset Management Systems

1. Depending up on the Enterprise Resource Planning (ERP) for the healthcare facility electronic means for tagging assets are highly recommended. The asset management system may employ any combination of the following technologies.
 - Real Time Location System (RTLS)
 - Radio Frequency Identification (RFID) - Active and/or Passive
 - Bluetooth Low Energy (BLE)
2. The choice of technology employed largely depended on the type and size of healthcare facility. The choice of asset tracking technology to be decided during the early stage the facility design, so that appropriate infrastructure is made available. Whilst, designers are encouraged to embrace modern innovative technologies for improved patient care delivery it is important to ensure that the selected solution is proven and reliable. Designs shall pay special attention to ensure only healthcare grade tested solutions are deployed in healthcare environments.

3. Healthcare facilities having maternity and neo-natal departments shall be provided with infant protection system. This system shall be interfaced with the access control system to set off alarms and activate selected door locks.

4.11 Health Information System (HIS)

1. Dubai Health Authority is responsible for Health Information Interoperability Standards in the Emirate of Dubai. All Health Information System (HIS) software deployed in the healthcare facilities shall follow the Health Information Interoperability Standard issued by DHA.
2. The objectives of the Interoperability Standard are as follows;
 - To serve and establish a cooperative partnership between the public and private sectors to achieve a widely accepted and useful set of standards that will enable and support widespread interoperability among healthcare software applications in a city-wide eHealth Information Network for the Emirate of Dubai.
 - To harmonize relevant standards in the healthcare industry to enable and advance interoperability of healthcare applications, and the interchange of healthcare data, to assure accurate use, access, privacy and security, both for supporting the delivery of care and public health.
 - Interoperability contributes to enhanced healthcare delivery facilitating continuity of care and better decision making while delivering cost savings. Interoperability is seen by the Dubai Health Authority as a state of readiness to deal with new technologies, clinical practices and changes in policies. DHA's aim is to provide a standardized coding system for describing the specific items and services provided in the delivery of health care in the Emirate of Dubai. Refer to the DHA interoperability standard for further details on standardization of coding.

- Compiling population health data for research, analysis and improvement measures to enhance the health level of the population of Dubai.
3. The HIS system provided for the healthcare facilities shall be HL7 and DICOM compliant, to enable seamless exchange of data between the healthcare facility HIS, other healthcare facilities and EMR system of Dubai.
 4. The basic de-identified information that will have be shared with DHA, will include but not limited to services provided, lab reports, radiology reports, admission and discharge and other information updated by DHA from time to time. Certain information may remain confidential at each facility as informed from time to time by the DHA. As a minimum the HIS must have the above-mentioned capabilities until such time as the DHA declares the detailed requirements. The health information record sharing with other health facilities is subjected to the consent from the patient with option to opt-in or opt-out anytime.
 5. HIS Coding and terminology employed by the healthcare facilities to describe specific items and services for delivery of healthcare shall be in standardised in accordance to latest version of Health Information Interoperability standard from DHA.
 6. Whilst EMR system increase the safety and efficiency of healthcare delivery, concerns related to patient data privacy to be carefully addressed. In additional to data encryption the key to preserving confidentiality is to allow only authorized individuals to have access to the information.
 7. Authorization levels and accountability to be clearly defined in healthcare facility HIS manuals and thoroughly implemented. Assigning user access privileges is a major aspect of medical record security. Strong privacy and security policies are essential to secure patient's information.

8. Cloud service provider for the healthcare facility shall have the following;
 - a. Cloud based data storage must be local and within the boundaries of the UAE. Any exceptions has to be approved by the Minister of MoHAP in coordination with relevant Healthcare Authority.
 - b. Cloud service provider must be classified as Tier 3 or above.
 - c. It is recommended that the Cloud service provider has HIPAA (Health Insurance Portability and Accountability Act) - compliant business associate agreement (BAA). This is optional for the first two years and it will become compulsory afterwards.
9. Information Governance and Risk Management Framework shall include third party auditing for;
 - a. Implementation plan for ISO 270001 with a grace period of 2 years.
 - b. Data sharing agreements.
10. Electronic Medical records of the healthcare facilities shall have;
 - a. Certified by DHA (within 2-3 years) of hospital opening.
 - b. Government's data submission requirements shall be fulfilled.
 - c. Audit trail and Role-based access is required.
 - d. PHI encryption to be employed.
 - e. Third party review (Dubai Electronic Medical Record Adoption Model, EMRAM).
11. Data Breach Reporting procedure shall be implemented based on the following.
 - a. Healthcare facilities shall report any healthcare data breach incidents that are caused by theft, loss of computers of devices, cyber-attacks, negligence, etc.

- b. Patients can also report suspected data breach incidents or miss-use of their protected healthcare data
 - c. DHA has the right to investigate these incidents and apply the articles of the Federal Law no. 2019 on ICT usage for Healthcare.
12. All healthcare facilities existing as well as newly proposed are required to enhance the HIS system of their facilities to comply with the DHA interoperability standards by end of year 2020.

4.12 Fire detection and signalling

Fire detection and signalling to be provided as per local civil defence requirement. This include fire detection and alarm systems comprising detectors, sounders, alarm speaker and strobes. In addition, the following healthcare specific design recommendation to be considered during the design.

1. Critical care areas where patients are not normally mobile and likely to be connected to medical equipment are not required be provided with audible means of alarm sounders or speakers to avoid panic. Such areas shall be provided with discrete means of fire alarm notification at the corresponding nurse stations, by providing fire alarm repeater stations at the nurse/supervision stations. In addition, interface shall be provided between Nurse Call System and Fire detection system to alert staff of any fire alarm incidents.
2. Alarm speakers or strobes are not required in operating theatres. Associated nurse station to be alerted of a fire condition though discrete means.
3. Fire alarm and signalling system cables used in the health care facilities shall be “enhanced” grade not standard grade.

4.13 Public Address System

Public address System is recommended in healthcare facilities for broadcasting call for prayer, background audio, announcements etc. in areas such as waiting areas and circulation corridors. Staff paging over public address system is not encouraged. Discrete staff paging over wireless network is recommended.

1. Acoustics characteristics of the built environment shall be taken into consideration while designing public address systems to ensure audio intelligibility. Zone wise volume control shall be provided so that different volume levels can be set depending on the areas. Volume control knobs shall be placed near respective supervision stations. IP based solutions are recommended over conventional analogue systems.
2. The public-address system to be zoned to suite the operational requirements of the facility. Such zoning to be agreed with the stake holders during the initial phase of the design to ensure cabling is designed to suite.

4.14 System Testing, Commissioning and Operation

The system commissioning is an important phase in the project timeline and is critical in confirming that the design parameters are met by the installed system and the system meets the minimum code requirements and commissioned as per manufacturer recommendations.

For medium to large scale healthcare facilities an independent commissioning agent should be employed by the facility owner/client to oversee and integrate the commissioning process.

The following points should be kept in mind while preparing for commissioning of the systems for healthcare facilities.

1. Method Statements
2. Testing and Commissioning plan

3. Testing and commission shall be carried out by respective system manufacture's trained and authorized represented.
4. All testing and commissioning records to be included in the O&M documents. It is highly recommended that an online solution is deployed for O&M documentation for ease of retrieval and reference.
5. Training on the systems installed should be conducted by the authorized representatives of original equipment/system manufacturer.
6. Routine maintained activities shall be carried out as per the respective system manufacturer's recommendation and easily retrievable records are maintained in the facility. Deployment of online software-based facility management solutions incorporating necessary maintenance modules are highly recommended depending upon the nature of the facility.

5. Public Health – Water Systems Design (WS)

This PH-WS design guideline written for DHA healthcare facilities, is a consolidated document listing out the design requirements for all new construction and major renovation healthcare projects, within the Emirate of Dubai, under the licensure of DHA.

Water supply is an essential for every development. In healthcare facilities, the importance of clean hygienic, and a good quality of water are critical. This has an impact on infection control parameters, equipment, staff and patients. Potable water supply must be treated and monitored to ensure that bacteria such as legionella is eliminated. Hence, the temperature maintenance and treatment of water in healthcare facilities play a pivotal role.

The requirements outlined in these guidelines are not intended to conflict with Federal Regulations, Local Municipality Laws, Executive Orders, or the needs of the end users.

This document is intended for the Architect/Engineer (A/E) and others engaged in the design and renovation of DHA facilities. Where direction described in applicable codes are in conflict, the A/E shall comply with the more stringent requirement. The A/E is required to make themselves aware of all applicable codes.

The document should be read in conjunction with other parts of the Health Facility Guidelines (Part A to Part F) & the typical room data sheets and typical room layout sheets.

5.1 Aim & Objectives

The Aim of this section of the guidelines is to promote the correct design of water systems for healthcare facilities in the emirate of Dubai, under the jurisdiction of the Dubai Health Authority (DHA).

The scope of the Water Systems design will include the following:

- Potable Cold-Water System
- Potable Cooled-Cold Water Systems
- Water Treatment System
- Hot Water Systems
- Healthcare Sanitary Fittings
- Irrigation Systems
- Grey-Water Systems
- Steam Systems

5.2 General

1. The design, installation and commissioning of the potable water systems are very critical for healthcare facilities. Especially for patients, visitors and operators. Many systems and operations in healthcare facilities are dependent on clean, treated water being provided for patient and staff as well as for the use of medical equipment.
2. Reliability and resiliency of water system is also crucial. Thus, it is important to ensure that disruption in water supply from the network or via main storage tanks are eliminated or reduced to the lowest risk possible. The designer for healthcare facilities needs to be aware that many activities within any healthcare facility depend on clean uninterrupted water supply. The engineer needs to ensure that although there may be a requirement of providing sufficient water storage, the engineer needs to take note that there must also be sufficient water movement to prevent water stagnation in the storage tank and the pipe system.
3. To ensure clean, safe hygienic water, the discussion of the control of waterborne pathogens must be considered. *Pseudomonas Aeruginosa* is where water outlet to patient transfer can take place. Generally, serious *Pseudomonas* infections occur in patients, visitors and hospital

operators staff within healthcare facilities. Therefore, water treatment as well as the monitoring of water within healthcare facilities is a must to ensure the correct water quality is provided.

5.3 Design Codes & Standards

The water system will be designed in accordance with the latest edition and requirements of the relevant standards, codes and guidelines issued by Dubai Authorities having jurisdiction and internationally recognised institutions including but not limited to the entities listed below. Where there is a conflict between local and international standards, then the one that falls in line with the Dubai Health Authority guidelines shall take precedence.

Code Reference	Description
	Local Standards
Water Network	Dubai Electricity & Water Authority Regulations
Water & Drainage for Buildings	Uniform Code of Plumbing, Abu Dhabi
DHA	Dubai Health Authority - Guidelines
Al Sa'fat	Dubai Al Sa'fat Green Building System
	International Standards
BS EN 805	Water Supply System
BS 6700	Design, Installation, testing and maintenance of services supplying water for domestic use within buildings.
BS EN 12201	Polyethylene Specification for Water Systems
BS EN 1057	Copper Specification

HTM 04-01	Safe water in healthcare premises. (Part A, B, C & D)
HTM 07-04	Water Management & Water Efficiency Best Practice for Healthcare Sector
HBN-13	Sterile Services Department (SSD or CSSD)
HBN-07-01 & 02	Satellite Dialysis Unit & Main Renal Unit
IoP	Institute of Plumbing – Plumbing Engineering Services Design Guide
IPC	International Plumbing Code
UPC	Uniform Plumbing Code
ASPE	American Society of Plumbing Engineers
CIBSE Guide G	Chartered Institute of Building Services Engineers Guide - Public Health & Plumbing Engineering Guide
ASHRAE Applications	American Society of Heating & Refrigeration Air Conditioning Engineers Applications, Chapter 50
HSE – L8	The control of legionella bacteria in water systems.
WSR – 1999	Water Supply Regulations (Water Fittings) 1999 (U.K)
Laboratory Safety Guidance – OSHA	Laboratory Safety Guidance – OSHA
NRC	Nuclear Regulatory Commission (NRC)
WHO-1	WHO - Guidelines for Drinking Water Quality
WHO-2	WHO - Guidelines for Safe Recreational- Water Environments Vol 2 - Chapter 5 - Managing Water & Air Quality

5.4 Glossary & Abbreviations

Above Ground Installation – System installations that are not buried, i.e. within the basement space and floors above.

Backflow – Flow upstream, that is in a direction contrary to the intended normal direction of flow, within or from a water fitting.

Biofilm – a complex layer of microorganisms that have attached and grown on a surface. This form of growth provides a niche environment for a wide range of microorganisms to interact and where the secretion of exopolysaccharides by bacteria will form an extracellular matrix for both bacteria and other unicellular organisms such as amoebae and flagellates to remain in a protected state.

COSHH – Control of Substances Hazardous to Health [Regulations]

CQC – Care Quality Commission

Dead-leg – a length of water system pipework leading to a fitting through which water only passes infrequently when there is draw off from the fitting, providing the potential for stagnation.

DEWA – Dubai Electricity & Water Authority: The authority responsible for the safety of water that establishes good practices in local water distribution and supply. It will identify potential hazards, consider practical aspects, and detail appropriate control measures. They are the governing body for potable in the Emirate of Dubai.

DHA – Dubai Health Authority

DWI – Drinking Water Inspectorate

Healthcare-associated infections (HCAI) – encompasses any infection by any infectious agent acquired as a consequence of a person’s treatment or which is acquired by a healthcare worker in the course of their duties.

Healthcare facility/building – all buildings, infrastructure, equipment, plant, embedded systems and related items that support the delivery of healthcare and services of all types, irrespective of their ownership or operation by third parties.

Healthcare Operator: organisations that provide or intend to provide healthcare services for the purposes of the DHA.

HSG274 Part 2 – The Health & Safety Executive’s technical guidance on the control of Legionnaires’ disease in hot and cold-water systems

HTM – Health Technical Memorandum

Point-of-use (POU) filter – a filter with a maximal pore size of 0.2 µm applied at the outlet, which removes bacteria from the water flow.

Redundant pipework (also known as blind end): a length of pipe closed at one end through which no water passes.

Thermostatic mixing valve: valve with one outlet, which mixes hot and cold water and automatically controls the mixed water to a user-selected or pre-set temperature.

Waterborne pathogen: microorganism capable of causing disease that may be transmitted via water and acquired through ingestion, bathing, or by other means.

Water outlet: (In this document) refers mainly to taps and showerheads, but other outlets, as indicated by risk assessments, may be considered important.

Water supply [to the healthcare facility]: The water supplied can be via:

- the mains water supply from the local water undertaker;
- a borehole (operated by the healthcare organisation as a private water supply);
- a combination of mains water and borehole supply;
- emergency water provision (bulk tankered water or bottled drinking water).

WRAS – Water Regulations Advisory Scheme

5.5 Design Criteria

1. Healthcare facilities rely heavily on safe clean and hygienic water for patients, visitors, staff, and for clinical care areas. As well as complying with the design outlined in this part of the guidelines, the system components will need to comply with other recognised water regulating bodies such as WRAS, AWWA and DEWA requirements. Where there is a clash the international recognised requirements and local standards, the local DEWA standards shall take precedence.
2. One of the most important factors regarding water quality is the concern of legionnaires disease. The control and elimination of legionella is very crucial, and measure must be provided. The United Kingdom's Health and Safety Executive (HSE)274 & L8, provides one of the best Approved Code of Practice and guidance on regulations 'Legionnaires' disease: The control of legionella bacteria in water systems.
3. Metals in contact with water will also influence the quality of potable wholesome water. Therefore, for any material that is contact with water used for wholesome purposes shall all conform to BS 6920: 2000 Part 1 & 2 and Part 3 (Hot Water Service) for non-metallic materials or equivalent international standards i.e. WRAS approved fitting.
4. All materials that do comply with BS 6920: 2000 Part 1 & 2 and Part 3 (Hot Water Service) for non-metallic materials need to also be approved by DEWA.

5. The importance of the approval highlights the fact that materials (metal or non-metal) used for water distribution produce effects from the water such as colour, smell, flavour, turbidity, release of toxic metals, support of microbial growth and even reduce the quality of the water. For example, WRAS approval can be provided for to 60 months for a specific product, depending on the fact that method of manufacture, source or nature ingredients do not change in the life time of the approval.
6. If a supplier or manufacturer wishes to make any modifications, he must notify the approving body, this may be a U.K, U.S, European or local approving body as well as have that product tested to the requirements of these bodies.
7. The provision of potable wholesome water to the healthcare facility as well as ensuring that the quality of water in the facility is approved is governed by DEWA. The healthcare facility owner is obligated to preserve the quality of water according to the outline highlighted within these guidelines.
8. It is recommended that plumbing installation contractors and companies have the appropriate qualifications and the industry knowledge and competence of installing the correct system suitable for healthcare facilities Healthcare facilities rely heavily on safe clean and hygienic water for patients, visitors, staff, and for clinical care areas.

5.6 Source of Water Supply

1. The source of water for healthcare facilities is very important as the incoming water quality varies. Depending on the water source the incoming TDS/PPM can vary from 2000 PPM to 80PPM. Water must be treated to reach water quality levels of 0 – 150PPM.
2. The following water sources are acceptable for healthcare facilities:
 - Connection from the Potable Water Network Supplier

- Service Connection for Potable Water Trucks
 - Underground Water Wells
 - Bore Hole
3. Healthcare facilities shall ensure that they have second water supply to the facility.
 4. A second water supply can only be provided from the one of sources mentioned above (5.6 – 2).
 5. The Incoming water supply from the sources mentioned above must be checked via a water quality report.
 6. The Water report is to be used to provide the correct water quality design to the healthcare facility as well as the current flow requirements being provide from the network.
 7. The water sources to the healthcare facility must be spilt into two systems for resiliency, redundancy and to avoid having a concern of inadequate water supply to the system. One supply will be an emergency supply to the system.
 8. Water functions as one of the main deterrent for infection concerns and continuing to provide a clean and hygienic water supply to the facility. Hence, the system must be resilient system. This resiliency must be separate from the extra potable water storage (discussed in section 5.6)
 9. Both the main incoming supply as well as the emergency water supply will need to have components to protect the system healthcare facility from infection. This is provided through backflow prevention valves or Double Check Valves. The valve detail below provides an example of:

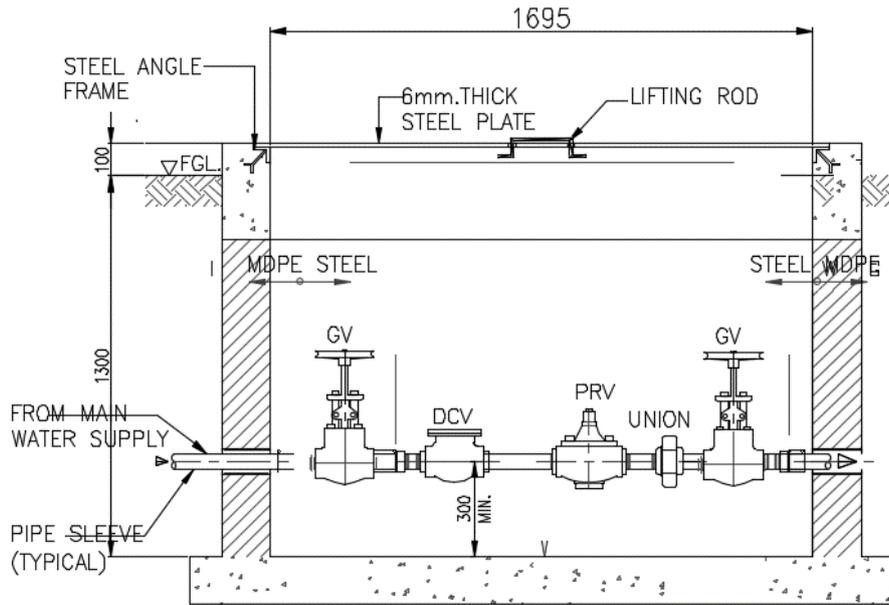


Diagram 5.1A – Incoming Mains Water Valve Detail Buried at the Ground Floor

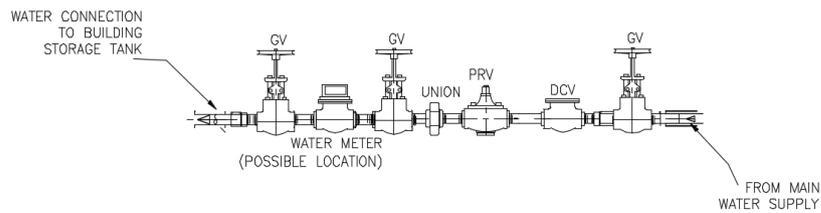
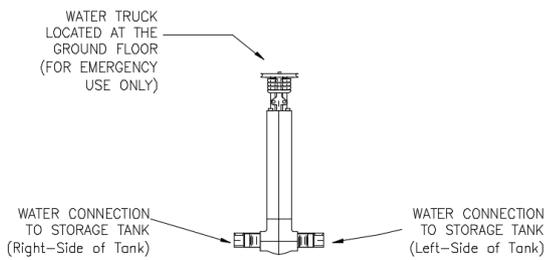


Diagram 5.1B– Incoming Mains Water Valve Detail at High Level Ground Floor or Basement (Water Meter Shown)

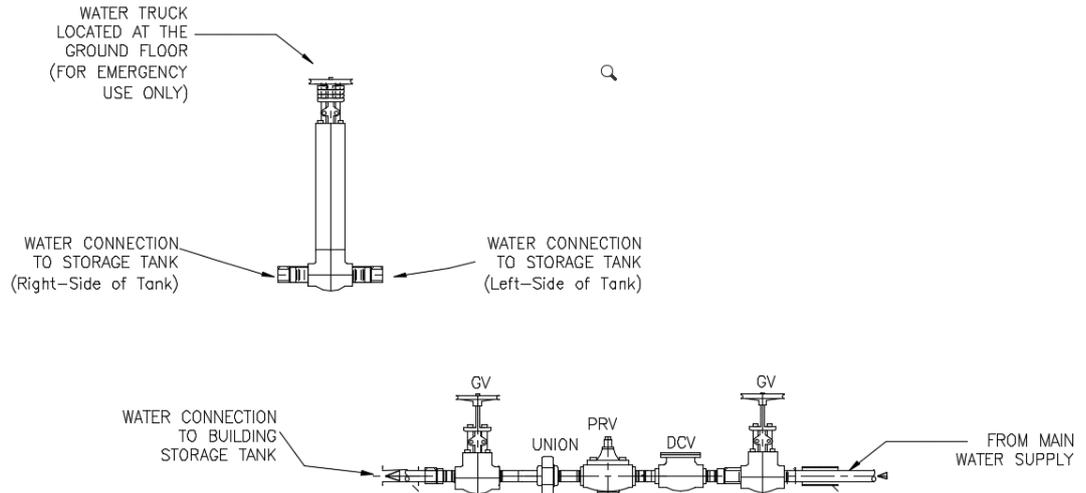


Diagram 5.1C– Incoming Mains Water Valve Detail at High Level Ground Floor or Basement (Without Water Meter Shown)

10. Diagrams 5.1A, 5.1B and 5.1C show an emergency water truck connection allowance as a redundancy measure in situations where the main water network will fail or in areas where the water network has not been established or a provision from the network has not been provided by the local authority.
11. To provide the most efficient water quality with the correct water treatment system installed, the following information must be known from the incoming water quality report:
 - Details of the elements and organisms in the source water supply such as the amount of metals, micro-biological etc.
 - The process or method of water purification used by the network provider chemical, a Reverse Osmosis treatment etc.
12. The design must take into consideration the maximum foreseeable water consumption and average flows as well as peak loads and pressure required from the DEWA water network.
13. The possibility of contaminated land is not and currently an issue in Dubai. But, due to Dubai’s developing nature and vision, this may come a concern like many other western countries. Therefore, the engineer should take note of the current site condition.

