



---

PARLIAMENT OF TASMANIA

---

PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS

# Royal Hobart Hospital Stage 2 – J-Block Redevelopment

---

*Presented to Her Excellency the Governor pursuant to the provisions of the  
Public Works Committee Act 1914.*

---

## MEMBERS OF THE COMMITTEE

Legislative Council

*Ms Rattray (Deputy Chair)*  
*Mr Valentine (Chair)*

House of Assembly

*Ms Butler*  
*Mr Ellis*  
*Mr Tucker*

## TABLE OF CONTENTS

1	INTRODUCTION .....	3
2	BACKGROUND.....	3
3	PROJECT COSTS .....	6
4	EVIDENCE .....	7
5	DOCUMENTS TAKEN INTO EVIDENCE.....	21
6	CONCLUSION AND RECOMMENDATION .....	22

## 1 INTRODUCTION

To Her Excellency the Honourable Barbara Baker AC, Governor in and over the State of Tasmania and its Dependencies in the Commonwealth of Australia.

MAY IT PLEASE YOUR EXCELLENCY

The Committee has investigated the following proposal:-

### **Royal Hobart Hospital (RHH) J-Block Refurbishment**

and now has the honour to present the Report to Your Excellency in accordance with the Public Works Committee Act 1914 (the Act).

## 2 BACKGROUND

- 2.1 This reference recommended the Committee approve works to undertake the Royal Hobart Hospital (RHH) J-Block Refurbishment. The proponent considers these works are of strategic importance to the ongoing development of the RHH, under the Stage 2 Project of the RHH Masterplan 2020- 2050.
- 2.2 The proposed works will be stratified across Levels 2 and 3 of J-Block, using the space of the previous open mental health ward, which has been relocated to K-Block. Level 2, J-Block will house the Cardiology/Cardiothoracic Inpatient Unit and the Sleep Studies Unit, while Level 3 will cater to patient needs as a general medical/ surgical decant ward.
- 2.3 The RHH is Tasmania's leading referral centre for Cardiothoracic services, catering for emergency and elective procedures. The current Cardiology Services ward in 2-D Block is deteriorating into a space which proposes a clinical risk to patients and staff members and does not reach contemporary standards of care. The relocation and expansion of the space to Level 2, J-Block will address the functional and safety concerns facing the ward.
- 2.4 Tasmania faces an ever increasing demand upon Cardiology Services, with heart disease currently killing two Tasmanians a day. The state also has the highest prevalence of cardiovascular disease nationwide, which comes with consequential comorbidities as a result of high levels of lifestyle risk factors throughout Tasmania.
- 2.5 The proposed works to J-Block will also facilitate the formation of a Sleep Studies Unit, run through the RHH.
- 2.6 Currently the sleep medicine service in the RHH is inadequate, with sub-optimal interim sleep services offered by the Department of Respiratory Medicine in the RHH. The Tasmanian population hence faces a disadvantage in their ability to access appropriate testing, care and treatment options.

- 2.7 A private sleep clinic is currently run in the North of the state, being the only available sleep medicine service in Tasmania. The location of the clinic, as well as its status as a private business, are sources of disadvantaged access for the Tasmanian community. Due to this generalised lack of local access, patients are often referred to interstate sleep medicine providers, a process of care which has become increasingly fractured during the Covid-19 pandemic.
- 2.8 The Sleep Studies Unit will become Tasmania's only public sleep medicine clinic and only sleep clinic run in the South of the state. The Service will cater to the already high and ever-increasing demand for such care and investigation in Tasmania. The provision of the Sleep Medicine Services at the RHH will increase the hospital's functional capacity in Respiratory and Sleep Medicine Services from a Level Five to a Level Six service. At a Level Six capability, the Respiratory and Sleep Medicine Services will offer the highest level of care and access to all residents of Tasmania, no matter their location.
- 2.9 The proposed Sleep Studies Unit will reach the clinical needs of the Tasmanian population by offering opportunities for inpatient, outpatient and at home treatments and tests. The provision of multi-form sleep medicine care will alleviate the necessity for patient travel for care.
- 2.10 The proposed refurbishment of J-Block also includes the development of a decant ward on approximately half of Level 3, J-Block. This ward is a strategically essential component of the continuing progression of the RHH Masterplan 2020-2050, as it will temporarily accommodate hospital wards whilst their long term location is constructed or refurbished.
- 2.11 Constructed as a general medical/ surgical ward Level 3, J-Block will play an immediate role in the implementation of the RHH Masterplan, first housing A-Block during ward refurbishments.
- 2.12 The proposed works will include the following elements:

Level 2, J-Block – Cardiology/Cardiothoracic Inpatient Unit and Sleep Studies Unit:

- 37 beds (including 1 N Class negative pressure isolation room):
  - 22 general cardiology beds;
  - 7 critical care cardiology beds;
  - 5 Cardiology Services day unit beds (which will increase to 6);
  - 3 Sleep Studies Unit beds; and
  - Sleep Medicine outpatient facility;
- Upgrades to electrical services to meet compliance with AS3003:2018 cardiac protection standards;
- Removal of existing room fittings which were used to cater to the needs of the relocated mental health ward; and
- Upgrades to staff areas.

Level 3, J-Block – Decant ward:

- 22 beds (including 1 N Class negative pressure isolation room);
  - Additional family/visitor spaces;
  - Additional storage, charging and clinical support areas;
  - Individual temperature control for each room;
  - Access to natural light for all bedrooms; and
  - Upgraded plant and equipment services.
- 2.13 The refurbished J-Block will combine the needs of patients, staff and visitors by providing optimum clinical care in wards fit for best practise. The wards will incorporate the following essential elements, services and provisions of a well-functioning medical setting:
- Strong focus on patients and staff and the experience of the ward environment;
  - Innovative planning which prioritises workflow;
  - Active prioritisation of Australasian Health Facility Guidelines (AHFG);
  - Creation of spaces which prioritise environmental sustainability;
  - Mechanical services (such as positive pressurisation);
  - Medical gases;
  - Electrical services upgrades;
  - Communication options (such as additional data outlets);
  - Security;
  - Fire protection; and
  - Hydraulics.
- 2.14 The proposed refurbishment of J-Block is considered strategically important to the Stage 2 Project of the RHH Masterplan 2020-2050. By re-purposing available space in the RHH, the development of J-Block will utilise pre-existing hospital features and welcome new services to meet the increasing demand for patient care in Tasmania.
- 2.15 The triad of J-Block facilities, being the Cardiology/Cardiothoracic Inpatient Unit, the Sleep Studies Unit and a general medical/ surgical decant ward, will allow greater access to care opportunities for Tasmanians. It is expected these developments will greatly increase the opportunities for emergency and elective cardiology care, provide necessary and in-demand sleep medical care and sustain an essential role in the continuing expansion of the Royal Hobart Hospital through the provision of the adaptable decant ward.

### 3 PROJECT COSTS

- 3.1 Pursuant to the Message from Her Excellency the Governor-in-Council, the estimated cost of the work is \$7.9 million.

The following table details the current \$12.331. million cost estimates for the project:

<b>Description</b>	<b>Estimated Cost</b>
Construction Costs	\$ 9,300,000
Post Occupancy Allowance	\$ 150,000
Professional Fees and associated costs	\$ 560,000
Statutory Fees	\$ 15,000
Information and Communication Technology Infrastructure	\$ 500,000
Furniture and Equipment	\$ 500,000
Other client costs	\$ 105,000
Tasmanian Art Scheme	\$ 80,000
Sub Total	\$ 11,210,000
Contingency (10%)	\$ 1,121,000
<b>PROJECT TOTAL</b>	<b>\$ 12,331,000</b>

## 4 EVIDENCE

4.1 The Committee commenced its inquiry on Monday, 13 December last with an inspection of the site of the proposed works. The Committee then returned to Committee Room 1, Parliament House, whereupon the following witnesses appeared, made the Statutory Declaration and were examined by the Committee in public:-

- Luke Clasener, Project Manager, Department of Health;
- Darren Jones, Architect, BPSM Architects; and
- Katrina Hodge, Nursing Director – Acute Medical, Tasmanian Health Services Southern Region.

The following Committee Members were present:

- Hon Rob Valentine MLC (Chair);
- Hon Tania Rattray MLC (Deputy- Chair);
- Ms Jen Butler MP; and
- Mr John Tucker MP.