14. There a number of direct connections that will be connected to the system. Depending on the system resiliency of the existing potable water system, the design engineer may request two potable supply lines. 1 no. for the main storage tank and a second to vital facility support areas. The sum of the healthcare facility being designed does factor in in this request. For example:

- If the facility is small (LDR 1-3), it may only require connection to the storage tank and a connection to the dirty utility, clean utility rooms.
- If the facility is large complex facilities (LDR 4-6), a larger storage system may be required instead of two systems. (In Dubai this will be the main design approach)

15. During the stages of design, the design engineer must inform DEWA of the hospital water consumption as outlined in Part A of these guidelines.

16. The water design for the healthcare facility must obtain approval from DEWA before any installation is carried out. The engineer must ensure that the following information is submitted:

- Service Connection Details
- Access to Valve Assemblies and Water Meters
- Flushing By-Pass
- Provisions for Fire & Rescue Service (If applicable)

5.7 Quality of Water Supply

1. In Dubai, there may be times in the year when the water supply from the network supplying the healthcare facility is interrupted and the network provider may provide the water supply from a different source to maintain the supply for the required demand. The change in water supply will most likely have different quality of water such as water hardness, metallurgy etc.

This change in water supply may cause issues such as scaling on hot water items. Water hardness can increase by at least 50% more in hardness when services change.

2. The design engineer will need to provide a strategy to ensure that water treatment is provided from the point of supply up until its use by the users. Below is a table that consists of DEWA as well as internationally recognised levels of potable water requirements.

Please note: For renal dialysis areas, the water quality will need to go through another phase of treatment as the levels of certain elements will need to be limited (Mainly copper and Silver as well as no use of chemical water treatment).

Factor	Standard	Factor	Standard
Temperature	20°C	Calcium	250 mg/l
pH	5.5-9.5	Potassium	12mg/l
Colour	20 Hazen Units	Sodium	150 mg/l
Turbidity	4 Formazin Units	Copper	3000 µg/l
Qualitative Odour	All Odour Investigations	Zinc	5000 µg/l
Qualitative Taste	All Taste Investigations	Lead	50 µg/l
Dilution Odour & Dilution Taste	Dilution No. 3 at 20°C	Silver	10 µg/l
Conductivity	1500 µs/cm at 20°C	Antimony	10 µg/l
Total Hardness – Alkalinity	Applies Only if Water is Softened	Barium	1000 µg/l
Free Chlorine & Total Chlorine	Comparison Against Average	Boron	2000 µg/l
Faecal Coliforms	0 / 100 ml	Cyanide	50 µg/l
Clostridia	1 / 20 ml	Cadmium	5 µg/g
Faecal Streptococci	0 / 100 ml	Chromium	50 µg/l
Total Coliforms	0 / 100 ml (95%)	Mercury	1 µg/l
Colony Count: 2-Day & Colony Count: 3-Day	Comparison Against Average	Nickel	50 µg/l
Oxidisability	5 mg/l	Selenium	10 µg/l
Ammonia	0.5 mg/l	Total Organic Carbon	Comparisons
Nitrite	0.1 mg/l	Trihalomethanes	100 µg/l
Nitrate	50 mg/l	Tetrachloromethane	3 µg/l
Chloride	400 mg/l	Trichloroethene	30 µg/l
Fluoride	1500 µg/l	Tetrachloroethene	10 µg/l

Phosphorus	2200 µg/l	Fluoranthene 3, 4-Benzofluoranthene 11, 12-Benzofluoranthene 1, 12-Benzoperylene Indeno (1, 2, 3-cd) Pyrene	Individual Testing of these Substances to Provide Total
Sulphate	250 mg/l	Total Polycyclic Aromatic Hydrocarbons (PAHS)	0.2 µg/l
Magnesium	50 mg/l	Anionic Detergents	200 µg/l
Aluminium	200 µg/l	Pesticides and Compounds	5 µg/l total

Table 5.1 – Water Quality Table

3. The design engineer, should consider the type of water treatment used by the water network supplier (DEWA) to ascertain what type of water treatment should be used. In some supplies, the water may have residual chemical treatment used during extreme hot climates and cool weather at different times of the year. This will affect certain immunodeficient patients in the healthcare facility.
4. The design of the healthcare facility must also consider any possible concerns that will affect the quality of water in the facility such as “dead leg” or stagnate water areas. The design must eliminate these areas.

5.8 Potable Cold-Water (Cooled-Water) System

1. Many of the water design standards are based on an optimal water temperature limit when discussing cold water systems. In Dubai and in relation to health facilities under DHA jurisdiction, water temperature is very crucial in determining the quality of water that is used in a healthcare facility. Incoming water as well as the water stored can go up to 40°C or

higher in extreme areas in Dubai. This then becomes an area for bacterial growth, water contamination concerns which will affect the well-being of all users within the healthcare facilities. Many of the most dangerous types of bacteria such as pseudomonas legionella thrives in such stagnate water temperatures. Therefore, potable water must be cooled.

2. The healthcare design for healthcare facilities should ensure that water is cooled and kept cool for the temperatures between 15-20Deg C, where a maximum temperature of 20°C. This should be done via plate heat exchanger arranged in an N+1 provision. (Heat exchangers will need to be manually switched on a weekly basis to ensure that both are used for the system). The heat exchanger will be connected to the final distribution tank serving the healthcare facility.
3. Cooled water is to be used for wash hand basins, sinks, baths, showers and Shatafs (hand-held bidet).

5.9 Normal Temperature Potable Cold-Water System

1. Water that shall not be cooled, shall still be treated for the purposes for water quality, legionella protection.
2. For this service, potable water service shall only be used in the following:
 - WC flushing System.
 - Maintenance areas, Work Shops, Back of house areas for services areas.
 - Cleaners Sinks
 - Bib Tap Points
 - Cooling Tower Makeup Water

5.10 Water storage

1. Potable water storage is any healthcare facilities most dependent source of water. The purpose of water storage is to act as a safe net for when the main incoming water supply is interrupted or the continuous flow and service to the healthcare facility is disturbed.
2. Many healthcare guidelines limit the amount of water storage to be kept at 12 hours storage. This will ensure that the prevention of bacterial contamination is kept at a minimum. Water storage provides a back-flow prevention to the system and takes pressure off the incoming potable water distribution network. Furthermore, the risk of stagnate water is kept at a minimum, by ensuring a dynamic flow of emptying and top up is occurring within the tank and thus the healthcare facility is being provided with constant clean water.

Please Note: 12-Hour storage shall applied for Dubai Healthcare facilities.

3. For Dubai Healthcare Facilities, the following strategy must be used:
 - 3 days of Potable Water Storage
 - Out of the 3 days, 2 Days are actual Raw Water Storage.
 - The remaining 1 day shall be divided in 2 No. tanks.
 - 1 No. Tank will be treated cold-water (cooled) to serve fixtures mentioned above (5.8-3)
 - 1 No. Tank will be treated Cold water serve non-clinical areas as mentioned above (5.9-2)
4. The main 2-day storage tank shall be concrete, buried or GRP tank(s). The treated water storage tanks must be insulated GRP tanks. Treated water tanks water quality shall be as per Table 5.1. Diagram 5.2 flow diagram shows a more detailed design provision of the water system but provides the design strategy behind the water storage.

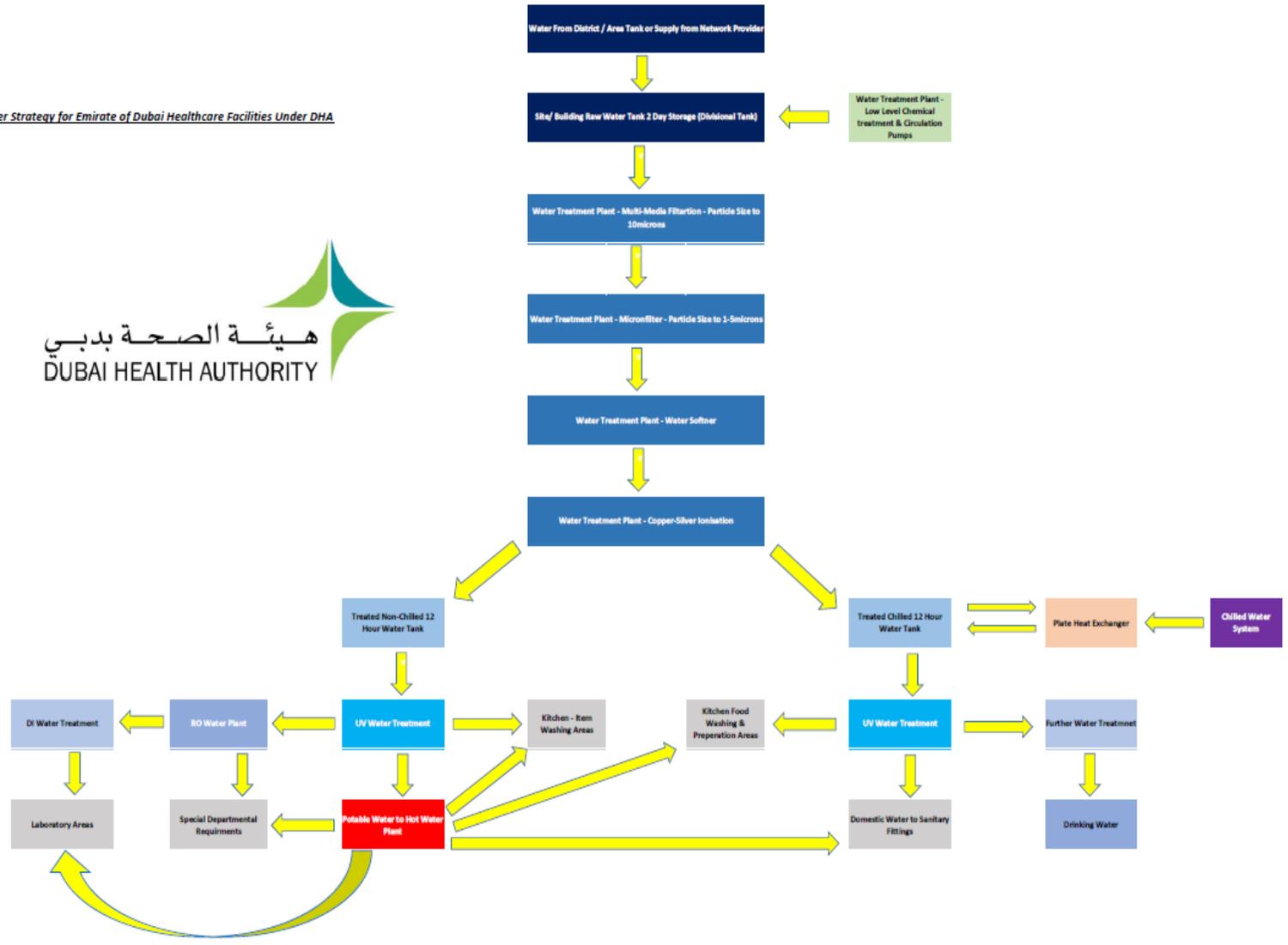


Diagram 5.2 – Water System for Healthcare Facilities

5. Potable water supply to the network, must be after the valve assembly shown in Figure 6.1.
In some facilities, the valve assembly may be part of an existing building or include a water meter requirement, nevertheless the valve assembly must always made of valves shown in Figure 5.1.
6. For water storage tanks used for healthcare facilities, the water must be designed to minimise the risk of water stagnation and the deterioration of water quality. Low level chemical treatment as well as circulation pumps must be provided.
7. When determining how to size the water storage to meet the required capacity, this should be based on the peak demand and the rate of water supply make up from the main external water source.
8. For general potable water sizing, water demand or loading units are used for calculations. These contain a natural water diversity factor.
9. There is no diversity factor to be considered for special departments such as SSU's, Laboratories, Renal Dialysis etc. This will be sized with full provision.
10. As mentioned in Part A of these guidelines, there are many different types of healthcare facilities using the RDL 1-6 designation. Tables 5.2 (below) provides the water demand based on a KPU (bed numbers) for hospitals as bench mark requirement, this is only to be used in the early stages of design calculations.

General Hospital – RDL 4-5 (Acute Healthcare Facilities)	
Number of Beds	Average Water Consumption (Litres Per Day Per Bed)
0-50	299
51-100	398
101-200	490
201-400	590

401-600	599
Over 600	978

Centre of Excellence – RDL 5-6 (Specialist Acute Healthcare Facility)

Number of Beds	Average Water Consumption (Litres Per Day Per Bed)
0-25	319
26-50	347
51-100	362
101-200	479
Over 199	530

LTC – (Long Term Care)

Number of Beds	Average Water Consumption (Litres Per Day Per Bed)
0-50	180
51-100	269
101-200	247
201-300	217
Over 300	306

Recovery and Convalescent Facilities

Number of Beds	Average Water Consumption (Litres Per Day Per Bed)
0-25	216
26-50	206
51-100	185
Over 100	181

Geriatric & Chronic illness Facilities	
Number of Beds	Average Water Consumption (Litres Per Day Per Bed)
0-50	246
51-100	203
101-200	164
Over 200	127

Psychiatric Facilities	
Number of Beds	Average Water Consumption (Litres Per Day Per Bed)
0-100	180
101-200	269
201-400	247
Over 400	350

Teaching Facilities	
Number of Beds	Average Water Consumption (Litres Per Day Per Bed)
0-100	680
101-200	866
201-300	830
301-500	904
Over 500	1228

Table 5.2 – Water Consumption Data for Healthcare Facility types in relation to number of beds

11. A number of healthcare facilities may include residences for doctors and nurses being served from the main hospital potable water system. The designer is to take the data based on the healthcare definitions mentioned in Table 5.2.

12. The water consumption figures provided in Table 5.2, do consider special departments such as SSU, Laundry etc.
13. In later stages of design, this requirement will be more detailed, and these departments will require a separate provision.

5.10.1 Water Storage Tank Locations

1. The strategy in the past was to provide two sets of potable water storage tanks (not including fire). 1 No. tank at the incoming main (basement or ground floor) and 1 No. at the roof of the healthcare facility. This strategy may continue to be used for healthcare facilities due to the site space restrictions, flood risks which could contaminate the potable water source for the facility.
2. A flood risk assessment must be carried out to determine the best location of the potable water tanks.
3. If there is a risk of flooding the potable water tanks must not be placed in areas of flooding risk such as the basement, ground floor etc.
4. If there is no risk of flooding the potable water tank must be located at the lower levels of any healthcare facility (basement, ground floor etc).
5. To ensure resiliency in the system and not to solely depend on gravity roof water tank approach, the booster pumps will need to be connected to emergency power. This ensures that the potable water supply will be available to all sanitary fittings within the facility.
6. The risk assessment must consider the following concerns for possible potable water contamination:
 - Location in relation foul & waste water drainage
 - Ingress of insects, rodents, dust, sand, debris etc.
 - Danger of oil or fuel seepage (if installed below a car park or other fuel vessels)

7. The option of storing water below ground should be provided as the last option if this impacts healthcare MEP systems and hospital operations or if the water supply along with the emergency power strategy is not reliable enough.
8. Tanks should be installed with a watertight bund allowing sufficient space all around and beneath the storage vessel to permit inspection and maintenance. For buried underground tanks the construction may not allow for risk elimination of the tank being contaminated.
9. The tank chamber should include provision for a sump to collect drainage water and any piping necessary to pump out tanks to the site drainage
10. During the healthcare design process, the healthcare facility may be required to constructed in phases. Phases may last months, years and sometimes maybe decades. The design engineer shall ensure that the actual size of the water tank is to be designed for the completed facility. The reason for this is for the following:
 - Risk of cross water contamination of providing multiple sources and risk to patient, visitor and operational staff safety.
 - Space planning restrictions
 - Laboratory Break Tank
 - Equipment costs of providing separate systems
 - Due to the risk of providing multiple water supplies at later stage as well as space planning requirements

5.10.2 Future Water Considerations

1. Many healthcare in Dubai expand their services. This expansion of services will require extra system capacity to be provided. The design engineer must provide a 15% spare water capacity to the system to allow for future expansion of the facility. This means that 15% must be added when submitting requirements to DEWA for water demand approval (Please

note that this 15% is on top of the water consumption requirements provide in Table 6.2A & 5.2B).

5.10.3 Material Tank Construction

1. As per international standards, the construction of the water of the tanks shall be Glass-reinforced plastic (GRP) as per BS EN 13280 if above ground. Tanks must be in a conditioned space. Tanks must not be exposed to external Dubai climates.
2. There shall 1m provision around all sides of the GRP tanks for equipment maintenance.
3. Raw Water Tanks can be concrete tanks buried or within a conditioned room.

5.10.4 Divisional Tanks

1. Maintenance in Dubai is very important concern. Buildings operate in a very extreme climate and thus critical equipment such as the healthcare facilities water tanks need to be maintained even during operating hours.
2. The water tanks support with the tank must not retain water within the supports. If so, these areas become localised areas of water stagnation and then the quality of the water within the tank will start to deteriorate and become a health concern. Water should be allowed to flow freely within the tank. Structural elements should ensure that this is the case.
3. The water storage tanks must always be divided into two compartments. These parts should be the total tank capacity divided into two (50/50 configuration).
4. This type of arrangement allows for one part of the tank to be cleaned, disinfected, serviced, repaired, inspected etc. while the other is in operation through healthcare operating times. This means that a water supply pipe will to be supplied to each part of the tank as per local requirements.
5. To ensure that the water flow is provided when required and that each tank is provided with equal volume of flow a water meter should be installed as well as a solenoid valve linked to

the ball float or chain valve.

6. In each section of the divisional tank the following needs to be provided:
 - An Isolation Valve at the inlet and outlet of the tank division.
 - A Valve Strainer at the outlet of each tank division.
 - Drain Connection at the bottom of each tank. The invert of the drain should be located to fully drain that division of the tank.
 - Over flow pipe from each division of the tank. Overflow connection to be connected directly to drainage
 - Over Flow warning pipe with insect protection screen (0.65mm mesh – design needs to ensure that the screen area will pass the same amount of water as the overflow or warning pipe)
 - An External and Internal Access ladder of the tank division.
 - A vent pipe with an air inlet corrosion resistant mesh.
7. In certain circumstances, it may be difficult to install an over flow or a warning pipe directly to a drain line. In this instance, the design must include an audible warning alarm to inform the facility team of overflow scenario.
8. A Sectional GRP Tank should not be installed directly on a concrete plinth that is protected by an asphalt membrane. This is because irregular settlement into the asphalt may lead the tank leak.

5.11 Pressure vessels

1. Pressure (Expansion) vessels are designed to deal with the thermal (natural, not heated) expansion of the system. But for healthcare facilities they are a potential area for microbial colonisation. The requirements for pressure vessels need to ensure that the protection of

human health is maintained. This is done by preventing the possible transfer of taste and odour to the potable water system as well as ensuring that harmful substances into the potable water are prevented.

2. The materials for the pressure vessels varies from place to place depending on the local requirements. The most recognised certificate is the KTW (Germany & Netherlands/Holland) approved certificate. For example, KTW provides guidelines for organic materials in contact with water. They provide the concentration of substances that are permitted.
3. The installed pressure vessels must have certification and are installed as per manufactures specifications. This ensures that they are operated in a manner that prevents the accumulation of debris, water stagnation and increase of water temperature within the vessel.
4. The design of the pressure vessel must have water entering the vessel at low level and exiting at high level. Some manufactures use special valves which encourage water flow or pressure movement within the pressure vessels, this is an acceptable alternative.
5. For general pressure vessels for medium to large systems, there must be drain connections for flushing at the top and bottom of the vessel. If a diaphragm/bladder type expansion vessel is used, then only at the bottom of the vessel.
6. Pressure vessels must be provided on the cold potable water side of the system and the pipes to the vessel should be insulated to minimise heat gain.

5.12 Water Treatment Systems

1. In healthcare facilities the treatment of water and the control of microbiological safety of water is an important functionality to ensure a safe, hygienic clean water provision.

2. The extent of water treatment will vary for each application depending on water quality, intended usage etc. But the source of water supply is also important to identify the type of water treatment to be used. Source of water supplies such as “Wadeez”, Wells, Reservoirs, Rivers and Lakes may contain organic matter, higher TDS/PPM and will require water treatment prior healthcare operator active facility use.
3. Generally, to control microbiological growth within water systems, temperature, chemical and mechanical control methods will be enforced to reduce the risk of water contamination.

The methods that will be used are the following:

- Pasteurisation
 - Chemical Treatment (Biocides, Chlorine etc)
 - Silver-Copper Ionisation
 - Filtration
4. Depending on the type of healthcare and departments the water treatment strategy needs to be considered for current hospital departmental plan, design and possible future expansion. For example, of haemodialysis department, a separate mains water supply must be considered so that other areas of the healthcare facility may be dosed without affecting the RO plants.

5.12.1 Pasteurisation Treatment

1. Pasteurisation or water heat treatment flashing of the system is a method used in some healthcare facilities by raising the water temperature of the hot water system to 70-75°C for at least 60mins and running each sanitary fitting within the facility for 5mins. A well-insulated system is required so that heat is maintained to all sanitary fixtures. This is a temporary solution and does not prevent re-infection of the system. This method must not be used for new facilities.

2. Existing facilities may only use this method as a temporary solution but will need to install a permanent water treatment method. This method is costly and huge waste of electricity and water as well as it will require complete shutdown of all sanitary fixtures for 5mins, which will be very difficult or impossible for medium to large for facilities, but for smaller facilities it may be possible.
3. In relation with this method and biocide water treatment, the effectiveness of biocides concentration is difficult to achieve in hot water systems due to gassing off.

5.12.2 Biocidal treatment

1. Biocide treatment used for water treatment should be done with the lowest concentration to protect patients within healthcare facilities. The concentration should be as per international requirements for healthcare facilities.
2. The concentration levels should be as per UK COSHH regulations 2002.
3. Since Legionella and other water contamination organisms play a huge part of water quality, there are occasions where biocide water treatment will be used to maintain the water quality. But the engineering designer needs to understand that water treatment for healthcare facilities is very complex and depending on the use and departments one may have multiple water treatment methods for a single facility.
4. It is important that biocides system must not be drawn for bathing, food preparation or drinking until the treatment chemical has been completely flushed from the system. The hospital operator must ensure that that measures are taken to protect vulnerable patients such as those in renal dialysis units.
5. As per international standards, biocides used for water treatment must have the following:
 - Contain an active substance approved for that use
 - Be suitable for drinking-water use.

6. For effective biocide water treatment, there must be an implementation of a very rigorous water monitoring regime with a fail-safe system to ensure the safety of the system as well as ensure the correct dosing of biocide concentration is applied which reduces risk of water contamination.
7. Local monitoring will still be required by healthcare operational staff.
8. The equipment supplying biocide water treatment shall be provided with a leak detection system.
9. If the concentration of biocide treatment increases and caused the water to be unwholesome water a separate line will need to be labelled provided that is wholesome and labelled as such, especially certain departments such as neonatal feeds etc.
10. As described by the European Union Biocides Regulation 528 (2012), biocides are used to control harmful unwanted organisms within water systems. The regulations also require supplies of biocide to be registered. This registration must in accordance with DEWA requirements.

5.12.3 Chlorine dioxide

1. Chlorine dioxide water treatment is an oxidising biocide that is capable of reacting with a wide range of organic substances within the water. As per BS EN 12671, the treatment method has been shown to effective to control organisms within the water. Chlorine-dioxide water treatment equipment is a dispersive water treatment method and the equipment needs to generate a product efficacy greater than 90% to provide the optimum performance. Hence, since it's a dispersive treatment method, bacteria in the water continue to be killed.
2. As per international legionella control requirements, Chlorine Dioxide is an approved method of control for legionella bacteria in water systems for PPM values greater than 0.1 and for DWI requirements of less than 0.5 PPM for total oxidants. But as mentioned for biocide

treatment, it will require rigorous control and monitoring.

3. Chlorine Dioxide is also a very powerful disinfectant that kills both planktonic and sessile organisms. This is important as the majority of organisms live in sessile bacteria.

5.12.4 Chloramine Water Treatment

1. Healthcare operators and healthcare engineering designers must take note that DEWA may have introduced chloramine as a disinfecting agent in potable water supply network as alternative to chlorine. This is because chloramine is able to provide a more stable approach of providing a residual antibacterial activity with lower chlorine levels. In systems, where free chlorine is rapidly lost, such as typical hot and cold-water service systems, chloramines can remain for much longer, which is of grave concern for dialysis patients and their respective departments.
2. Chloramines and to a lesser extent chlorine in dialysis water can cause haemolysis – a condition whereby red blood cells are ruptured. In addition, all renal patients suffer from anaemia to some extent because they are lacking in erythropoietin. This natural hormone, which stimulates bone marrow to produce red blood cells, is not available in sufficient quantities in patients with damaged or diseased kidneys. Synthetic erythropoietin is administered to dialysis patients but, apart from its high cost, can have unpleasant side-effects. Where chlorine or chloramines are present, the need for erythropoietin escalates, and therefore it is imperative to eliminate chlorine and chloramines from water supplies to dialysis equipment to minimize the dosage of erythropoietin. Dialysis requires a water supply that has the minimum of chemical and bacterial impurities. Hence, special water treatment is required, such as reverse osmosis (RO), which removes chloramines or chlorine from the water.
3. For Water Supply using Chloramines a Reverse Osmosis water treatment will need to be

used, along with non-chemical water treatment (Copper-Silver Ionisation and Ultra Violet Water Treatment).

4. The use of deionisation should not be used for a water treatment method for the entire facility or as the sole water treatment method. This is because of the following:
 - There is some reduction of chloramines (not all)
 - The quality of water is at a high grade by degrades very quickly that the water will have to be deionised once more.

The water quality shall be as detailed in table 5.5 below.

5.12.5 Water Softener

1. Water Softening is used in areas where the quality of water is not suitable for its intended use. For example, hard water areas where the Calcium and Magnesium salts in the water are high, means that scale deposits in the systems equipment and pipework become a concern as they reduce the flow of the system, efficiency and increase the surface area of biofilm.
2. In healthcare facilities water softening is used in water to serve the following equipment within a facility:
 - Copper-Silver Ionisation Water Treatment
 - Steam Boilers
 - Laundry Area
 - Hot Water Systems
3. International Studies have shown some concern with cardiovascular disease tends to be higher in areas with soft water supplies than in areas with hard water supplies. The association is clearest where the soft water supplies contain hardness below about 150 mg/L (as CaCO₃). Therefore, the correct water softening regime is necessary to remove any

risk to patient within those healthcare facilities, especially in areas where the water supply will be used for drinking water (including LDR Nurseries for baby bottle feeding) and kitchen washing facilities.

Recommendation: If it is considered essential to provide water softening to drinking water and kitchen areas, then the softening system must be maintained to a minimum and the manufacturer must be informed to provide the correct disinfection regime of the water softener.

5.12.6 Copper-Silver ionisation

1. Copper-Silver Ionisation is a water disinfection system used for Legionella and other organisms that exist in contaminated water supply and storage. The system works by passing a current through a copper-silver plate and thus forcing the plate to release ions of Copper-Silver. The ions are used to control planktonic and sessile bacteria and effective against the formation of bio-film.
2. The concentration of Copper-Silver ratio must be as per the table below:

Healthcare Facility Size	Copper-Silver Ratio
Small to Medium Facilities (RDL: 1-4)	10% Silver & 90% Copper
Large Facilities (RDL: 5-6)	30% Silver & 70% Copper

Table 5.4 – Copper-Silver Ratio in Relation to Healthcare Facility Size

Important Note: Ratio percentages does not mean an amalgam of the elements. It refers to the ratio of the elements to each other i.e. if 90 % of Copper is 1 kg then 10% of silver is 0.1kg etc.

5.12.7 Reverse Osmosis Water Treatment

1. Reverse Osmosis (RO) is a type of water treatment process is one of the most widely used treatment process in healthcare facilities. It is the water treatment technology that removes a majority of contaminants within the water by applying pressure through a semi-permeable

membrane.

2. In healthcare facilities, RO water is required to be served to Renal Dialysis Units/Departments, SSU's, Dirty Utilities (for washer sterilisers) and Laboratories.
3. The RO water requirements for healthcare facilities as well as the concentration of copper-silver ionisation in the water system must be as detailed in Table 5.1, except for dialysis units. For dialysis units, the quality of water shall be as per Table 5.5 below. The table is based on ANSI/AAMI 13959 requirements.

Contaminant	Maximum Allowable Level (mg/l)
Contaminants with Documented Toxicity to Hemodialysis	
Fluoride	0.2
Chloramines	0.1
Copper	0.1
Aluminium	0.01
Lead	0.005
Total Chlorine	0.1
Nitrate (as N)	2
Sulfate	100
Sulfate	100
Zinc	0.1
Total Dissolved Solids	5-1000
Trace Elements	
Antimony	0.006
Arsenic	0.005
Barium	0.1
Beryllium	0.0004
Cadmium	0.001

Chromium	0.014
Mercury	0.0002
Selenium	0.09
Silver	0.005
Thallium	0.002
Microbiological Standards	
Colony Forming Units	<100 CFU/mL (Standards) And ≥50 CFU/ML (Action Level)
Endotoxin Units	<0.25 CFU/mL (Standards) And ≥0.125 CFU/ML (Action Level)

Table 5.5 – DHA Water Quality Requirements for Dialysis Use

Important Note: For Microbiological Standards, the term standard refers to the acceptable microbiological level. The term Action Level refers to the testing protocol used to determine the bacteria level.

4. As can be seen from Table 5.5 above the concentration level of Copper & Silver is much lower than the standard mentioned in Table 5.1.
5. Copper-Silver Water treatment needs to be installed prior to the main treatment. This solution allows the treatment process to work best as well as encourage the water to remain at a high quality for a longer period.
6. Copper-Silver Ionisation also requires the water feeding it to be treated with softened water. This method prevents scaling.

5.12.8 Ultraviolet treatment

1. Chemical Water Treatment methods are used mainly as a dispersive treatment method. But non-chemical water treatment methods are used as a final point of water treatment in healthcare facilities.

2. The function of the ultraviolet (UV) water treatment is to kill or deactivate the bacteria in the water. This is done by the UV light disrupting the natural make organic makeup of the bacteria. This technique is in sharp contrast to techniques such as high temperatures and chlorine dioxide which 'burn' the outside of the cell wall. For this technique to work successfully the correct UV wavelength must be selected. This is because different wave lengths of light are absorbed in different proportions and for this method to be successful, the UV light must be absorbed to cause the necessary disruption within the bacteria. Optimum wavelength for the destruction of biological matter occurs close to 254nm, and therefore it is important that the lamps used to provide UV light which is close to this ideal value. The process of killing bacteria, via this technique is often referred to as 'inactivation'.
3. Ultra Violet (UV) disinfection will be provided at the distribution side. System shall incorporate system sensor to monitor the effectiveness of the disinfection. For typical potable water applications, the target exposure dose is 400j/m² for a wavelength of 254nm (as mentioned above).
4. Hydrotherapy pools in healthcare facilities will have an exposure target of 400 j/m² for a wavelength of approx. 313nm.
5. All biological species require different levels of UV light to inactivate/kill them. For example, legionella pneumophilla, will die at relatively low exposures and others like pseudomonas, which can also cause problems, are more robust and do require a higher dose of UV light to inactivate them.
6. The UV water treatment plant shall be connected after the packaged cold-water tank and pumps. It shall incorporate a UV photo sensor to monitor the effectiveness of the disinfection. The output of every lamp will drop with time, typically lamps last between 11 months – 24 months (dependent on the lamp) for 24 hours of lamp operation and after it

will require replacement.

7. It should be remembered that all water borne bacteria, undesirable or benign, will enter the system via the incoming main, and despite the water suppliers care and diligence it is simply not possible to deliver water across the network in total sterility, thus the job of protecting the system starts with treatment of the incoming main. This treatment adds considerable value and security to the water handling process. Incoming water main must be treated.

5.12.9 Ozone Water Treatment

1. Ozone is a method of treatment that uses an unstable gas made up of 3 oxygen atoms and the active gas usually lasts only for a few milliseconds.
2. Ozone Water Treatment usually provides a good disinfection effectiveness any odour and taste from the water by reducing the concentration of elements such as iron and manganese.
3. An Ozone system consists of passing dry, clean air through a high voltage electric discharge, thus creating an ozone concentration. The raw water is then passed through a venturi throat which creates a vacuum and pulls the ozone gas into the water or the air is then bubbled up through the water being treated. The following are important part of ozone water treatment:
 - It rapidly reacts with the bacteria in the water and is effective on a wide range of PH values.
 - The Treatment process does not require to add chemicals to the water
 - It is unable to prevent or inhibit bacterial growth.
 - The system will require pre-treatment water plant to be installed before the unit.
 - There is a potential hazard of the system being fire risk as well as toxicity issues, which may raise approval concerns with Civil Defence.
4. In healthcare facilities, ozone water treatment needs to be used with a combination of other

water treatment means to element the weaknesses in the system and ensure continued operational clean system.

5. Many designers and hospital operators in the region are not familiar with ozone water treatment for healthcare facilities, but rehabilitation clinics that use hydrotherapy pools use this approach instead of the chemical cleaning system.
6. Ozone water treatment should not be used as the only source of water treatment for healthcare facilities but with a combination of other water treatment methods.
7. Oxygen Gas to this type of water treatment can be from the healthcare facility medical oxygen bulk supply (VIE Tanks or PSA Generation).
8. Pipe Material for this system shall be Stainless-Steel (316L).

5.12.10 Point-of-use filtration

1. Many small clinics within Dubai may use small point of use filtration systems to provide water treatment for pathogenic waterborne organisms including multi-drug-resistant strains, at a minimum.
2. If small clinics wish to proceed with this approach a risk assessment strategy must be conducted for the water treatment strategy. This strategy should be made to determine the sterilising grade of the filters installed with the filter by determining the bacteria retention and have a management strategy based upon that.

5.12.11 Multi-Media Filtration & Microfiltration

1. Multi-Media filtration (MMF) is the most common type of filtration system used generally in healthcare facilities, they ensure particles are removed as well as odour and taste from the water system used. Whereas, microfiltration removes small particles from the water post MMF use.
2. In healthcare the design of MMF should be as follows:

- Sand Filtration – Removing Particles down to 10microns (this includes turbidity/suspended solids as per WHO definitions)
 - Carbon Filtration – Removing Odour & Taste from the Water
3. MMF suppliers and manufactures shall provide this approach in a two-vessel system, one for Sand Filtration and one for Carbon Filtration.
 4. Microfiltration uses a bag & cartridge filtration method that removes particles of less than 10microns. This type of water treatment method needs to be maintained by the healthcare facility staff and bags need to be checked on a monthly basis. If the system is maintained correctly, bags should be changed between 6-12 months strategy.
 5. Both water treatment methods are unable to prevent or inhibit bacterial growth. Therefore, this water strategy method must be used with other water treatment methods.

5.12.12 Distilled Water

1. Distilled water is the condensed purified water from condensed steam. Distilled water is provided for laboratory use in healthcare facilities.
2. Distilled water requires a RO water connection from the plant or DI water connection (depending on the requirements of the laboratory functions).
3. Due to the amount of distilled water used, this will be a local bench top unit and not a major plant or a centralised system.

5.13 Drinking Water

1. Some healthcare facilities may provide a separate water supply for drinking water fountains (as shown in Diagram 5.2). The quality of drinking water with Chemical treatment must be as per the requirements highlighted in Table 5.1 or as per DEWA requirements.
2. The chemicals used for water treatment for drinking water need to ensure that there have

no adverse effects for human consumption. Chemical products used have been provided in an approved list by the Drinking Water Inspectorate (DWI).

3. To prevent the drinking water system from stagnation and from the likelihood of temperatures exceeding 20°C (thus affecting the quality of water) the drinking water strategy shall will need to be provided from a central chilled water storage tank and pump made for drinking water purposes only.
4. Drinking water without a storage requirement must not be installed.
5. If a central drinking water system has not been provided, then a bottled water drinking water system shall be provided a via a water cooler.
6. Bottled water coolers shall be provided with chilled and hot water capability but shall only be supplied with a dedicated single water supply (1 No.) designated for drinking purposes only.
7. In healthcare facilities pantry areas, there is a requirement for above bench or below bench hot water boiler/chiller unit (as per Part B of these Guidelines). These will be required to be supplied with a normal potable water supply (these units will have internal low level water treatment).
8. The water supplied shall already be treated as per the water treatment strategy for the hospital and it is not requirement that the supplied water be cooled cold water.

5.14 Specialist Water Systems Provisions

1. For healthcare facilities that are expanding their departmental services or providing new FPU's as part of the expansion, local water treatment solution shall be provided if the potable water supply is not treated. An example of this requirement is a new Dialysis unit or Endoscopy clean-up area etc.

2. For locally installed water treatment system, the connect from the main supply line to the treatment plant must be provided with a valve assembly set (DCV/BFP, PRV & IV's).

5.14.1 Hydrotherapy Pools

1. Water treatment for Hydrotherapy pools shall be a via combined water treatment system.
2. The intent of the water treatment system is to control the water mineral concertation. The combined water treatment system will be a combination of MMF and chemical water treatment or Ozone water treatment.
3. The treatment system shall be a backwash system that reuses the water within the pool.
4. Plant equipment must be installed according to manufacturer's specifications and shall be located in close proximity to the Hydrotherapy Pool with easy access for staff to monitor and service the water treatment systems.
5. The water temperature of the pool needs to range between 28 to 35°C as per healthcare requirements. For most conditions being treated the optimum temperature is between 33-35°C .

5.15 Cold-Water & Cooled Cold-Water Distribution System

1. In healthcare facilities, the water system design relies heavily on the installation practices in any region. The installation practices determine the type of contingencies the water distribution should designed with.
2. The water design and installation should be as per Water Supply (Water Fittings) Regulations 1999 and relevant parts of BS EN 806-2 and BS 8558 (as mentioned by DEWA).
3. To maintain the chilled water conditions of the system for healthcare facilities and reduce the risk of heat gain, the pipework should be insulated. The installation should be a vapour seal type to avoid any condensation as per BS 5970.

4. Water Hammer Arrestors or Surge Water Arrestors should be connected to discharge to waste via appropriate type AA air gap as per BS EN 1717.