### Overview

4.2 The Committee asked the Department's witnesses to provide an overview of the need and objectives of the proposed works:

***Ms RATTRAY**- It would be useful to have a brief outline overview of the proposed development on the public record. I know we get to it for the need of the project, but given we have the primary objective, the background and the like, it would be useful to have an over-arching statement on the project.*

***Mr CLASENER** - What we are doing in this project is developing the current level 2 and part of level 3 of J Block in the Royal Hobart Hospital. Level 2 will be a cardiology service, or the bulk of it will be a cardiology service, relocating from an aged facility in D Block, into a new facility which meets future growth and need for that service.*

*Within that ward on level 2J there is also identification of three beds for a specified sleep study service. The current service provided is sub-optimal for Tasmania. Part of 3J is unoccupied at the moment. Level 3, J-Block will be repurposed into a decant ward, where other wards across the development of the campus of the Royal Hobart Hospital - A Block in particular - gets redeveloped in a staged approach. Those wards will move into the ward on 3J temporarily, while that ward gets redeveloped, refurbished, then they move back in and we shuffle wards through that....*

***Ms HODGE** - In regard to our current cardiology ward, it is not standard for Australasian standards to provide inpatient care. Currently we have a 32-bed ward; four of those are cardiac care unit and five are cardiac day unit, which are day procedures that can be done at the RHH with patients discharged at the end of the day.*

*We will be moving to a contemporary new area to comprise 22 just cardiology cardio-thoracic inpatient beds. We are going to have capacity to build for the future with an increasing*

chronic disease burden for cardiac disease, improving to seven cardiac care unit beds and increasing to six cardiac day unit beds.

With our sleep medicine study, we will be providing an inpatient and outpatient service. In 2019, a physician retired and we have not had a proper inpatient service at all in the southern region of Tasmania. We have a population basis which 600 sleep studies per 100 000 population a year we should be providing. At the moment we are only providing up to 100 in equal service between public and private patients. Some of our patients have been either going to the mainland or travelling to Launceston for some studies.

What they are showing, when you have inpatient sleep apnoea studies done overnight for those patients who are deemed suitable, you can reduce the stroke rate by 20 per cent to 56 per cent and also reduce cardiac disease by 15 per cent to 37 per cent by early diagnosis and having preventative strategies put into place.

We believe the transfer of our cardiology to the new contemporary will be what we are looking for future development of chronic disease. ... We [Tasmania] have a high burden of cardiovascular disease, hypertension, diabetes and obesity, which will contribute to that and which also contributes to the burden of sleep apnoea. So, we have an early preventative care to actually look at preventative management.

...

**Ms BUTLER** - Under project definition which is paragraph 3, there is a reference to a shift from a level 5 service to a level 6 capability, can you explain to me what the difference in those two are?

**Ms HODGE** - Level 6 capability service is a Tasmanian-wide service, so patients may access a service from across Tasmania and the highest level of service. Anyone from the north, north-west may access, for example, the sleep apnoea service. Also, for cardiology we do cardio-thoracic surgery and have access for level 6 patients from across the state to come down to this service. Level 5 service is a lower level of service and level 6 is the highest.

**Ms BUTLER** - Level 5 is just for, say, the southern region, where a level 6 encompasses the whole state?

**Ms HODGE** - Absolutely.

### **Structure of Refurbishment**

#### **4.3 The Committee sought confirmation on the number of beds in the new J-Block:**

**CHAIR** - As we discussed during the tour, just to be 100 per cent clear as to exactly the beds: seven cardiac care beds?

**Ms HODGE** - That is right. That is high-level cardiac care.

**CHAIR** - That's an extra three beds. So seven beds. Twenty-two inpatient?

**Ms HODGE** - That is right.

**CHAIR** - And five day procedure or six?

**Ms HODGE** - We have five now, increasing to six.

**Ms RATTRAY** - You would have liked seven but there was not quite enough room.

**Ms HODGE** - There was not quite enough room at this stage.



**CHAIR** - And the sleep medicine unit, you are going to have three beds?

**Ms HODGE** - We have an outpatient service, so we can do outpatient service plus three inpatient beds to observe people's severe sleep apnoea.

**CHAIR** - Then, on level three, which is above, 22 beds for decanting inpatients, which is what you were talking about earlier?

**Ms HODGE** - Yes.

### **Synergy between cardiac and sleep medicine services**

4.4 The Committee, noting that the proposed Cardiology/Cardiothoracic Inpatient Unit and Sleep Studies Unit are to share Level 2, J-Block, asked if the two medical fields shared a clinical connection which would explain the pairing:<sup>1</sup>

**Ms BUTLER** - Is there a synergy between cardiac and sleep apnoea? Are they located close to each other because of that?

**Ms HODGE** - There's always been a synergy. You could put a synergy for respiratory medicine and sleep apnoea. That's probably even a closer synergy. But we do know that people who have sleep apnoea often have cardiovascular disease, obesity or high hypertension, high risk of stroke, et cetera. There's certainly a synergy with cardiovascular as well as respiratory, with probably stronger synergy with respiratory.

**Ms BUTLER** - Was that part of the reasoning for locating them close to each other?

**Ms HODGE** - Yes, it's a good synergy to put them together, especially if you have outpatient services. If a patient clinically deteriorates, you've got very quick access to emergency care as well.

The other thing with the synergy, having an inpatient sleep unit very close to the cardiac care unit, if a patient clinically deteriorated overnight, with medical technicians who care for those patients, you've got support from high-level capable nursing staff to support that patient if they had what we call an emergency call.

### **Prevalence of cardiovascular disease and associated risk factors**

4.5 The Committee understood the considerable risk factors associated with cardiovascular disease which are of a high prevalence in the Tasmanian community. Noting the use of Australian Bureau of Statistics findings in the Department's submission for the Refurbishment of J-Block, the Committee queried the presentation of these findings:<sup>2</sup>

**CHAIR** -.... Okay, it says here:

*Tasmania also has the highest prevalence of cardiovascular disease in Australia, in excess of 9.5 per cent across all regions, compared with a national average of 6.6 per cent.*

---

<sup>1</sup> Royal Hobart Hospital (RHH) J-Block Refurbishment, Submission to the Parliamentary Standing Committee on Public Works, Department of Health, November 2021 p. 5.

<sup>2</sup> *Ibid*, p. 6.

That's no small thing, that's half again.

**Ms HODGE** - Just for general medicine, in one of our highest diagnostic-related groups, which is admissions, heart failure is probably one of the bigger ones. We're noting that across general medicine as well as the cardiology area. Heart failure is big for Tasmanians. We have lower socio-economic and obesity. That adds in cardiovascular disease and it all affects.

**CHAIR** - Towards the bottom there, second last paragraph. ... It says that 70.8 per cent of all Tasmanians aged over 18 years were overweight or obese, whereas the national average is 67 per cent. That gives a fairly good indication. In terms of the number that are overweight and the number are obese. If we go to page 6, the averages say 36 per cent are overweight, 34.8 per cent are obese.

We don't have the split. It just doesn't seem to add up, 67 per cent versus 31.3 nationally. So, is that 31.3 simply not supposed to be there? Can you explain that figure, so that we can have that corrected for the record? Clearly the 36 and the 34.8 adds up.

**Ms HODGE** - Yes, 70.8, so they've added it together. Compared against the national average of 67 Tasmanians, or southern Tasmania particularly, we have a higher rate of obesity and overweight.

**CHAIR** - It's just that 31.3 per cent is confusing -

**Ms HODGE** - It is, yes.

**CHAIR** - I wonder whether that needs correction.

**Ms HODGE** - Yes, I think you're correct. Just to take the 31.3 out.

**CHAIR** - I think take that out, just for the record, at the top of page 6, the 31.3 per cent comes out -

**Ms BUTLER** - It doesn't mean anything.

**CHAIR** - It doesn't.

### **Sleep Studies Unit**

4.6 The Committee questioned the witnesses in relation to the estimated need for the Sleep Studies Unit and how this is reflected in its proposed functioning capacity:

**CHAIR** - How much in demand are the sleep medicine services? Do we know the numbers that would be treated with this type of sleep medicine treatment over a year?

**Ms HODGE** - Yes, 600 per 100 000 should be treated. We are currently only treating about 100. We are sending some of those people up north who need more outpatient services. We have recently had a sleep physician appointed so we are doing some outpatient studies, some outpatient work and appointments. We are not fulfilling the population need.

...

**Ms RATTRAY** - Just for clarification, the sleep apnoea beds are for people who can't be monitored with one of those sleep apnoea machines that go home. They've got a higher level of medical need?

**Ms HODGE** - Absolutely, and they would have to travel to Launceston at the moment. But if you haven't got a carer, and they've got no travel, it is an inequitable service for a lot of people in southern Tasmania. This will bring us into contemporary.