5.16 Cold Water & Cooled Cold-Water Booster Pumps

1. As part of the World Health Organisation Infection Control Strategy high flows are essential for hygienic hand washing. Healthcare facilities depend on high flows and constant pressure to ensure hygienic clean infection control strategy is maintained. Clinical fixtures need to be provided with the following:
 2. The cold-water pressure range at fixtures shall be between the following:

Minimum: 1.38 Bar (gauge)

Maximum: 5.52 Bar (gauge)
 3. The cold water piping maximum flow velocity shall be the following:

Piping to 50mm: 1.5 meters per second (m/s)

Piping 65mm and larger: 1.8 meters per second (m/s)
4. A pumped water system ensures that an inadequate water supply is not provided throughout the healthcare facility. To be in line with Dubai Green building code and Dubai local authority regarding energy saving methods, the potable water booster pumps must be variable driven speed pump system.
5. The booster pumps should be a multi-stage pumping system rather than a duty-standby single pumps system. This approach provides a longer system life with higher energy efficiencies as well as a wider range of flow rates for the facility.
6. As part of the healthcare facility resiliency strategy and to continue to provide the healthcare facility with clean, hygienic water, the booster pumps must be connected to the emergency power supply.

7. All booster pumps should have automatic control to prevent stagnation.
8. Many healthcare facilities may have higher occupant loads on upper floors, thus the pumping amount to these levels will be higher. This amount of pumped water should be controlled by transmitting sensors within the tanks at high level.
9. A low-level water alarm should also be provided so that the pump does not run dry.
10. The water pump and water storage plant room must be installed with a waterproof and non-dusting floor as well as and non-dusting walls and ceilings. The floors must fall to the dedicated floor drainage locations provided. The drainage floor gully should be provided with a trap. The trapped gully should incorporate provisions to either avoid or replenish any trap-water seal loss. In Dubai, traps are usually susceptible to evaporation, thus a to Primer valve must be installed (refer to Drainage (section 6) for more details).

5.17 Hot Water Strategy

1. As part of the infection control strategy for healthcare facilities, hot water is used to provided 2 types of systems to healthcare facilities:
 - Warm Water to Clinical Hand Wash Basins (Including Scrub Sinks) & General Hand Wash Basins
 - Hot Water to Clinical Sterile Areas, Kitchens, Maintenance Areas and Cleaners Sinks.
2. The Hot water system in healthcare facilities should be designed as outlined by BS 6700 (with respect to the Water Supply (Water Fittings) Regulations 1999, BS EN 806 (Parts 1–5), BS 8558 and BS EN 6700.
3. The potable water serving the hot water plant shall be treated via a finial water treatment method which is Ultraviolet, before connecting to the hot water system.
4. In Healthcare facilities hot water system can be vented or unvented systems.

5. Vented hot water systems are usually the approach that was adopted in older healthcare facilities. This approach consists of a cold-water storage (open to atmosphere) provided above sanitary fixtures which feeds a hot water storage vessel. This approach is no longer accepted in new facilities.
6. Unvented hot water systems are connected to a boosted main line (network or internal water system) via a valve assembly set. Unvented Hot water cylinders must always be used for providing hot water in healthcare facilities. This strategy maintains the efficiency of the system by maintaining the water quality.

5.17.1 Types of Hot Water Generating Systems

1. There are four main types of hot water systems that are acceptable in healthcare facilities (they include direct and indirect heating methods) the following:
 - Electrical Hot Water Generation (Direct)
 - Fuel Burning Hot Water Generation (Indirect, Including Boiler/Steam)
 - Solar Hot Water Generation with a combination of one or both of the above (Direct & Indirect)
 - Heat Pump System
2. In the design of a healthcare facility, the redundancy and resiliency of a system is of fundamental importance in the design that a combination of the above systems will be used in healthcare facilities. Such as solar for initial water heating then a fuel hot water system for achieving the required temperatures.
3. In healthcare facilities, the design of the system must be provided with a backup water heating strategy along with the above mentioned hot water systems. Generally, the electrical heating element is the back-up to the other two systems, but it may also be the primary source of hot water generation.

4. Solar water system to be provided with a duty and standby system setup.
5. The hot water must be heated to a minimum of 65°C with one of the above-mentioned systems.

5.17.2 Hot Water Storage & System

1. The water storage temperature must be kept at minimum of 60 - 65°C to any prevent bacterial growth within the stagnant water.
2. Energy conservation is achieved with an integral thermostat set between 60- 65°C and return water temperature is to be from 50 – 55°C.
3. The domestic hot water pressure range at fixtures shall be between the following:
 - Minimum: 1.38 Bar (gauge)
 - Maximum: 5.52 Bar (gauge).
4. Many healthcare facilities in Dubai use instantaneous hot water system approach by having an electrical hot water generation locally to the department or sometimes to each wash hand basin. This approach not only has huge capital costs on purchasing the units but on the operational costs also.
5. Having local small hot water generators does have its advantages over a large central storage system. They are easier to maintain and provide a quicker hot water temperature provision. Furthermore, balancing the hot water system becomes much easier and less of a problem. This approach also wastes a lot of energy and moves away from the sustainable approach of Al-Sa'fat Dubai Green Building Code. Most of hot water generated is heated but not used as the basin is only used for approximately 30 seconds.
6. A central hot water system is the best approach for healthcare facilities.
7. A hot water return should always be provided to the central hot water system, unless provided with electrical trace heating tape.

8. A central hot water system encourages a low risk of infection concerns for healthcare facilities.

5.17.3 Hot water Return Approach

1. Hot water return systems are used to ensure that water temperatures to each of the sanitary fixtures are provided with the appropriate temperature and it ensures that the initial heat generated from the hot water flow is used once again as part of the main hot water system.
2. A balancing valve is to be provided on the hot water return system.
3. The hot water return is to ensure hot water is provided almost instantly when needed, keeps water consumption low and prevents bacterial growth within the hot water system.
4. All hot water supply pipes shall be insulated with flame-safe moulded pipe insulation, having a factory-applied jacket suitable for temperature increase.
5. The hot water return connection shall be as close to the sanitary fixture as possible. This allows for hot water to be achieved between 10-20 Seconds.

5.17.4 Direct Hot Water Approach

1. Direct hot water system approach can be used. This may be provided in RDL5-6 facilities where the return system may take longer to return to the central hot water plant.
2. The direct approach will require a hot water system pumps and the pipes to be trace heated to maintain the hot water temperature of the system.
3. The trace heating ensures that the hot water is maintained at a minimum temperature of 50°C.
4. All hot water supply pipes shall be insulated with flame-safe moulded pipe insulation, having a factory-applied jacket suitable for temperature increase.

5.17.5 Hot water temperatures

1. In healthcare facilities, the provision of a hot water is required for several healthcare operational needs and systems, Such as the following:
 - Main Facility Kitchen
 - Food Preparation Areas
 - Facility Laundry
 - Clinical Service Areas
2. The remaining areas outside these areas will depend on the operational policy of the healthcare facility provider.
3. For above areas mentioned to be provided with hot water for a single hot water supply to a fixture, the draw-off water temperature must be a minimum of 50°C and maximum of 55°C.
4. Hot water temperatures must be achieved within a certain time frame as per BS 6700.
5. This requirement is to ensure that appropriate control of microbial elements in hot water systems are in place. For 50°C, this water temperature must be achieved within 30 Seconds and for 55°C, this temperature must be achieved within 60 Seconds.

5.17.6 Hot Water Plant Safety Blow Down (Air Vent)

As part of the healthcare facility infection control strategy, it is important to preserve the quality of the stored water. The previous practice was to provide a vent pipe to terminate back into the hot water storage vessel. This approach is no longer permitted. The vent should be arranged to discharge over a separate air-break-to-drain (tundish) and then to a floor drain as per BS EN 1717.

5.17.7 Instantaneous Water Heaters

1. Generally Instantaneous hot water heaters are susceptible to scale formation in hard water areas, where they will require frequent maintenance. If the design engineer wants to include such a system, they must ascertain the water quality being provided to the healthcare facility.

Furthermore, if the system is to be used for shower areas the system should be thermostatically controlled and provided with a BEAB mark of approval.

2. Instantaneous hot water heaters may only be used for RDL 1-3 healthcare facilities.

5.17.8 Hot Water Storage Calorifiers

1. Storage calorifiers are usually cylindrical vessels mounted either vertically or horizontally; the base of the vessel usually where the heating element is located or where there is an indirect heat exchange. Sometimes areas below the element can have a lower water temperature than the heated water above. This area can provide an ideal breeding ground for bacteria.
2. Galvanised type cylinders are particularly susceptible to scale formation, which can also provide a source of nutrition and shelter for bacteria. Therefore, galvanised cylinders are not allowed in healthcare facilities.
3. The storage water cylinder lining should be resistant to bacterial growth.
4. Storage requirement for hot water should be based on the peak water usage with a 24-hour usage. As mentioned earlier in these guidelines, there may be multiple peak demand areas. Therefore, it is important that the issue of vessel stratification is dealt with.
5. Many storage vessels suffer from stratification, where the lower part of the vessel has not reached the higher part of the cylinder water temperature of 60-65°C. The lower levels provide a breeding ground for legionella bacterial growth. Therefore, destratification pumps attached/mounted in the cylinder are to be provided in larger vessels.

5.17.9 Hot water circulating pump

1. For all healthcare facilities, the hot water circulating pumps have been installed on the hot water flow side or the hot water return side. When installed on the flow or return the connection is provided with a valve assembly set along with a bypass and where the pump is

mounted or connected.

2. In healthcare facilities, the type of pump installed is important. For example, duplex pumps should not be installed as the purpose of the system is to keep circulating to maintain water temperature. But rather a clean dry standby pump should be provided or a permanently installed standby pump should be made available.

5.18 Water System Isolation Valves

1. In healthcare facilities, it is important that the design provides a strategy for future maintenance as well as system durability. Isolation valves are to be fitted before entering main sanitary fixtures in toilets, clinical departments etc. Please note that for the design or maintenance of the design, these isolation valves should not be used for balancing the system flow rates.

5.18.1 Thermostatic Mixing Valves

1. As mentioned previously, the provision of Hot water service to sanitary fixture is very important as it promotes an infection control regime. However, the discussion of temperature at outlets in healthcare facilities is very important. In healthcare facilities there is a risk of scalding (water burning) for vulnerable patients and ensuring that that scalding does not affect them, the hot water service needs to be blended down to warm conditions with a use of a thermostatic mixing valves (TMV). There are three main types of TMVs; TMV-01, TMV-02 and TMV-03. TMV-03 is the type of valve that must be installed in healthcare facilities. While the other two are for a more domestic type of installation and operate at a lower operating pressure than TMV-03.
2. In healthcare facilities wash hand basins and scrub sinks will be provided with a TMV that allows outlet temperature control. This limits the maximum temperature of water delivered from the basin taps. Diagram 5.3 below provides a brief detail on the installation of a TMV

to a basin.

3. Not all sanitary fixtures will require TMV's. Some sanitary fixtures such as stainless-steel sinks in dirty utilities, clean up rooms, kitchens need a higher temperature requirement. All areas not used for hand washing facilities i.e. any tap outlet to other fixtures other than a wash hand basin (such as dirty utility, clean utility, pantry and kitchen etc.) shall not have TMV's installed. Diagram 5.3 below provides a brief detail of the installation without a TMV.

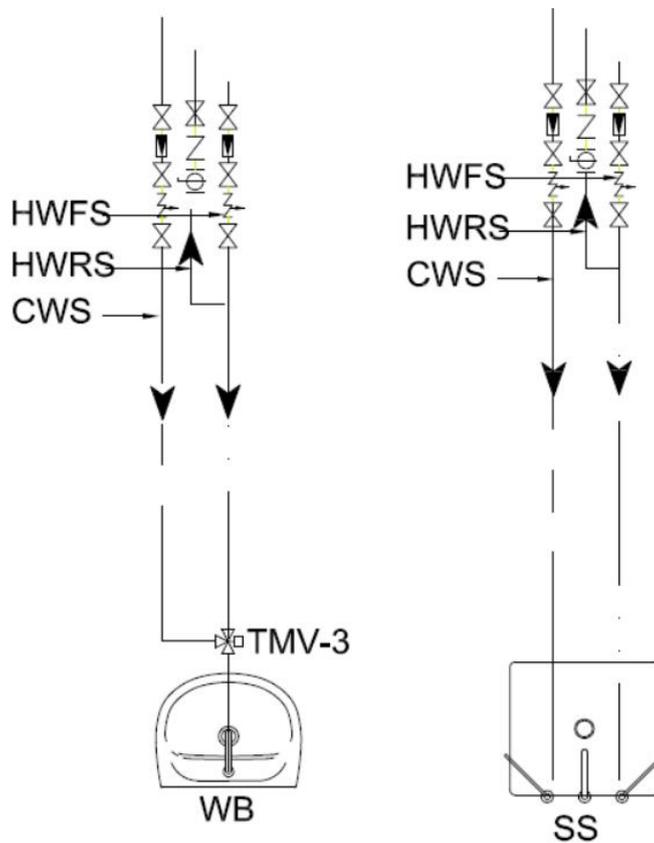


Diagram 5.3 – Location of TMV in relation to Sanitary Fixture

4. In recent years, sanitaryware manufacturers have provided a combined TMV and sanitary tap into a single fitting. Some of these are as per healthcare requirement and some are not. The fittings that in contact with the water being discharged must be WRAS approved or equivalent.
5. TMV's, along with the hot water return should always be installed as close as to the sanitary fixture as possible to remove any dead leg concerns as many of facilities have high ceilings

and long runs (maximum 3m from the basin).

6. Close location of the TMV to the sanitary fitting ensures ease of maintenance.
7. Table 5.5 below provides the water temperatures required for sanitary fittings required to be installed with a TMV-03 (this must have an enhanced performance testing certificate of D08).

Healthcare Areas & Fixtures	Maximum Recommended Temperature °C
Showers & Hair Washing Facilities	41
Unassisted Baths	44
Baths for Assisted Bathing	46
Bidets and Hand-Held Shatafs	38
Any Basin	38-41

Table 5.5 – TMV location and Maximum Temperatures

8. For assisted baths and areas, water temperature is to be monitored and checked by hospital operational staff (Medical or Non-Medical Staff)
9. Some facilities may wish to provide higher temperatures than the above recommended maximum temperature value. If healthcare operators wish to do so, then a safe means must be provided to prevent access to these areas by vulnerable patients.

5.19 Healthcare Sanitary Fittings

1. Healthcare requirements for sanitary fittings differ from other commercial facilities. The goal is always an infection free, safe, hygienic environment for all users (vulnerable users in particular).
2. International Water Supply Regulations places limits on water draw of and requirements to prohibit basin or sink waste plugs (blocker), therefore no drainage waste plugs shall be provided for all sinks and basins.

3. Providing an overflow or a waste plug provides an environment for bacterial growth and infection infringement concern. No over flow hole shall be provided for all sinks and basins.
4. In healthcare facilities sensor taps should be used for basin washing facilities or as per Part B of these Guidelines.
5. The sensor tap solenoid valve is to be checked at least once a month.
6. Since legionella is most dangerous in its spray form and can live in the system at any time, spray-type mixer taps are prohibited in healthcare facilities.
7. Water flow from the mixer tap should fall in such a way that it forms a shape around the basin discharge area.
8. The basin spout should not discharge directly over the waste drain or in an area that causes splashing.
9. Some sanitary mixing taps have flow restrictors and aerators at the point of discharge. Flow restrictors or aerators shall not be provided for basins or sinks in healthcare facilities. These tend to be locations where bacterial growth can occur as well as restrict high flows required for healthcare washing requirements.
10. Showers in healthcare facilities are generally provided with an integral TMV along with the shower mixing valve.
11. Shower heads should not be installed with adjustable spray option around the shower head. This type of issue leads to water stagnation issues.
12. Moveable flexible hose type systems should be provided with a back-flow prevention valve and should be selected on ease of descaling and disinfection.
13. The purpose of having a back-flow prevention on hose type fixtures such as 'Shataf' bidets and hose showers is to ensure that submersion of the units into a WC or floor drains does not contaminate the supply system.

14. Hand held Bidets or 'Shatafs' should be served from the same water supply serving wash hand basins. They must not be served from water supply lines serving WC's (unless this is the same line serving the basins).

5.20 Irrigation Water Supply

1. For healthcare facilities, the irrigation system needs to be spilt into two different systems.
 - Internal and external landscape areas where patients, staff and visitor will be loitering.
 - Internal and external landscape areas where there will not be any patient, staff and visitor loitering
2. Water used for irrigation shall be served from a dedicated irrigation water tanks for each area mentioned above.
3. The internal irrigation system is prohibited to be served with a TSE water supply to areas described in section 5.19-1(a)above.
4. Irrigation to areas described in section 5.19-1(a) can only be served with clean potable water supply (Non-Cooled).
5. Irrigation to areas described in section 5.19(b) can be served with TSE water from STP plant or treated condensate water supply (or both).

5.21 Grey Water (WC Flushing Only) & WC Flushing Systems (Non-Chilled Systems)

1. Grey water strategies are generally avoided for healthcare facilities, due to the level of water treatment is sometimes not sufficient to be used with the healthcare facilities. But they maybe times where Due to the local water requirements and local water shortages, strategies have been provided within this design to allow for water to be re-used. Dubai Al-Sa'fat Green Building Code requirements encourage the use of a grey water system, therefore grey water systems are allowed but only for the following systems:

- Non-loitering Irrigation Areas
 - WC Flushing Systems
 - Maintenance Bib Tabs
2. All other areas except for the areas mentioned above (5.20-1) shall not be provided with grey water service.
 3. The following sources can be used for grey water systems:
 4. Water from Basins, Showers, Floor drains that have been treated (Waste-Water Drainage) and RO Water Rejection Water

5.22 Steam System

1. There are three types of steam services provided for any healthcare facility and they are the following:
 - Plant Steam – A steam supply service used for Healthcare facilities Laundry and food and beverages area
 - Clean Steam – A steam supply service used for healthcare laboratories and sterile store units (SSU)
 - Pure Steam – A steam supply used for high grade healthcare facilities or biotech or pharmaceutical laboratories.
2. In healthcare facilities, the quality of steam will depend upon the application it will be used for and this will be known for the healthcare briefing provided by the healthcare facility operator. The water quality serving the steam system must be treated (including softened water in some cases to reduce the mineral deposits in the system).
3. Plant Steam and Clean Steam are main type of services that will be used in healthcare facilities.

5.22.1 Source of Steam System

1. There will be two types of sources for the steam system used for healthcare sterile services and they are the following:
 - Central Steam Boiler System
 - Local or Central Electric Generation Steam Boiler
2. Both systems will provide any healthcare facility with the quality of steam they require, depending on the water quality supply into the system.

5.22.2 Plant Steam

1. Plant steam is based on having central local plant serving the healthcare facility. This system then serves multiple applications.
2. The steam system must have chemical additives added to control the pH level of the steam as well as the foaming of the water.

5.22.3 Clean Steam

1. Clean steam requires a supply of specialised treated water such as RO or DI water.
2. The production of clean steam contains no dissolved minerals on surfaces of cleaned items.
3. Where medical equipment requires steam supply, it shall be clean steam.
4. Clean Steam provision is required for Medical Equipment that requires steam.
5. Medical Equipment with integrated steam generators shall be provided with RO or DI water service to generate clean steam.

5.22.4 Steam System Pipe Materials

1. Piping must be stainless-steel due to the quality of the water and its contents.
2. Stainless-Steel is a non-reactive metal and is able to resist corrosion as well as being a hard metal.

3. Other types of metal such as copper are more active metals and they leach when in contact with this level of water quality and thus they lead to corrosion of the metal.
4. Plastic Pipes or FRP are not allowed for steam service pipes.

5.22.5 Central Steam Generation vs Local Steam Generation

1. While the option is the most economical to operate a central steam generation plant it is not the most efficient type of system for healthcare facilities. Having a local generation makes the system resilient against any failures as the local generation is intended for a single unit and purpose. If unit fails, the parts are easily repaired or replaced, whereas failure of the central steam plant system will have devastating impact on healthcare facility operation.
2. Some healthcare operators may use a combination of both systems. A combination of both systems should only be used for the following reasons:
 - Redundancy – Having the local steam generators be a backup set of steam generation
 - Sterilisation Speed – Increase the Sterilisation speed by having the incoming steam at a lower temperature and the integral unit being the second stage of steam (this will require advance control strategy)
3. Both steam generation methods can be used for healthcare facilities, but proper maintenance must be provided to the units.
4. Steam equipment serving SSU areas to be provided with equipment backup.

5.23 Public Health Maintenance

1. In healthcare facilities, it is crucial to have a maintenance strategy to maintain the quality of the system along with a fully qualified team.
2. A maintenance strategy to be provided to entail who is responsible for cleaning the water tanks, checking the water treatment filters and equipment operation as well as the water

temperature and quality of the water system.

3. Water tanks are to be cleaned on a weekly basis. The water tank must be a divided water tank that allows the system to operate for least 12 hours without incoming water. All cleaning within the tank must be completed within that time.
4. Post treatment tanks cleaned after the water treatment process (except UV water treatment) must be cleaned to a level where large particles have been removed as reasonably as possible.
5. After the tanks or water treatment systems have been cleaned, the healthcare operator will need to observe the water system for 24 hours to ensure for the system is fully clean, safe, and hygienic for the healthcare facility.
6. For hot water systems, the maintenance team must have a strategy in place to check the hot water heating element being used. This can usually be done monthly via the access manhole provided by the element.
7. For steam, correct healthcare design and maintenance of the system is needed. This will allow for a successful steam sterilisation outcome to the required healthcare areas. Maintenance tasks should ensure that wet packs are minimised, equipment staining, and chamber scale is minimised in the system.
8. The maintenance team for the facility must be familiar with water maintenance strategy as well the equipment installed within the facility.

5.24 System Configuration

1. Diagram 5.4 below provides a detail line schematic layout of the potable water system. Not elements in the system are used. The scheme below provides a system with all the complete requirements.

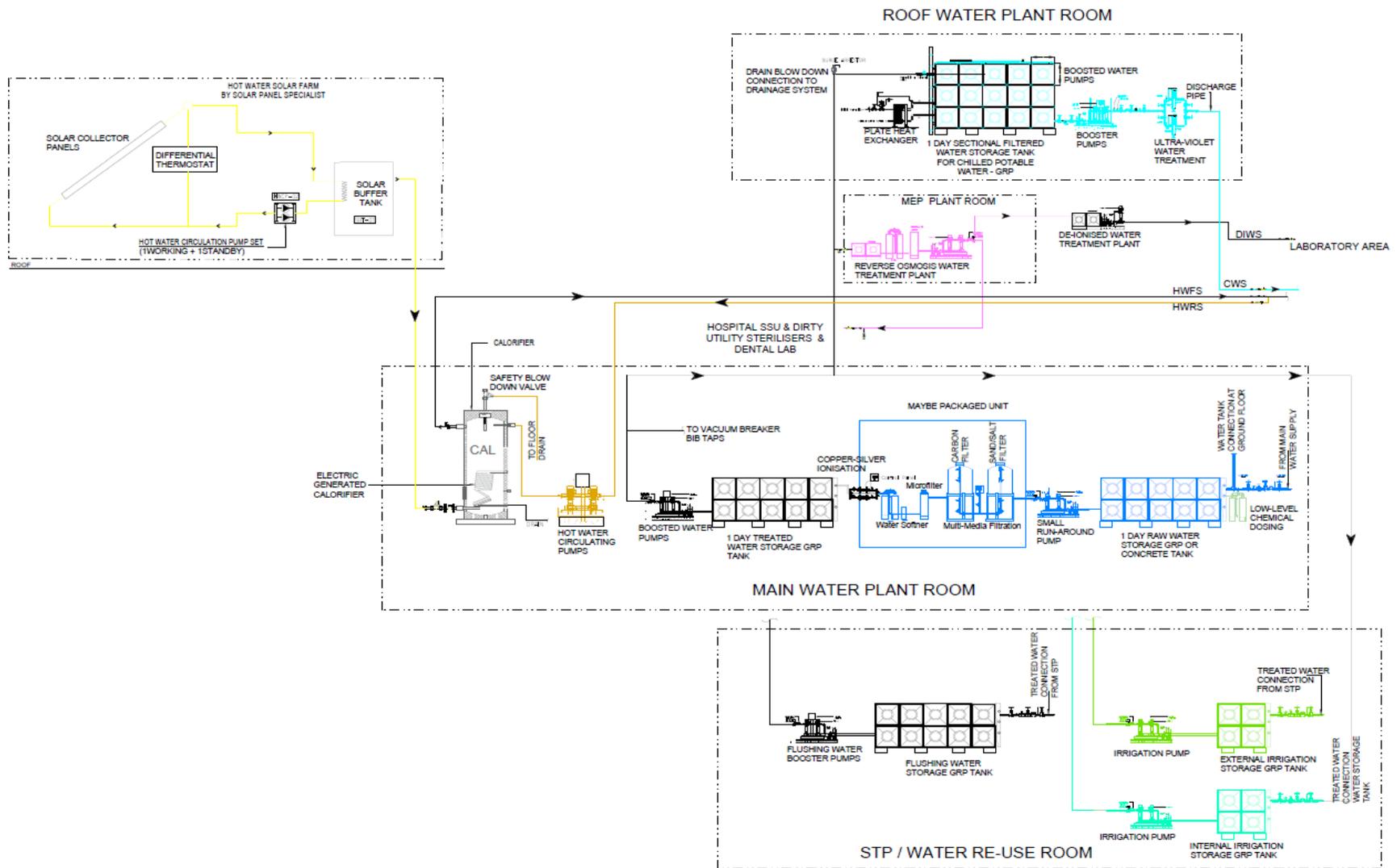


Diagram 5.4 – Water System Configuration

6. Public Health - Sanitary Drainage System Design (DS)

This PH-DS design guideline written for DHA healthcare facilities, is a consolidated document listing out the design requirements for all new construction and major renovation healthcare projects, within the Emirate of Dubai, under the licensure of DHA.

A good sanitary disposal system are essential systems for every development where the importance of sanitation are critical especially in new healthcare facilities. This has an impact on infection control parameters, equipment, staff and patients.

The requirements outlined in these guidelines are not intended to conflict with Federal Regulations, Local Municipality Laws, Executive Orders, or the needs of the end users.

This document is intended for the Architect/Engineer (A/E) and others engaged in the design and renovation of DHA facilities. Where direction described in applicable codes are in conflict, the A/E shall comply with the more stringent requirement. The A/E is required to make themselves aware of all applicable codes.

The document should be read in conjunction with other parts of the Health Facility Guidelines (Part A to Part F) & the typical room data sheets and typical room layout sheets.

6.1 Introduction

1. Drainage design will need to ensure a safe, clean and hygienic treatment areas are maintained and unaffected.
2. The drainage system design needs to deal with amount of effluent delivered in the system.
The standard drainage principles shall apply as per DM requirements unless specially stated otherwise within these guidelines.
3. For drainage design of healthcare facilities, the following details are important for the best

design of a facility:

- Healthcare facility geographical location
 - The ground surface level of where the healthcare facility is located
 - The locations of existing drainage network main holes and main connection points (if any)
 - The healthcare facility operational hours and times of peak load (if known)
 - Type of special drainage that will be discharged from the healthcare facility (radiation, chemical, grease etc.)
4. The drainage connection points for the external network must be as per DM requirements.

6.2 Drainage Strategy

1. The drainage system that must be a gravity drainage system for general drainage systems.
2. Pressure drainage system shall only be used externally to the building or within the basement areas via a sump pump connection.
3. Pressure drainage systems within buildings lead to a number design failures and risk of the healthcare clean environment being jeopardized in case of a leak in the system.
4. The drainage design of the system needs to ensure the following:
 - Prevent any odours emerging from the drainage system via dried traps.
 - Minimise the frequency of blockages.
 - Provide sufficient drainage gradient to discharge waste into main sewer network (or central plant)
 - Drainage discharge to be connected from sanitary fixtures to the main drainage runs and not via a floor trap or any other fixture.

5. The DHA drainage design guidelines for healthcare facilities shall only concentrate on drainage systems within healthcare facilities i.e. above ground installations.

6.3 Types of Drainage Systems

1. In healthcare facilities, there are several different types of drainage systems. It is imperative that these systems are kept separate in healthcare facilities, so that the infection control strategy is not jeopardized, and the system maintenance is easier to maintain.
2. The drainage systems are the following:
 - Waste Water Drainage – Generally drainage from Wash Hand Basins, Showers, Baths, Sinks, Scrub Sinks and Floor Drains. Drainage that does not contain human waste or contaminated water discharge.
 - Soil Water Drainage – Drainage from systems that contain human waste. Such as WC's, Urinals, Dirty Utility Flushing Rims (Slope Hopper) and Baby Washing Rooms.
 - Storm Water Drainage – This is drainage from water precipitation from external conditions such as rain, sprinkler water discharge or bib tap discharge.
 - Chemical Drainage – Drainage from dedicated laboratory areas where systems will need to be neutralised before connecting to the main system.
 - Radiation Drainage – This is drainage from the healthcare facility oncology areas and hot labs and toilet areas. This only applies to low level of radiation and not industrial radiation uses.
3. Some of the above systems maybe combined with other systems to ensure the system operation and function, such as including designing for grease / oil interceptors.

6.4 Vent Pipes

1. All the above systems will be required to be vented to atmosphere via a vent pipe connection

to the drainage runs. The vent pipe can be provided at high level or just above the point of discharge of the sanitary fixture units.

2. For very small facilities, where there are local toilet facilities made up of a WC and WHB, then the system is not required to be vented at high level via vent pipes, but a stub stack shall be sufficient for a system to be vented via the drainage system connection.
3. For small rise and small floor area healthcare facilities, an automatic air vent or air admittance valve can be provided at the top of a sanitary drainage system. This scenario is sometimes existing when a facility in a high-rise building is being refurbished on a single floor of a building and a separate drainage system needs to be installed.

6.5 Drainage System Design Types

1. A number of international drainage systems from different countries around the world use their local drainage system requirements (System 1, System 2, System 3, System 4 etc). In DHA these same systems can be adapted to be used in the emirate of Dubai. The drainage design will be based upon the requirements of BS EN 12056 unless mentioned otherwise by DM.

6.6 Waste Water Drainage

1. The drainage from sanitary fixture units in the drainage system must be directly connected to the main drainage line (vertical or horizontal main drainage lines).
2. Clean outs must be located behind the sanitary fixture unit or above ceilings or floor access in service areas.

6.7 Floor Drains

1. Floor drains are required as per Part B briefing requirements for areas such as in dirty

utilities, SSU, clean-up areas.

2. Floor drain and clean out shall be a combined fitting with trap to prevent odours in areas requiring floor drains
3. Floor drains located in an environment that will dry out will need to be connected to a primer valve that is connected to the potable water system to ensure that the trap refills with water if the trap dries up due to evaporation.
4. A special floor drains with a special seal can be used in place of a combined trap and primer valve.

6.8 Soil Water Drainage

1. Soil drainage shall be the drainage discharge from Toilets (WC's), dirty utilities and baby washing facilities.
2. These can be S-Trap or P-Trap discharge systems.
3. The type of discharge will depend on the local some parameters limiting the designing of the drainage system. Ceiling space may be restricted, structure may prevent core drilling through below or shaft space may be limited. Figure 6.1 below provides the difference between the two discharge systems.

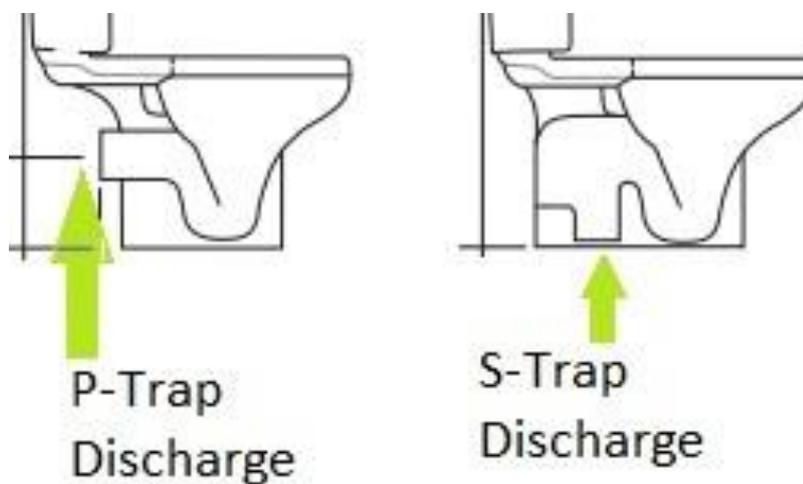


Figure 6.1 – Types of WC Discharge

4. It is highly recommended to install a P-trap system. It is easier to maintain and replace parts of fittings to the WC. Furthermore, it provides the shortest possible drainage route and eliminates any drainage runs over healthcare sensitive areas.
5. The WC drainage connection must be a minimum of 150mm (160mm) if more than 1 No. WC is connected to the system.
6. Bends of 90° must not be installed on soil drainage lines as these are the points of the system that blockage is likely to occur.
7. All bends must be provided with a Rodding Eye (RE) access door for unblocking the soil system if it suffers from blockage.
8. The RE should be located in service areas or behind WC's, never in clinical areas. Figure 6.2 below provides further detail.

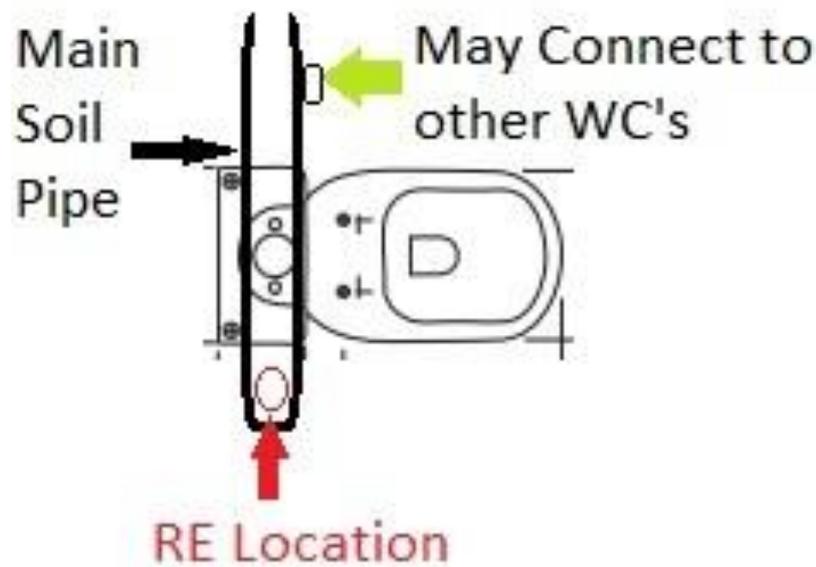


Figure 6.2 – Rodding Eye (RE) location behind WC.

6.9 Soil & Waste Water Drainage Over Critical Areas

1. The opportunity of having a clear drainage route over non-sensitive areas may not always be possible. There are some instances where the drainage will need to be taken over Grade

A and B areas.

2. Where health planning briefing design does not allow for such leisure the drainage design shall be sleeved or double walled completely through the critical area that the pipe is routed through. The end of the pipe sleeve is to be open on both ends to the external areas (that are not critical). This strategy allows for any leaks to be taken out if the critical zones completely.
3. If a double wall pipe solution is not used, then a double ceiling system over the clinical areas must be provided.
4. For Dialysis areas, there should be a dedicated drainage point for each proposed dialysis station. The drainage connection shall be provided below the water supply point and shall be a clean drainage connection with no air gaps. The drainage pipe shall be easy to disconnect between machine and station.

6.10 Rainwater Drainage System

1. Complete rain water drainage system needs to be provided to any healthcare facility.
2. Rainwater Drainage at healthcare facility roof (s) will be collected via a network of horizontal pipes and transferred to a level to connect to the external storm water network or within the facility holding tanks or in some cases into soakaways used to increase the water table level. In DM, the rainwater system will connect into a collection tank or the external storm water network. DM requirements shall be the design that is followed for connection requirements.

6.10.1 Syphonic Rainwater systems

1. It is highly recommended that these items should only be used in areas where there is limited ceiling space for services and thus several bends will be used, or a water seal has been

provided at the rainwater floor gullies/drains to ensure that the symphonic process is enabled.

6.10.2 Pipe Materials for Drainage Systems

1. The drainage system pipe materials shall be as per BS EN 12056 or DM requirements. These requirements shall be as follows:
 - Sanitary Sewer, Storm water and Vent, Above Grade: uPVC (un-plasticized polyvinyl chloride) as per BS EN 1329. Gravity Drainage to UPVC for local to the sanitary fixtures.
 - Force Main Below & Above Grade as well as gravity drainage: HDPE (High Density Polyethylene) as per 12201. Gravity drainage for min stacks to be HDPE.
 - Kitchen Waste: HDPE (High Density Polyethylene)

6.11 Special Drainage Systems

1. Special drainage systems are used in laboratory and in special healthcare departmental areas such as morgues, incinerators etc.
2. Special drainage systems are the following:
 - Acid Waste Drainage
 - Infectious Contaminated Drainage

6.11.1 Acid Waste Drainage

1. An acid waste drainage system deals with drainage liquid discharge of liquids with a PH level lower than 7. Generally, this type of drainage system is provided at high level fully operational teaching healthcare facilities where pharmaceutical drugs are prepared and manufactured.
2. All the drainage from the acid waste drainage must be neutralised to a pH of 4 as minimum before being connected to the external drainage network.

3. Floor drains should be avoided in laboratory areas.
4. Where floor drains are provided in laboratory areas, the floor drain shall be covered with a special odour type seal and the floor drain must have a disinfection capability.
5. Any spillage should be wiped away with a cloth and that cloth used for wiping be placed in hazardous waste bins.

6.11.2 Acid Waste Drainage Health and Safety Concerns

1. Concentrations of Acid drainage can cause a number of severe damage (eyes, skin etc) to healthcare operators. Emergency showers, eye wash units, drench system shall be provided by exit doors as per Part B healthcare briefing.
2. A floor drain be needed to prevent the flooding of the area where the emergency is being provided.
3. The floor drain shall be connected to a neutralisation plant. If gaseous or fog acid is generated in a facility, fog water nozzles are to be used to prevent the gas from spreading.

6.11.3 Acid Waste Drainage Design Considerations

1. Each sanitary fixture will need to be individually trapped and each unit to be provided with a vent pipe to atmosphere.
2. Drainage from laboratory systems shall be connected to a single acid neutralisation plant unless mixing of the chemicals causes a hazardous or a catalytic reaction, then another drainage system along with another neutralisation plant will need to be provided.

6.11.4 Acid Waste Drainage Pipe Material

1. The following pipes materials are required for acid waste drainage systems:
 - Polypropylene with Electrofusion welding joints
 - Glass with Compression Joints (encased in plastic for protection) – But not Vent pipes.

- High Silicon Cast Iron with Compression Gasket Joints
2. Other materials such as PVC or UPVC or CPVC may be considered but should be avoided as they have a lower chemical compellability and lower temperature rating.
 3. Polytetrafluoroethylene (PTFE) seal is the only material that is resistive to a wide range of chemicals as well as having the highest temperature rating.
 4. The pipe for the acid waste drainage systems should be supported through the system to prevent drainage spots in the drainage system that could lead to leaks.

6.11.5 Acid Waste Drainage Treatment

1. Acid waste drainage pH levels from healthcare laboratories require to be neutralised to a pH between 4 and 7 before being connected to the main external drainage network. DM may have a more stringent requirement and that does not allow any discharge to the network from the laboratory.
2. Probes will be required after the neutralisation process to ensure that the pH level is correct when connecting to the external drainage network.
3. If drainage cannot be connected to the DM from laboratory waste, then a storage/holding tank system shall be provided for a number of days.
4. The storage/holding tank can only be emptied by a licenced contractor.
5. The type of neutralised system used is the drainage laboratory discharge to be in contact with lime stone chips or a lime stone gel/liquid or chemical faeces or equivalent.
6. The design of the treatment system should be designed for the maximum flow rate foreseen from the laboratory area.
7. In smaller DHA facilities or clinics, a central neutralisation plant or equipment may be too costly. If this is the case, then single isolated sink(s) should be provided.

8. These sinks will need to have an acid neutralising trap as part of the unit. These should be used for discharging acid waste drainage only.

6.11.6 Infectious Contaminated Drainage

1. Drainage that will consist of biohazardous material carrying suspended living organisms which is risk of causing infection to patients, visitors and healthcare operational staff is considered infectious contaminated drainage.
2. The drainage will be from type Q isolation rooms.
3. These systems need to be disposed of correctly and safely to ensure the continuity of the facility clean and safe environmental conditions via discharge to a holding tank.
4. The holding tank will be connected to all the areas of concern where there is a biohazardous material being discharged.
5. The containment is divided into the following parameters:
 - Primary Measures – Particular equipment such as the biological safety cabinet, glove boxes etc.
 - Secondary Measures – Measures used to support primary measures.

6.11.7 Types of Biological Safety Levels

1. CDC/NIH Guidelines for Biosafety in Microbiological and Biomedical Laboratories have provided biosafety level of contaminates for facilities. The range from Biosafety Level (BL) BL1 – BL4. In the majority of healthcare facilities, the safety level is between BL1 and BL2, (BL3 is very rare).

6.11.8 Infectious Contaminated Drainage Treatment

1. The holding which is also known as a 'Kill Tank', is the when the tank is injected with a chemical that attacks the hazardous organisms.

2. Please note that the decontamination process is not an instantaneous process, but the 'Kill Tank' works in stages for the drainage to be neutralised before connecting to the system.