**CHAIR** - The service in the north is actually a private service, just to be clear. It is not a public service?

**Ms HODGE** - No.

**CHAIR** - This one that you want to put in here is the only public service that would be provided in Tasmania?

**Ms HODGE** - Yes.

**CHAIR** - Some need to go to Melbourne now, but this will obviate that.

**Ms HODGE** - The COVID-19 pandemic affected people to have the ability to go to Melbourne so this will bring us to gold standard of what we should be supplying in modern health care.

...

**Ms RATTRAY** - Also, for clarification, the people of the north who already access the sleep apnoea services, they won't be disadvantaged in any way by having to use a private provider whereas in the south you will be able to have a public provider?

**Ms HODGE** - There's about 50:50 of people from public and private who need access for sleep apnoea services. You have the ones in the north, they can probably apply to come to the south as well. We are not going to discriminate against people coming to that service.

## **Australian Health Facility Guidelines**

### **4.7 The Committee was interested to understand the implementation of the Australian Health Facility Guidelines in the architectural design of J-Block:**

**CHAIR** - Regarding the Australasian Health Facility Guidelines, I'm presuming that sort of matter is addressed. Are there any other particular matters in those guidelines which you have used as part of your brief to improve things, such as widths of corridors? Can you give us an overview as to how those guidelines have impacted on your design?

**Mr JONES** - Certainly. With regard to the guidelines, generally speaking the guidelines cover a one- or a two-bed inpatient bedroom with an ensuite. As a rule, that is what we have applied across the board. The only other difference is the guidelines have a room type or a briefing document for a critical care bedroom. Where we have the critical care bedrooms, we've applied that particular guideline to those. With regard to overall design philosophy, there is not a lot of difference. It is more about the servicing.

Because we are using an existing building which we are refurbishing we're governed by an existing footprint and existing configuration. We are utilising all the existing bedroom locations, all the existing ensuite locations. The guidelines stipulate a desired dimension regarding width and length. While we don't quite achieve those, because that fit out is a relatively new fit out but we achieve the overall footprint with regard to the square meterage of the rooms, we've been lucky to be able to utilise that same footprint.

Other than that, it's more about some design philosophies, the application of colour theory to particular types and styles of patients, utilising colour-corrected lighting so that when you are dealing with a cardiology patient, a critical care patient, there are subtleties around being able

to identify conditions such as jaundice. Obviously, you don't have warm yellow lighting and you don't have yellow paint -

**Ms RATTRAY** - Or purple.

**Mr JONES** - Or purple. Mind you, sometimes purple can be a bit of a personal choice. The interesting thing is if you take colour theory associated with hospital colour theory, purple is one of the colours associated with a cardiology unit.

**Ms RATTRAY** - There you go.

**Mr JONES** - In this particular case and the nature and configuration of the building, purple from my point of view, would be too dark to apply so therefore you are not going to get depth of light and lightness and that sort of airy feeling that we want to achieve.

### **Staff and visitor amenities**

4.8 The Committee recognised the importance of appropriately catering for staff and visitor needs within hospital settings and asked the witnesses to detail the spaces assigned to such considerations:

**Ms BUTLER** - There doesn't seem to be much space for staff rooms, or seminar rooms for that floor. I know when we've looked at things before, staff have been trying to find spaces where they can have meetings and things. Is that part of the consideration? I can see one seminar room and one staff room. There's a staff base though as well, isn't there?

**Mr JONES** - At either end you've got, from a staff-utilisation point of view, there's a staff base or a nurse station at either end of the floor in terms of their respective treatment areas. Sleep studies has its own discrete office. Attached to the nurses' station at the critical care end there's also a multi-disciplinary office zone for handover and nursing staff to prepare and transfer notes. You have a similar thing down the other end - next to the nurses' station there's another staff office area for note-taking. In addition to that, there is a staff room and a seminar room.

**CHAIR** - A staff breakout room.

**Mr JONES** - Yes, so there's an existing staff breakout room on what is currently the older persons unit area.

**Ms HODGE** - There's also in Level 2, where ward 2D is now, at the end, a big meeting room which has media to look at x-ray, pathology, et cetera, and we can utilise that for staff meetings as well as education.

**CHAIR** - This is the decanting unit that you're -

**Ms HODGE** - No, this is for the Level 2, where the cardiology ward is, where the cardiology offices are. There's a meeting room in that space as well, which staff can use if they book.

**Ms BUTLER** - Where are the areas for families? Are there visiting areas or are the rooms big enough to allow for that visitation with families? That was one of the problems with the design at the moment, isn't that right?