6.11.9 Infectious Contaminated Drainage System Components

1. For healthcare facilities, the drainage system must be closed system and the floor drains (if provided) are to be sealed.
2. Floor drains will need to have valve connections when the system is not in use.
3. In many of these areas the HVAC areas (as discussed in section 2 of these guidelines) will have negative air requirement, therefore the floor trap will need to be 90-100mm deep.
4. The floor trap seal will need to be filled with a disinfectant solution that can prevent the spread of organisms.
5. The pipe system will be a double wall pipe system with leak detection.

6.11.10 Infectious Contaminated Drainage System Pipe Material

1. The proposed drainage materials for such systems are the following:
 - Stainless steel
 - PTFE – For higher temperature systems
 - PVC, CPVC, PP, or lined FRP pipe – For lower temperature systems.

6.11.11 Infectious Contaminated Drainage System Vent

1. Vents from pipe, fixtures, sealed sump pits, and kill tanks must be filter-sterilized prior to leaving the system using an HEPA (EP1) filter (connected to HVAC system exhaust).

6.12 Radiation Drainage

1. As per international standards (Federal Authority for Nuclear Regulation (FANR – Abu Dhabi)), there is no need for radiation (Contaminated Drainage) holding tanks for drainage from toilets coming from patients who have just used iodine-131 or other low-level

radioactive isotopes as per FANR.

2. If a healthcare facility would like to provide a radiation tank they will need to provide the tank external to the building in a location where there is limited to radiation exposure. The level acceptable radiation levels will be determined by the radiation safety officer.
3. DM may not allow for radiation drainage to be diluted and connected to the external drainage network, therefore a holding tank shall be provided.

6.12.1 Radiation Drainage Strategy

1. Radiation drainage shall be discharged to its own dedicated system. The system may be a diluted type of system or a holding tank system for a licenced contractor to remove the tanks contents.
2. A sample access to the system is to be provided for the radiation safety officer to take periodic samples of the system.
3. Many facilities may wish to hold radiation drainage confined to glove boxes or protected hoods. Radiation drainage in these areas should be shielded.

6.12.2 Radiation Drainage Holding & Decontamination

1. External radiation storage tank shall be a divisional storage tanks to allow for operation and maintenance of the radiation storage tank.
2. Depending on the level radiation used, the tank storage volume can be for 30 to 90 days storage capacity (it may sometimes be less for an oncology dedicated facility).
3. It is highly recommended a second set of holding tanks should be provided to reduce the risk of healthcare operations. This provision should be based on a risk assessment carried outlining the capability of the licenced contractor being available as well as the operational parameters of the facility and oncology department.

6.12.3 Radiation Pipe Material

1. The pipes used for radiation drainage will depend on the level of radiation being discharged or carried in the drainage system. As per the NRC requirements, the pipe material will need to have the following properties:
 - Pipe to be nonporous.
 - Pipe must be easy to clean and decontaminate.
 - Pipe must be acid resistant.
 - Pipe to be nonoxidizing as the oxides of the pipe can become radioactive
 - The pipe joints should not form a crud trap for drainage discharge
 - The pipe joints should not be by radiation exposure such the weakening of gaskets.
2. For healthcare facilities with low levels of radiation drainage levels some materials such as plastic are not acceptable since there is possibility for certain plastics to react to different types of radiation drainage.
3. Stainless Steel pipes (typical 316L) with welded joints is the only pipe that covers the above requirements as well as not allowing crud trap on the pipe joints.
4. Stainless-Steel press fitting pipe fittings with smooth surfaces may also be used instead of welded joints.
5. In bunker areas, where thick concrete is used, the drainage pipe shall be pipe-in-pipe, the pipe, with a Duplex Stainless-Steel pipe to be the exterior pipe that is in contact with concrete.
6. Pipe joints are to be outside the concrete cast (unless its unavoidable).

6.13 Condensate Drainage

1. All condensate drainage from local air conditioning, HVAC main equipment and plant to be

collected or discharged to foul drainage via a trap (i.e. hepVo trap).

2. For water re-use efficiency, condensate should be collected in a single tank and treated prior to use.
3. In line with the Dubai Al-Sa'fat Green Building Code, condensate collected shall be used as irrigation purposes (please refer to irrigation water system in these guidelines).

6.14 Kitchen Grease Drainage

1. Where there is a facility for hot food to be cooked then a grease interceptor is to be provided for all the drainage in that area to be connected to before being discharged to the external drainage network.
2. If the healthcare facility is a small clinic (RDL 1-2), then a local below the kitchen sink grease interceptor is to be provided.
3. In larger facilities (RDL 3-6) the grease interceptor should be provided in an area that is readily accessible by the healthcare maintenance staff.

6.15 Oil or Fuel Drainage

1. Many healthcare facilities may have main electrical equipment that relies on a fuel source. Any drainage around this area is to be provided with an Oil Interceptor as per BS EN 858.
2. Oil Interceptor as per BS EN 858 to be provided car park areas where car washing takes place.
3. For generator areas where a foam extinguishing system has been activated, the drainage from the discharge shall not be directly discharged into the sewer network.
4. Foam systems have a high BOD and therefore will need a storage drainage tank stored below the generator and treated before discharging to the external drainage network via Oil Interceptor as per BS EN 858.

7. Public Health - Medical Gas System Design (MGS)

This PH-MGS design guideline written for DHA healthcare facilities, is a consolidated document listing out the design requirements for all new construction and major renovation healthcare projects, within the Emirate of Dubai, under the licensure of DHA.

The Medical Gas System security, resilience and storage capability have to be designed ensure that patient safety as well hospital operations are not at risk.

The requirements outlined in these guidelines are not intended to conflict with Federal Regulations, Local Municipality Laws, Executive Orders, or the needs of the end users.

This document is intended for the Architect/Engineer (A/E) and others engaged in the design and renovation of DHA facilities. Where direction described in applicable codes are in conflict, the A/E shall comply with the more stringent requirement. The A/E is required to make themselves aware of all applicable codes.

The document should be read in conjunction with other parts of the Health Facility Guidelines (Part A to Part F) & the typical room data sheets and typical room layout sheets.

7.1 Introduction

1. The aim of this section of the guidelines is to promote the correct design of Medical Gas Systems for healthcare facilities. The design will be based on the requirements of HTM-02-01 or NFPA-99 tailored for healthcare facilities in the Emirate of Dubai under the jurisdiction of DHA.
2. The design will discuss storage requirements, type of system proposed as system locations for the following Medical Gas Services:
 - Oxygen

- Medical Air (MA4)
 - Surgical Air (SA7-SurgicalTool Air 7Bar)
 - Vacuum/Suction Air
 - Nitrous Oxide (N2O)
 - Helium/Oxygen (Heliox)
 - Nitrogen (N2)
 - Carbon Dioxide (CO2)
 - Nitrous Oxide/Oxygen (Gas Mixture – Entonox)
 - Gas Scavenging Systems (AGSS)
3. These design guidelines are to be used in new healthcare facilities as well as facilities that will be refurbished in Dubai under the process of DHA as mentioned in Part A of these Guidelines.
 4. When designing the medical gas requirements for healthcare facilities, a risk assessment needs to be carried out to understand the requirements of the facility. Requirements such as distance from supplier of medical (if applicable), the geopolitical understanding, traffic, work days, peak times, particular times of year where work load is affected (Ramadhan, Public Holidays etc) as well as patient safety.
 5. The objective of the risk assessment is to ensure that the risk to patient safety is eliminated or reduced to as low as possible as well as ensure that hospital operation is undisturbed.

7.2 Design Criteria

1. The Medical Gas Service is designed to provide a safe and effective method of delivering quality medical gas service to the terminals within FPU's in healthcare facilities.
2. In addition to Medical Gas Services being supplied to the department, some areas will require

gas scavenging disposal systems to control the exposure to nitrous oxide.

3. Unless otherwise mentioned within these guidelines, the design shall follow the medical gas design shall be as per HTM-02-01 or NFPA-99 (Not Both).
4. Medical gas services shall only be supplied to clinical areas as per the healthcare briefing requirements shown in Part B of these guidelines.
5. Medical gas service should not be provided for non-clinical areas such as workshops (not biomedical workshops) and pathology departments. These areas shall be provided by 11Bar Compressed Air.
6. For sensitive patient areas such as patients having infectious diseases, portable suction devices should be used in order to not contaminant the medical gas system.
7. The Medical Gas System should be providing a number of sources to serve the facilities. Within these guidelines the sources shall be stated primary, secondary and reserve/emergency systems.
8. The purity of the medical gases shall be as the European Pharmacopoeia requirements table as shown in table 7.1 below
9. Particulate level tests are to be provided with medical gas purity requirements.
10. To maintain the sterile services of the medical gas service throughout the healthcare facility, the quality in terms of particulate content, dryness and concentration of impurities should comply with the requirements for maximum concentrations given in Table 8.1 below.
11. Bacteria filter are to be included in medical and surgical compressor systems to reduce the risk of delivering spores of infectious material to vulnerable patients.
12. The medical gas service connected to the bacteria filter must be a dry service. This is to ensure that any micro-organisms are prevented from bypassing the bacteria filter.
13. Micro-organisms can penetrate a bacteria filter if the material is wet. The filter is to be

checked every 12 weeks of hospital operation.

14. For Medical Gas purity tests these are to be checked by the healthcare operator every 6 months for new builds and refurbished/retrofit facilities.

Gas & Source	Oil	Water	CO (Carbon Monoxide)	CO ₂ (Carbon Dioxide)	NO (Nitric Oxide) & NO ₂ (Nitrogen Oxide)	SO ₂ (Sulphur Dioxide)	Odour/ Taste
Oxygen from Bulk Liquid Storage	-	≤67 vpm ≤0.05 mg/l, atmosphere dew-point of -46°C)	≤ 5 mg/m ³ , ≤ ppm v/v	≤ 300 ppm v/v	-	-	None
Oxygen from PSA Plant (Oxygen Generation)	0.1mg/ m ³	≤67 vpm ≤0.05 mg/l, atmosphere dew-point of -46°C)	≤ 5 mg/m ³ , ≤ ppm v/v	≤ 300 ppm v/v	≤ 2ppm v/v	&	None
Nitrous Oxide	-	≤67 vpm ≤0.05 mg/l, atmosphere dew-point of -46°C)	≤ 5 mg/m ³ , ≤ ppm v/v	≤ 300 ppm v/v	≤ 2ppm v/v		N/A
Nitrous Oxide/Oxygen Mixture	-	≤67 vpm ≤0.05 mg/l, atmosphere dew-point of -46°C)	≤ 5 mg/m ³ , ≤ ppm v/v	≤ 300 ppm v/v	≤ 2ppm v/v		N/A
Medical & Surgical Air	0.1mg/ m ³	≤67 vpm ≤0.05 mg/l, atmosphere dew-point of -46°C)	≤ 5 mg/m ³ , ≤ ppm v/v	≤ 900 mg/m ³ ≤ 500 ppm v/v	≤ 2ppm v/v		None

Synthetic Air	-	≤67 vpm ≤0.05 mg/l, atmosphere dew-point of -46°C)	-	-	-	-	None
Helium/Oxygen O ₂ < 30%	-	≤67 vpm ≤0.05 mg/l, atmosphere dew-point of -46°C)	≤ 5 mg/m ³ , ≤ ppm v/v	≤ 300 ppm v/v	≤ 2ppm v/v	-	None

Table 7.1 – Quality of Medical Gases

15. For all healthcare facilities and to maintain the operation of the system, the medical gas supply throughout should be designed to achieve continuity of supply to the terminal units in normal condition and in a single fault condition. Loss of supply due to maintenance of a supply source (or a component within it) is not considered a single fault condition.
16. The medical gas design provided will need to ensure that both system design parameters and the need for supply security of the service haven been identified. This will need to be carried out via a system/healthcare operator requirements risk assessment.
17. As mentioned via the sources of supply section of these guidelines, security of medical air supplies must be given a high priority and electrical failure must not be allowed to jeopardise supplies (as mentioned in the electrical sections of these guidelines (Sections 3.7 & 3.8), all medical gas system is to be connected to Primary, secondary and tertiary power supplies).
18. Gas Scavenging system (AGSS) shall only be provided to areas being serviced with Nitrous Oxide.

7.3 Sources of supply

1. Medical Gas services within the medical system in healthcare facility operate based on a

redundancy and resiliency provision of the service to ensure patient safety and maintain the operation of the healthcare facilities.

2. Liquid Oxygen Cylinder Systems

- **Primary Supply** – Liquid Cylinder Manifold System (No Change over panel, all cylinders are on at the same time)
- **Secondary Supply** – Automatic Cylinder Manifold System. Activated when Primary Supply fails or there is a shortage of primary supply.
- **Reserve Supply** – Automatic Cylinder Manifold System to Grade A areas.

3. Oxygen Generation Plant (PSA):

- **Primary Supply** – Multiplex Compression Unit
- **Secondary Supply – Automatic Cylinder Manifold System. Activated when** Primary Supply fails or there is a shortage of primary supply. The number of cylinders should be based on a 4-hour operation storage provision.

Recommendation: The secondary supply should be filled from the primary supply. This will provide an indication to the hospital operator when the primary supply fails and ensures that the secondary supply serving the healthcare departments are always filled.

- **Reserve Supply** – This type of supply will depend on the risk assessment carried out by the design consultant. The conclusion may lead to the use of an Automatic Cylinder Manifold System, a manual Cylinder Manifold system or another Oxygen generated plant located at a different location on site or local bottles to departments to serve Grade A areas.

4. Medical Air Supply (MA4)

Duplex Compressor Set-Up

- **Primary Supply** – Duplex Compressor System
- **Secondary Supply** – Automatic Cylinder Manifold System. Activated when Primary Supply fails or there is a shortage of primary supply. The number of cylinders should be based on a 4-hour operation storage provision.
- **Reserve Supply** - Automatic Cylinder Manifold System. Activated when Primary Supply fails or there is a shortage of primary supply. This type of manifold system may only be located locally near Grade A areas.

Triplex Compressor Set-Up

- **Primary Supply** – Two Compressor of a Triplex Compressor System.
- **Secondary Supply** – Third Compressor of a Triplex Compressor System.
- **Reserve Supply** – Automatic Cylinder Manifold System to support the entire healthcare facility.

Quadruplex Compressor Set-Up

- **Primary Supply** – Two Compressor of a Quadplex Compressor System.
- **Secondary Supply** – The Other two Compressor of a Quadplex Compressor System.
- **Reserve Supply** – Automatic Cylinder Manifold System to support the entire healthcare facility.

Recommendation: Each compressor/pump is sized to cope with half the system design flow

5. Surgical Medical Air (SA7 /Tool Air-7Bar)

Simplex Unit Set-Up

- **Primary Supply** – Simplex Compressor Unit.
- **Secondary Supply** - Automatic Cylinder Manifold System. Cylinder system shall be

Activated when Primary Supply fails or there is a shortage of primary supply. The number of cylinders should be based on a 4-hour operation storage provision.

- **Reserve Supply** – Departmentally localised valved Cylinders with flow regulators and meters. This will be located in a small plant room near Grade A areas such Operating Theatres.

Duplex Unit Set-Up

- **Primary Supply** – One Compressor of Duplex System.
- **Secondary Supply** – Second Compressor of Duplex System.
- **Reserve Supply** - Automatic Cylinder Manifold System. Cylinder system shall be Activated when Primary Supply and Secondary fails or there is a shortage of the supply. The number of cylinders should be based on a 4-hour operation storage provision of the specific department.

6. Combined Medical Air & Surgical Air Plant

Duplex Compressor Set-Up

- **Primary Supply** – Duplex Compressor System.
- **Secondary Supply** – 2 No. Automatic Cylinder Manifold System (1 No. for Medical Air and 1 No. for Surgical Air). Cylinder system shall be Activated when Primary Supply fails or there is a shortage of primary supply. The cylinders may be filled by the primary source or already filled cylinders provided by a local supplier. The number of cylinders should be based on a 4-hour operation storage provision.
- **Reserve Supply** - Automatic Cylinder Manifold System. Activated when Primary Supply fails or there is a shortage of primary supply. This type of manifold system may only be located locally near Grade A areas.

Triplex Compressor Set-Up

- **Primary Supply** – Two Compressor of a Triplex Compressor System.
- **Secondary Supply** – Third Compressor of a Triplex Compressor System.
- **Reserve Supply** – Automatic Cylinder Manifold System to support the entire healthcare facility.

Quadruplex Compressor Set-Up

- **Primary Supply** – Two Compressor of a Quadplex Compressor System.
- **Secondary Supply** – The Other two Compressor of a Quadplex Compressor System.
- **Reserve Supply** – Automatic Cylinder Manifold System to support the entire healthcare facility.

Recommendation: Each compressor/pump is sized to cope with half the system design flow.

7. Liquid Gas Mixture (Oxygen & Nitrous Oxide)

- **Primary Supply** – Liquid Oxygen and Liquid Nitrogen Vessels with Mixer Unit.
- **Secondary Supply** – Secondary Liquid Oxygen and Liquid Nitrogen Vessels with Mixer Unit.

Recommendation: The for Primary and secondary unit, depending on the speciality and size of the facility a cylinder system may be sufficient, but this will need to be confirmed by a risk assessment.

- **Reserve Supply** – This type of supply will depend on the risk assessment carried out by the design consultant. The conclusion may an Automatic Cylinder Manifold System, a manual Cylinder Manifold system or another Oxygen generated plant located at a different location on site or local bottles to departments to serve Grade A areas.

8. Medical Vacuum System

Triplex Compressor Set-Up

- **Primary Supply** – Two Compressor of a Triplex Compressor System.
- **Secondary Supply** – Third Compressor of a Triplex Compressor System.
- **Reserve Supply** – Portable Suction Equipment.

Quadruplex Compressor Set-Up

- **Primary Supply** – Two Compressor of a Quadplex Compressor System.
- **Secondary Supply** – The Other two Compressor of a Quadplex Compressor System.
- **Reserve Supply** – Portable Suction Equipment.

Recommendation: Each compressor/pump is sized to cope with half the system design flow.

Important Note: In the event of power failure, cylinder- or medical-gas-system-powered vacuum generators can be used, but the use of venturi-type vacuum generators is recommended only for emergency use, as these units are generally driven from the medical oxygen system and use large amounts of gas. This can lead to oxygen enrichment and present a potential fire hazard and may result in the emission of pathological material.

9. Gas Cylinder Manifold System

- **Primary Supply** – Automatic Cylinder Manifold System and the number of cylinders based on the system design. Number of hours of operation as well as the availability of the cylinder supplier needs to be considered through a risk assessment to determine the number of operating hours, which will provide the exact number of cylinders.
- **Secondary Supply** – Manual Emergency Reserve manifold. System to come in line via a non -return valve. Number of cylinders based on 4 hours of system operation.

- Reserve Supply –
 1. Automatic Cylinder or Manual Emergency Reserve manifold supplying the system via a non-interchangeable screw threads connecter.

Or

 2. Local gas cylinder bottles or cylinders within departments with flow regulators.

Important Note: For Carbon Dioxide Gas or Carbon Dioxide Mixture Gas, depending on the number of beds as well as the type of facility, gas bottles shall be provided local to the departments as per Part B requirements. But for larger facilities they shall follow the cylinder manifold arrangement as mentioned above (Primary, Secondary and Reserve Supply).

10. Vacuum Insulated Evaporator System (VIE)

Simplex Unit Set-Up

- **Primary Supply** – A Simplex VIE Vessel System.
- **Secondary Supply** – Automatic Cylinder Manifold System. Activated when Primary Supply fails or there is a shortage of primary supply.
- Reserve Supply –
 1. Automatic Cylinder Manifold System. Activated when Primary Supply fails or there is a shortage of primary supply. This type of manifold system may only be located near Grade A areas.

OR

 2. Automatic Cylinder or Manual Emergency Reserve manifold supplying the system via a non-interchangeable screw threads connecter.

Please Note: Medical vacuum is provided by means of a central vacuum plant. The

vacuum system should always be used in conjunction with vacuum control units that include vacuum jars. In the event of inadvertent contamination of the pipeline systems resulting from vacuum jars overflowing, immediate action is required to clean the system before any fluids etc dry out.

Duplex Unit Set-Up

- **Primary Supply** – One Vessel of a Duplex VIE Vessel on plinth.
- **Secondary Supply** – Second Vessel of a duplex VIE System on the same plinth as Primary Supply.
- **Reserve Supply** – Automatic Cylinder Manifold System. Activated when Primary Supply fails or there is a shortage of primary supply. Reserve to be used to serve the entire healthcare facility.

Seperate VIE Vessel Set-Up

- **Primary Supply** – One Vessel of a Duplex VIE Vessel on plinth.
- **Secondary Supply** – Second Vessel of a duplex VIE System on a separate plinth as Primary Supply. Location of supply is carried out through a s risk assessment as it determines that there is a risk of the primary supply in that location being a failure and therefore the secondary supply needs to be located in a different location. Secondary supply to be installed with a non-return or double check valve to prevent gas loss in the event of one vessel leak or failure.
- **Reserve Supply** – This type of supply will depend on the risk assessment carried out by the design consultant. The conclusion may an Automatic Cylinder Manifold System, a manual Cylinder Manifold system etc. The risk assessment may also a certain that a reserve supply is not required as there is a dual supply or ring main approach has been provided by the secondary supply system.

Important Note: For all compressor systems with a design flow greater than 500 L/min, two receivers, each able to be isolated individually.

11. Gas Scavenging System (AGSS)

For operating theatres and other critical clinical spaces (Grade A), the number of AGSS plant depends on the number of Air Handling Units to those areas. For example, for each operating theatre having its own dedicated Air Handling Unit then a Simplex AGSS plant is to be provided for each operating theatre. The reserve provision shall be a Simplex AGSS unit that can serve up to 6 No. Areas. If there are 12 areas then 2 No. simplex units shall be spare if all 12 areas are being served by 12 No, Simplex AGSS Units.

Simplex Unit Set-Up

- **Primary Exhaust** – Simplex Compressor Unit.
- **Reserve Exhaust** – Simplex Compressor Unit in Manual Change Over.

Important Note: For operating theatres and other critical clinical spaces (Grade A), where more than two areas are being served by a single Air Handling Unit, then a Duplex AGSS plant is to be provided with an automatic change over to the spare pump.

Duplex Unit Set-Up

- **Primary Exhaust** – Duplex Compressor System (one Compressor).
- **Reserve Exhaust** – Second Compressor from Duplex AGSS Unit.

7.4 Basic Sizing of Medical Gas Cylinder Sources

1. HTM-02-01 provides, a table in chapter 2 (table 10) that provides the basic cylinder storage provision for a healthcare facility.
2. Table 10 in HTM-02-01 must only be used as the conceptual design provision if the healthcare briefing has not been provided. It must not be used as the actual sizing

requirement for any of the healthcare facility.

3. The sizing of the cylinders and major systems such as VIE system, will need to be carried out via risk assessment based on the following parameters:
 - Healthcare operating Hours
 - Distance from Supplier
 - Traffic Data
 - Supplier operating Hours
 - Supplier Response time in Peak working hours of the day
 - Supplier Response time in slow night operating hours.
 - Cylinder Delivery and Restocking History (if Known)
4. This is to ensure that the Medical Gas Supply is adequate and that continuity as well as quality of supply is maintained.

7.5 Number of Medical Gas Outlets and Locations

1. As per the part B of these guidelines, the number of medical gas outlets as well as the type of medical gas service to FPU's shall be provided via the use of Room Layout Sheets (RLS) and Room Data Sheets (RDS).
2. Healthcare facilities under DHA, RLS and RDS must be used for medical gas briefing and no other international or local guidelines.

7.6 AVSU and LVA

1. Area Valve Service Units (AVSU's) and Medical Gas Zone Valves (LVA) are the main isolation valve terminal units used to isolate the medical gas services serving the clinical departments.
2. The AVSU's & LVA must be located by a nurse station that is continuously occupied during

the healthcare facility operating hours.

3. The panel is to be a combined panel with valves as well as alarm panel. This is not a separate alarm panel in one location and service isolation valve in another.
4. The installation height requirements of the panel for healthcare facilities in DHA, shall be as per figure 7.1 below. This height is based on the comfortable average heights for nurses within DHA facilities.

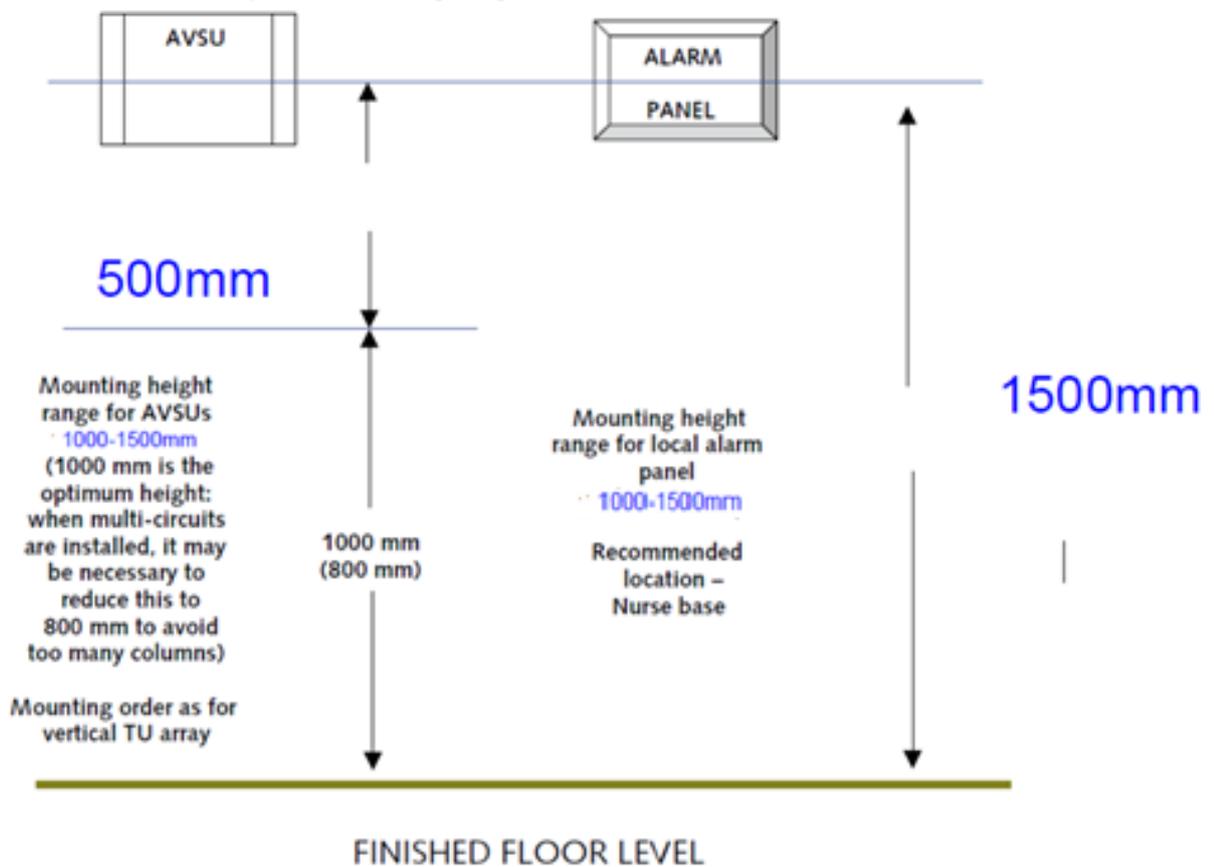


Figure 7.1 –Panel Installation Details

5. The installation height of the panel ensures that the healthcare operational staff can operate the panel if needed (alarm mute, valve isolation in emergencies).
6. The panel needs to be provided with access requirements to operate the valves if need be.
7. Access to the panel must be provided via a dedicated key or a break glass hammer. These shall only be provided for hospital operational staff (Nurses, Doctors and Maintenance staff).

8. The minimum height for AVSU installation shall be 1m for dual circuits.
9. Dual circuits shall only be arranged (in two columns) if the height from the top to bottom of the unit exceeds 1m.
10. To avoid using an excessive number of Panels, this can be increased to 1.2m.
11. The panels located on a wall will need to ensure that there is a minimum clearance of 100mm behind the unit for Medical Gas pipework (175mm for back to back pipes serving the AVSU's).
12. The panels are to be labelled with permanent naming templates and not adhesive labels.
13. A key is to be provided at the fire command centre for Dubai Civil Defence Access.

7.7 Medical Gas Plant Rooms

1. Table 7.2 below provides a safety distance compliance for location of Bulk Liquid Oxygen Tank from buildings, vehicles etc (based on the volume of gas liquid stored).

Safety Distances from Exposure to Vessel/Point Where Oxygen Leakage or Spillage Can May Occur	Up to 20 tonnes (Distance in m)	Over 20 tonnes (Distance in m)
Areas where open flames / smoking are permitted	5	8
Places of Public Assembly	10	15
Offices, Canteens and areas of Occupancy	5	8
Pits, Ducts, surface water drains (un-trapped)	5	8
Openings to underground systems	5	8
Building Foot Print	5	8
Public Roads	5	8
Railways	10	15
Vehicle Parking Areas (other than authorised)	5	8

Large Wooden Structures	15	15
Small Stocks of combustible materials, site huts etc	5	8
Process Equipment (not part of installation)	5	8
Continuous Sections of Flammable Gas Pipelines	3	3
Flanges in Flammable Gas Pipelines (Over 50mm)	15	15
Fuel Gas Vent Pipes	5	8
Compressor / Ventilator Air Intakes	5	8
Fuel Gas Cylinders (up to 70m ³)	5	5
LPG Storage Vessels (up to 4 tonnes)	7.5	7.5
LPG Storage Vessels (up to 60 tonnes)	15	15
Bulk Flammable Liquid Storage Vessels (up to 7.8m ³)	7.5	7.5
Bulk Flammable Liquid Storage Vessels (up to 117m ³)	15	15
MV or HV Electrical Sub-Station	5	8

Table 7.2 – Safety Distance Compliance for Medical Gas Plants

2. The Medical Gas Cylinder plant room must be located on the ground floor of any healthcare facility.
3. The Medical Gas Compressor and Vacuum may be located in the basement of a facility as long as that area is ventilated but is highly recommended for the plant room to be located on the ground floor for maintenance.
4. In the Emirate of Dubai, the Medical gas plant rooms (including the cylinder rooms) need to be air-conditioned to provide an air temperature of less than 40°C.
5. Medical Gas Cylinder Store Rooms should be well ventilated and that cylinders of this gases

(especially Mixture gases) are kept above 10°C for 24 hours before use, and arrangements should be in place to ensure that cylinders collected from a cold store are not used immediately for patient treatment.

6. Medical Gas Cylinders should not be subjected to extremes temperature. Cylinders should be kept away from sources of heat (this includes hot water service pipes, steam pipes, hot air emitters and direct sun exposure).
7. No other chemicals, flammable material or rubbish to be stored within the medical gas plant room.

8. Public Health - Fuel Systems Design (FS)

This PH-FS design guideline written for DHA healthcare facilities, is a consolidated document listing out the design requirements for all new construction and major renovation healthcare projects, within the Emirate of Dubai, under the licensure of DHA.

The requirements outlined in these guidelines are not intended to conflict with Federal Regulations, Local Municipality Laws, Executive Orders, or the needs of the end users.

This document is intended for the Architect/Engineer (A/E) and others engaged in the design and renovation of DHA facilities. Where direction described in applicable codes are in conflict, the A/E shall comply with the more stringent requirement. The A/E is required to make themselves aware of all applicable codes.

The document should be read in conjunction with other parts of the Health Facility Guidelines (Part A to Part F) & the typical room data sheets and typical room layout sheets.

8.1 General

1. The aim of the fuel system guidelines is to promote the correct provision of Fuel Systems for healthcare facilities. The design will be based on the requirements of the DM, but there will be parts of the design that will be tailored for healthcare facilities under the jurisdiction of DHA.

8.2 Design Criteria

1. The design will discuss which systems in healthcare facilities requires Fuel and they are the following:
 - Hot Catering Kitchens
 - Hot Catering Commercial Kiosks

- Electrical Generators
 - Hot Water Generators
 - Fuel Run Fire-Fighting Pumps
2. These design guidelines are to be used in new healthcare facilities as well as facilities that will refurbished under DHA.
 3. The fire and life safety requirements for installing these systems must be as per Dubai Civil Defence requirements. The design guidelines will not change this strategy in any form.
 4. When designing the medical gas requirements for healthcare facilities, a risk assessment needs to be carried out to understand the requirements of the facility.
 5. Requirements such as distance from supplier of medical (if applicable), the geopolitical understanding, traffic, work days, peak times, particular times of year where work load is affected (Ramadhan, Public Holidays etc) as well as patient safety.
 6. The objective of the risk assessment is to ensure that the risk to patient safety eliminated or reduced to as low as possible as well as ensure that hospital operation is undisturbed.

9. Public Health - Pneumatic Tube System Design (PTS)

This PH-PTS design guideline written for DHA healthcare facilities, is a consolidated document listing out the design requirements for all new construction and major renovation healthcare projects, within the Emirate of Dubai, under the licensure of DHA.

The PTS must not jeopardize the continued operation of a healthcare facility and incur any huge capital costs due to equipment replacement.

The requirements outlined in these guidelines are not intended to conflict with Federal Regulations, Local Municipality Laws, Executive Orders, or the needs of the end users.

This document is intended for the Architect/Engineer (A/E) and others engaged in the design and renovation of DHA facilities. Where direction described in applicable codes are in conflict, the A/E shall comply with the more stringent requirement. The A/E is required to make themselves aware of all applicable codes.

The document should be read in conjunction with other parts of the Health Facility Guidelines (Part A to Part F) & the typical room data sheets and typical room layout sheets.

9.1 General

1. Pneumatic Tube Systems (PTS) are internal logistics and transport solutions used to transport small items or documents, placed in a container or carrier, from one point to another, through an air pressurized network of tubes.
2. In healthcare facilities, Pneumatic Tube Systems (PTS) transport small materials, documents, laboratory samples etc. to and from pharmacies, laboratories, blood banks, surgery centres, emergency departments and nursing stations, as well as other locations throughout healthcare facilities.

3. The PTS can be constructed as a single-zone-system or as a multi-zone-system. The major components of such a system include the blower, tubes, stations, diverters, carriers and the central control unit that forms the command centre of such a system. Figure 9.1 shows a single zone operation with 4 stations (two stations on the Ground Floor, two stations on the First Floor and the blower and diverter in the basement area).
4. Each healthcare facility PTS is designed for its respective facility. Figure 9.1 below shows an example of PTS.

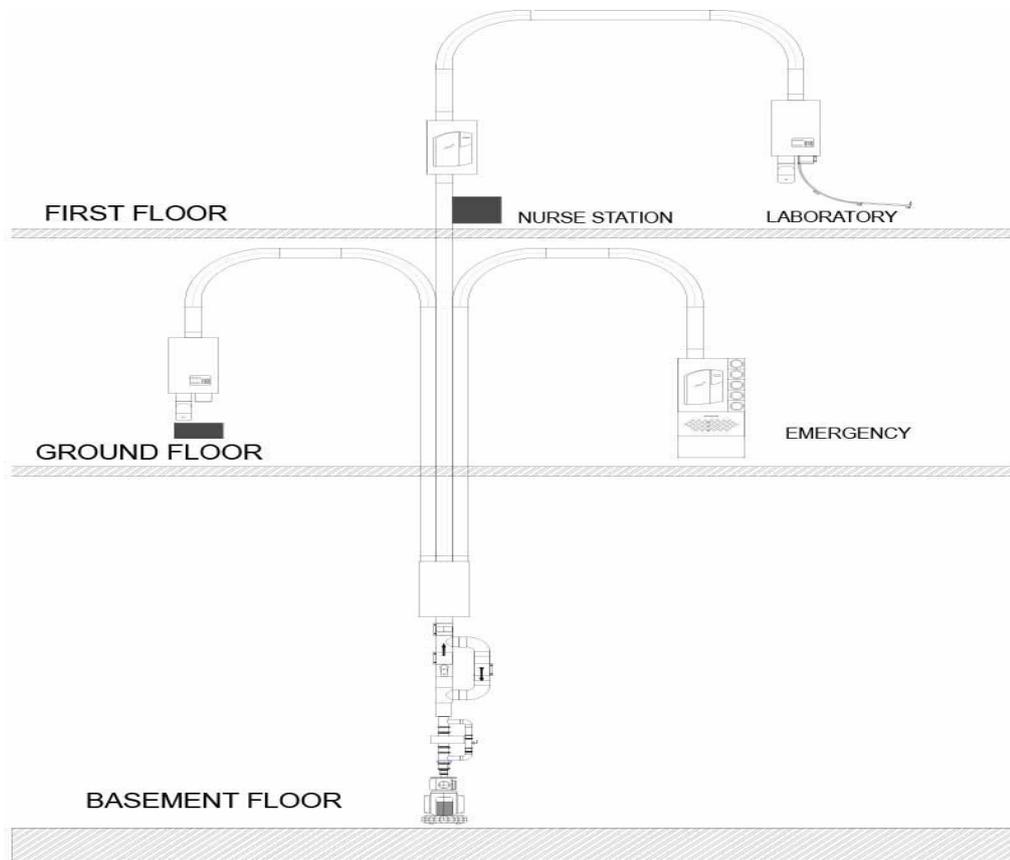


Figure 9.1 – Typical Pneumatic Tube System Layout – Single Zone System

5. Multi-zone systems, as seen in Fig. 9.2, are connected together by a transfer system. Each zone has its independent air supply (blower) so transmission can take place at the same time. Dividing a system into multi-zones increases the number of carriers that can be transported as each zone can operate independently. Productivity is improved, efficiency is increased

while NPA (non-productive activities) and staffing requirements are decreased.

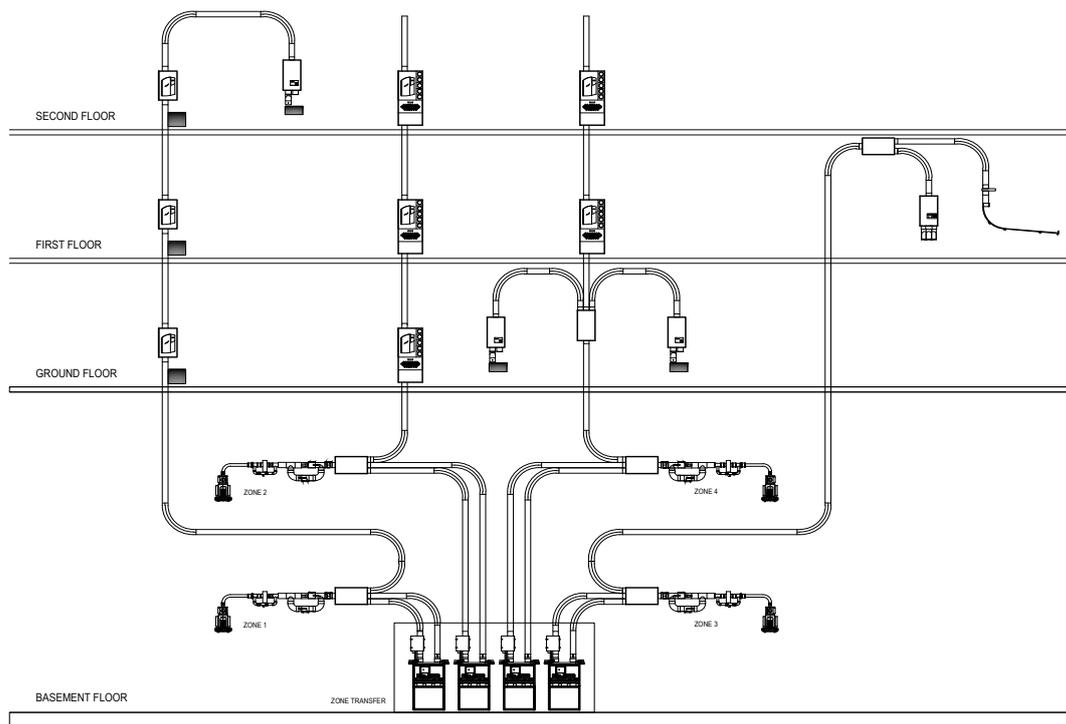


Figure 9.2 – Typical Pneumatic Tube System Layout – Multi-Zone System

9.2 Design Criteria

1. The PTS shall be provided as per HTM-2009, manufacturers requirements and healthcare facilities planning brief included in part B of these guidelines.
2. The contents of the items within the PTS delivery casing transports material between different sending and receiving modules called PTS Stations.
3. The locations of these stations are determined by the health planner and briefing requirements as mentioned in Part B of these guidelines.
4. The briefing will also state the details of the station operation i.e. the station is sending or receiving or both or a multiple sending and receiving station.
5. The PTS carrier, carries the following critical specimens through the system between departments:

- Blood Specimens for Chemistry and Haematology
 - Arterial Blood for Blood Gas Analysis
 - Urine Specimens for routine analysis and culture
 - Cerebral Spinal Fluid
 - Tissues for Biopsy and other Bodley Fluids
6. By simply placing the carrier in the station, the user can send it to a predetermined destination. Some key features are:
- A carrier can be stored at a station of a single-zone-system, independent of the stage of operation.
 - After a carrier is inserted into the station, it will be transported directly to its destination.
 - After one sending process, the system can automatically start the next.

9.3 Pneumatic Tube System Components

1. The system consists of many components that make the system as well as allow the system to be designed and operated correctly. The system components are the following:

Blower & Air Reverse Valve –The Blower (PTS compressor system) generates the air that moves the PTS carriers throughout the healthcare facility via pressure or vacuum suction. The location of the blower will be in the healthcare facility plant room as per coordination with the healthcare operator and health planning briefing. As soon as all pending processes are finished, the blower disconnects automatically

Recommendation:

Blowers should come fitted as standard with energy efficient IE2/NEMA motors (acc. to destination country) conformant to the IEC 60034-30 standard.

Blowers to be installed in the plant room along with the system control unit and interzone/linear coupler if applicable.

Blower Group – This a group of PTS blowers that are interconnected that include sending and receiving drivers allowing any single blower to handle the carrier delivery from sending and receiving as well as vice versa. These are usually installed in large healthcare facilities such as a tier 4-6 delineation healthcare level.

Carrier – A PTS Reusable plastic containers that hold and protect contents (lab specimens, pharmaceuticals, blood products, etc.) sent through a pneumatic tube system. The carriers come in different sizes to cater for the function or requirement of the facility.

The carriers used in healthcare facilities include:

- **Standard carriers:** for medications or solid particles and small instruments
- **Leak-proof carriers:** for the transport of liquids or sensitive samples used in the PTS
- **Special carriers:** these designed and developed for very specific uses such as carriers lined with lead or cooling carriers

All carriers are equipped with an **RFID** sensor for easy distribution of carriers to departments by programming 'Home' station and 'Destination', which will automatically be guided by the scanner mode or dialled destination. The carrier's movement can be tracked.

Control Center – The PTS software that controls the communication between the stations, devices and user requirements. This also locates the current location of the carrier via a user interface.

Database – A repository of information for each of the PTS carrier movements including a

date and time as well as station operability.

Interzone Connection – A section of tubing that connects one zone to another zone.

Station – The user interface unit that may include an interactive touch screen system, a mechanical dialling system and or an RFID scanner, for the sending or receiving of the carrier.

Diverter – A PTS route switching device used at branching points within a tube network to allow a carrier to move from one path to another. In many healthcare facilities, this is usually located within riser shafts or above the ceilings.

Tubing – Tubing or system piping is generally provided for 110mm or 160mm. The tubes are available in PVC (Grey), PVC (Transparent), GI and Stainless Steel, depending on the environmental conditions of the site. Healthcare operators may request a pipe greater than 160mm to be provided for bulk pharmacy items or multiple samples or documents being carried from one location to another.

Zone – A collection of stations with direct tubing connections. Zones are interconnected with inter zone connections. A traditional zone includes approximately 10 stations, while a Blower Group Zone can support up to approximately 60 stations.

Slow Speed Device – This device used especially in hospitals where certain sensitive goods such as laboratory tests and blood samples require transport with a reduced speed.

9.4 Pneumatic Tube System Pipe Material

1. For PTS systems, they are 3 No. pipe materials used;
 - PVC
 - Galvanised Steel
 - Stainless Steel

- Each of the systems are dependent on the healthcare facility's needs, cost of operation and special requirements for the system to function correctly inside the healthcare facility. 

9.5 Pipe Material Comparison

- Below is a table providing the comparison of using Stainless Steel & GI Tube.

	Stainless Steel (SS) Tubes	Galvanized Iron (GI) Tubes
1	Manufactured by mixing molten steel with 10% molten chromium	Manufactured by dipping steel in molten zinc
2	Mixed with chromium to protect from rusting	Covered by a thin layer of zinc oxide to protect from rusting
3	Strong	Weaker
4	SS is made up of chromium, meaning that its protective layer is always in place. This makes stainless steel strong	GI has only a layer of zinc coating which eventually wears off
5	Because of its strength, major pipelines made of stainless steel. Its makeup also makes it the best to work with in marine environments, as it is more resistant to salt. By contrast, unlike Galvanised iron, stainless steel does not rust even when scratched since its protection is an integral part of it.	Galvanised steel is covered by a rust protective layer that is less than a millimetre thick. This means that whenever it is scratched, rusting immediately starts to occur around the scratched area.

Table 9.1a – Pros & Cons for Steel Pipes

2. Below is a table providing the advantages and disadvantages of using PVC Tube.

Advantages	Disadvantages
High grade of internal finishing	Low Fire Resistance. Fire Collars are required when passing a fire zone.
Easy to install due to the material being light and easy to cut	Low Mechanical against external damages
Easy to inspect and repair.	Flammable solvents used to install fittings
Good for long life as corrosion is not an issue	
Cheaper than Steel	

Table 9.1b – Pros & Cons for PVC Pipes

3. In healthcare facilities, PVC and Stainless-Steel systems are preferred above Galvanized Iron.

Recommendation: Due to the climatic conditions of the UAE, it is not recommended to use Galvanized Iron Tubes for the PTS installation due to oxidation and corrosion.

10. Fire Protection (FP) – Special Areas Design

This FP design guideline written for DHA healthcare facilities, is a consolidated document listing out the design requirements for all new construction and major renovation healthcare projects, within the Emirate of Dubai, under the licensure of DHA.

For FP Systems, the protection of the healthcare facilities and its occupancies are of prime importance when discussing fire and life safety. But more so in healthcare facilities, the continued operation is also as important.

The FP must not jeopardize the continued operation of a healthcare facility and incur any huge capital costs due to equipment replacement.

The impact of FP strategy on major imaging equipment in healthcare facility is very huge if not assessed correctly.

The requirements outlined in these guidelines are not intended to conflict with Federal Regulations, Local Municipality Laws, Executive Orders, or the needs of the end users.

This document is intended for the Architect/Engineer (A/E) and others engaged in the design and renovation of DHA facilities. Where direction described in applicable codes are in conflict, the A/E shall comply with the more stringent requirement. The A/E is required to make themselves aware of all applicable codes.

The document should be read in conjunction with other parts of the Health Facility Guidelines (Part A to Part F) & the typical room data sheets and typical room layout sheets.

10.1 General

1. The aim of this section of the guidelines is to promote the correct design of fire-fighting systems for healthcare facilities for the following areas:

- Burn Units
 - Imaging Department
 - Operating Theatres
 - Endoscopy Procedure Rooms
 - Day Surgery Rooms
 - Dental Procedure Rooms
2. The design will be for healthcare facilities under DHA jurisdiction.
 3. The systems below are the systems that are to be used in healthcare facilities, but not only limited to these systems.
 4. As per NFPA and UAE Fire Code (depending on the complexity/level of the healthcare facility departmental functions), the following fire protection system shall be used (but not limited to):
 - Sprinkler System (Active & Dry)
 - Standpipe System
 - Hose Reels System
 - Clean Agent System
 - Deluge System
 - Foam System
 5. Healthcare facilities rely heavily on a continued operation of the facility and its equipment post controlled fire extinguishing scenarios. Therefore, the correct fire protection system should be used with this objective in mind.

10.2 Design Criteria

1. The design, installation and commissioning of the fire-fighting protection system shall be as per UAE Fire Life Safety Code and NFPA requirements. Wherever there is a conflict between international and local codes, the local codes shall take precedence.
2. Discussion with Dubai-CD need to be carried when discussing the extinguishing requirements of the special areas mentioned above (Section 10.1).

10.3 Sprinkler Systems

1. As per FF strategy, all areas within a facility need to be fire protected.
2. Certain areas will require certain fire extinguishing systems that will work best for safety of inhabitants and the hospital operator costing concerns.
3. Rooms with huge capital cost equipment, such as medical imaging units, Bunker areas etc, should not be provided with a wet pipe sprinkler system for fire protection. Gas suppression system should be used in these areas or pre-action system.
4. Both pre-action and Gas suppression can be provided in the same room, with the gas suppression system extinguishing first completely before the pre-action system starts its extinguishing process (if the fire is still active)

10.3.1 Pre-Action Systems

1. In healthcare facilities, pre-action sprinkler systems are used for areas that a fire scenario event will be very disruptive to the operation of the healthcare facility. In cases disruption to these areas via an automatic sprinkler system may be hazardous or in some cases life threatening.
2. The system is usually installed in the following areas in healthcare facilities:
 - Operating Theatres

- Endoscopy Procedure Rooms
 - Day Surgery Rooms
 - Dental Procedure Rooms
 - Burn Units
 - Imaging Rooms
3. Pre-action systems should be a double interlocking system. This means that the system will have both a preceding and supervised event such as heat or smoke detectors as well as an automatic sprinkler activation. Figure 10.1 below shows a pre-action valve arrangement with an addressable panel. Generally, these types of systems operate faster and reduce fire and damage compared to the standard automatic sprinkler systems.

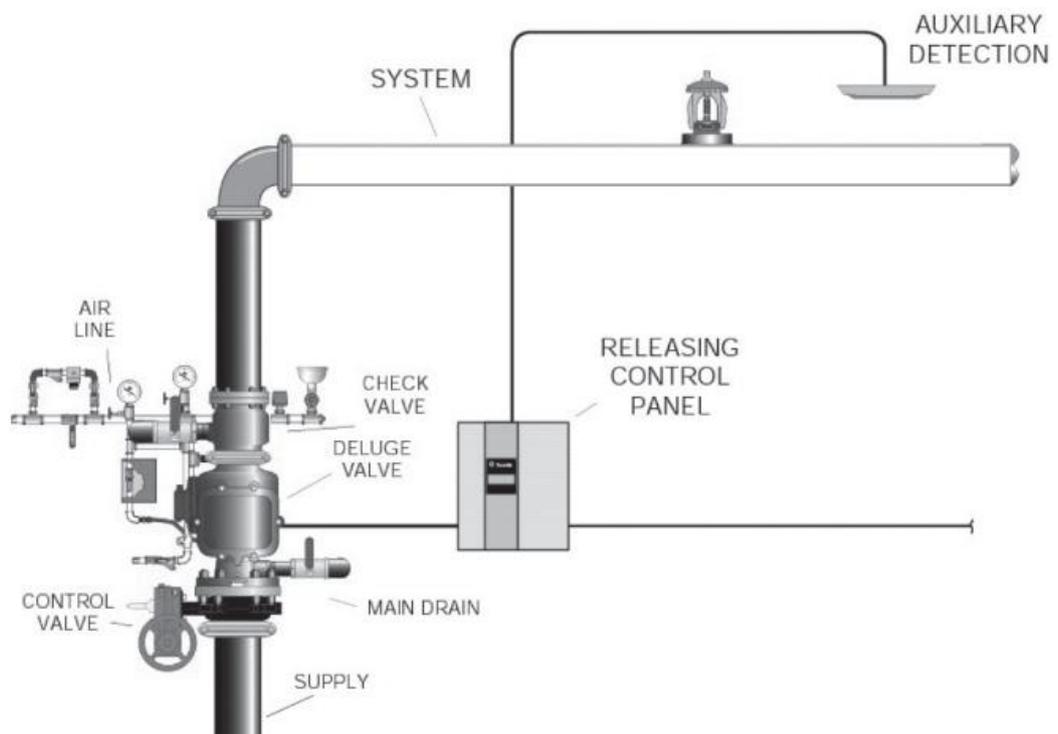


Figure 10.1 – Pre-Action Valve Setup

4. In operating theatres, audio alarms and strobe lighting shall be removed and replaced with light indication alarm fitting (non-audible) as part of the surgical panel

10.4 Clean Agent System

1. Clean agent systems are designed to be chemical inhibitors that react with the transient products of combustion. They are made to eliminate the chain reaction of combustible elements by reducing the oxygen content in a room, attacking one of the elements of the fire triangle. Oxygen levels are reduced below the point of a reaction for combustion to be maintained. This is done with use of an inert gases.
2. Inert gases have a low level of toxicity and in the healthcare facilities they are used for fire-fighting services in patient and healthcare operator staff occupied major medical equipment rooms. Therefore, it is important to ensure that the inert gas concentration does not exceed the limits of No Observed Adverse Effect Level (NOAL) as per the limits set out in NFPA-2001, which is 43%.
3. As per NFPA 2001, the maximum exposure limit should only be 5 minutes. Any personnel in the area where clean agent system is to be used will be required to evacuate in the count down time between the fire and the release of the clean agent.
4. A clean agent system does allow for an emergency push button cancellation in case of a false alarm or if the fire within the space has been contained.
5. The system can also be designed for time delay to give patients, staff and visitors to evacuate the area prior to the system being extinguished.
6. In healthcare facilities the following rooms will require a clean agent system.
 - Server Room (The distinction between Server Rooms and UPS room sizes will be based upon the requirements of Dubai-CD).
 - UPS Room
 - CT Scan Room
 - CT Scan Room

- CT Scan Equip Room
 - MRI Equipment Room
 - Chemo-Emboli Station Room
 - Computer Equip Room
 - SPECT Scanning Room
 - PET Scanning Room
 - Computer Equipment Room
 - Main Electrical Room
 - MRI-LINAC
 - Medical Records
 - Burns Unit (If water will cause more damage to the patient)
7. Burn Unit patients are at risk of infection if water is discharged from sprinkler system while they are in the space (not all patients, critical patients only)
 8. Clean agent cylinders should not be located in the same room, where clean agent ceiling nozzles will be discharged. If the cylinders are to be located in the same room, they shall be in a fire rated enclosure.
 9. A clean agent system can be used with a pre-action sprinkler system.

10.5 Deluge Water Systems

1. In healthcare facilities, deluge systems are used on external liquid oxygen and LPG storage systems. The pipes are installed to surround the storage vessel containing hazardous flammable liquids.
2. Deluge systems sprinkler systems provide high flow and high volume of discharge over the

hazardous area in a fire scenario in the quickest time possible.

10.6 Foam System

1. In healthcare facilities foam fire extinguishing system are used for special hazard areas. They should not be used for medical gas plant/systems or electrical rooms.
2. Foam, mostly a mass of air- or gas-filled bubbles formed by chemical or mechanical means, is most useful in controlling fires involving flammable liquids with a low flash point and specific gravity that are lighter than water. The mass of bubbles forms a cohesive blanket that extinguishes the fire by excluding air and cooling the surface and by separating the fuel from the fire. This strategy is used for Oil fuelled Generators.

11. Vertical Transportation System

11.1 General

Healthcare facilities are greatly depended on lifts to provide a reliable and efficient vertical transportat system for the movement of patients, staff, visitors, medical equipment and associated support services. They are also dependent on lifts to provide firefighting and evacuation facilities.

All lifts shall meet the statutory regulations from Dubai Municipality and Civil Defence authorities.

11.2 Lift Categories

The lifts in healthcare buildings shall be categorized and provisioned based on the function as below:

1. General Passenger Lifts

These lifts supporting general passenger traffic including wheelchair users. The clear internal dimension of a general passenger lift serving clinical areas should not be less than 2000mm wide by 1700mm deep with a minimum loading capacity of 1250kg with a minimum clear door opening width of 1100mm and clear height of 2100mm. This is to enable proper circulation space for patients on wheel chair and accompanying persons. The lifts inented for housekeeping services may be part of a group of general passenger lifts. However, housekeeping activities should be scheduled not to coincide with general peak passenger demands. As far as practically possible, care should be taken so that public passenger lifts are separated from the Bed, Service and Goods lifts with access to separate lifts lobbies.

2. Bed Lifts

These lifts are intended for the carrying of a patient on patient beds or stretchers

together with the necessary staff and support equipment. The bed lifts should have a minimum rated load capacity of 2500 kg, with a minimum clear car dimension of 1800mm wide by 2700 mm deep. Clear door-opening width must be no less than 1400mm and 2200mm high. Lift car internal height should not be less than 2500mm.

3. **Service/Goods Lift/s**

These lifts are intended for the movement of items such as furniture, equipment, building materials, equipment maintenance supplies, waste etc. The service/goods lifts should have a minimum rated load capacity of 2500 kg, with a minimum clear car dimension of 1600mm wide by 2200 mm deep. Clear door-opening width must be not be less than 1200mm and 2200mm high. Lift car internal height should not be less than 2500 mm. For smaller healthcare facilities (less than 50 beds) smaller sized goods lifts may be considered based on proper due diligence. However, in facilities where heavier equipment are anticipated to be transported, larger goods/service lift with wider door opening size to be provided.

11.3 Design Considerations

Below is key recommendations and requirements to be adhered with while designing vertical transportation solution for healthcare facilities.

1. Selecting the appropriate lift operational speed and drive system is important in order to optimise the operation, comfort and efficiency of the system.
2. Lifts to be located away from sensitive areas in consideration of vibration and acoustics, and with respect to magnetic distortion for MRIs.
3. Depending upon the nature of the facility firefighting lift/s to be provided where called for as per Dubai Civil Defence requirements.

4. In large facilities with numerous lifts, Passenger Lifts may be categorised based on different usage such as VIP Lifts, OPD Lifts and Visitor's Lift etc.,. Such designation, however is not mandatory.
5. It is recommended that as far as possible the Bed Lifts and Service Lifts to be identical in design and specifications. This will give the operator maximum flexibility allocate the lift types for different use as the need arises and the operation of the facility changes over time.
6. The Service Lifts need to be categorised for different types of use. As a minimum there should be two groups, Dirty Lifts and Clean Lift.
 - a. Dirty Lifts may be used for: Transport waste bins, Dirty Linen, Diseased patients, Infected Patients, Dirty SSU goods, Returned food trolleys and similar goods as well as staff.
 - b. Clean Lifts may be used for: Transportation of items from the central stores, clean food trolleys, Clean SSU goods, medication and occasionally a patient bed (when the bed lift is under maintenance) and staff.
7. In large facilities, with numerous lifts, the operator should consider designating specific tasks to the service lifts such as: Food Safe Lift, Waste Lift, Clean Goods, Etc. Apart from Clean/Dirty, the above subdivisions are not mandatory.
8. Firefighting lift can also be used for regular passenger/patient use during normal operation of the healthcare facility. However, it is recommended that the designated firefighters lift is not used for moving waste, goods, equipment etc in order to prevent the risk of the lift being occupied or its entrance being obstructed when the lift is required for firefighting.
9. In healthcare buildings, choosing the appropriate number, capacity and operational speed and drive system is important in order to minimize any adverse effects, particularly on patients and care providers. The criteria to consider while determining the vertical

transportation solution include but not limited to:

Anticipated number of patients

Anticipated number of staff

Operation and visiting hours

Nature of the departments

Location of Imaging equipment such as MRI's

Food deliveries

Waste disposal

Emergency evacuation

Clinical workflows

Configuration of the building

10. Because a healthcare environment has a higher percentage of sick and vulnerable people, special consideration needs to be given during the traffic analysis.

11. The selection of an appropriate speed is dependent on building height. Table below indicates suggested values. However, speed has very little effect on the handling capacity of lifts in healthcare facilities due to the longer loading and unloading times; therefore, rated speeds could be lower than would normally be required in office buildings. The average interval of the lift (the time between successive lift arrivals at the main entrance floor) can be longer than that is recommended for office building. Interval time of 30s to 50s is generally acceptable for healthcare buildings.

Travel Height (m)	Rated Speed (m/s)
18	0.63
30	1.0
48	1.6
75	2.5
100	3.5
120	4.0
150	5.0

12. Centre opening doors provide better traffic performance as compared to side opening doors; in consideration of this, only centre opening doors shall be provided for lifts serving patient and clinical staff. Side opening lifts may be acceptable for goods lifts not intended for clinical staff or patients. The centre opening doors shall be in two leaves or four leaves configuration to suite the available lift shaft.
13. In order to reduce the stress imposed on vulnerable patients the acceleration of the lift cars used to serve surgical and clinical areas shall not exceed 0.6 m/s^2 , while rate of change of acceleration or deceleration shall not exceed 1.0 m/s^3 .
14. During vertical transportation traffic analysis for healthcare buildings, lift car occupancy to be considered lower than the normal 80% of rated capacity used in commercial building traffic calculations to account for the space requirement for wheel chair, stretchers, equipment etc.; 25% of the rated capacity will be more appropriate for healthcare buildings.
15. Diffused soothing illumination of 100 lux to be provided in lift cars at floor level. The car should not be widely over lit or under lit due to patient safety and comfort considerations.
16. Emergency lighting to be provided in lift cars as part the lift car design with 3hr local battery back up to provide a minimum illumination of 10 lux.

17. Lift shafts generally penetrate all floors of a healthcare building and therefore pose a risk for the transmission of infection across the floors. To reduce this risk, lift shaft wall and ceiling should be sealed and painted.
18. Lift car doors should be fitted with contact free passenger/obstruction detection to minimize the risk of car/landing door collisions with persons, beds or equipment, working in conjunction with the automatic door operator.
19. Lift cars and all landing shall indicate the floor number and direction of travel of the lift car.
20. When function of the lifts physically located as a group are similar, such cars shall be grouped and controlled in “collective” method, while the function of each lift in the group are different (such as dirty, clean, staff etc) the cars may have to be controlled individually (simplex).
21. Depending upon operational work flows and security strategy, electronic card access systems to be implemented; along with emergency bed services function. Emergency bed services facilitate priority lift car call option for patients in critical care and associated staff.
22. At least one elevator in a bank of lifts to be fed from the emergency (secondary) branch of power distribution.
23. Power supply for lifts to be sourced directly (grouped or individually) from the main distribution board (MDB) of the healthcare building.