**Mr JONES** - Given that each individual bedroom, and if you look predominantly - certainly the critical care end, there are only three double bedrooms. Every other bedroom is a single bedroom. Given that they're very close to an Australasian Health Facility Guideline standard, it does provide enough space that, as you are there as a single patient, you do have plenty of space in there to have family members. We also have on one end a smallish family meeting room.

Particularly if there is one of those unfortunate discussions that may need to take place, there is a private space for that to happen.

**CHAIR** - Whenever you're in the circumstance where family needs to stay overnight like you would in a children's ward, or whatever, you are not going to have that?

**Ms HODGE** - No, especially at the moment with COVID-19 restrictions, we only allow one visitor per patient and we are very strict about that to protect the public.

**Ms BUTLER** - Did you mention then that it is not at an Australasian standard?

**Mr JONES** - No, it is.

**Ms BUTLER** - Just under it, or?

**Mr JONES** - Regarding square metreage, it's fine. It is one of those funny things. The Australasian Health Facility Guidelines have two areas it tackles. One is a square metreage per function but, based upon that square metreage, it identifies particular dimensions in terms of width and length. In this case, we are slightly wider but not quite as long, therefore we achieve the square metreage from a guideline point of view.

### **Proposed target for completion**

4.9 The Committee was aware of considerable difficulties facing the building and construction sector in relation to the commencement and completion of projects, as a result of increased demand limiting the availability of contractors and building infrastructure. With this in mind, the Committee sought to determine if this had been taken into consideration in the proposed target of completion detailed in the Department's submission:

**Ms RATTRAY** - In regard to the program, it says here that the target date for completion is around September 2022. Given that we know that there's a significant building boom, not only in Tasmania but right across the country, I am interested in whether you still believe that those targets will be met in regard to completion should this go through the appropriate process.

**Mr CLASENER** - We've gone through that process of programming out the risks in the market and that's where we've landed on that September date, so we still believe that's achievable.

...

**CHAIR** - As far as the project schedule is concerned, you are hoping this is still realistic?

**Mr JONES** - Yes.

**CHAIR** - And completion of design development, August. Development application, that is exempt because it is not new work in the sense of a new building is it, as such?

**Mr JONES** - That is correct. It is an existing building and not a change of use. It is exempt under the Hobart City Council planning scheme and that exemption is actually already in place.

**Ms RATTRAY** - If there is no DA required and there are no fees to go with it, what are the statutory fees?

**Mr JONES** - We still have a building permit and a plumbing permit we have to apply for.

**Ms RATTRAY** - Thank you.

**Mr JONES** - With the building permit comes the training and building levy.

### **Contingency cost**

4.10 The Committee recognised that the contingency costing in the Department's submission was estimated at a significant percentage in comparison to other recent proposed works.<sup>3</sup> The witnesses were asked to discuss the relative height of this proposed contingency costing:

**CHAIR** - As far as the project costs are concerned, there was a question on the contingency being 10 per cent. On other projects we have seen a contingency for construction and an uplift, an escalation. This is all wrapped up into the 10 per cent contingency?

**Mr JONES** - Yes. As we discussed earlier, fundamentally whether it be a design -

**CHAIR** - This is for the record. We have to ask the questions.

**Mr JONES** - Essentially, with regard to contingencies, there is a multitude of different contingencies. You have typically a design contingency, a construction contingency and also you have other risks such as, in this case, escalation. You can either separate them as a line-by-line item and call them individually, or as in this case, we have simply wrapped them up into one-line item.

### **Design considerations**

4.11 The Committee sought to understand the aspects specific to the new Cardiology/Cardiothoracic Inpatient Unit on Level 2, J-Block:

**Ms RATTRAY** - ... Design: ... Is there anything different - obviously this is part of the Stage 2 redevelopment and this committee has looked at previous areas for redevelopment not that long ago - are there any design differences in this one that you might like to walk us through?

**Mr JONES** - Essentially, in terms of the cardiology unit, cardiology inpatient delivery is very similar to a standard inpatient medical hospital room. The main real difference is in a servicing requirement simply because if you take a standard inpatient room, body protection is the standard we apply in terms of the residual current devices attached to all the power circuits. When it comes to a cardiology unit, the main difference there is we up that to 'cardiac protection level' which is a greater level of protection because by its nature you're dealing with cardiology patients. The difference between body protection and cardiac protection is body protection operates at a lower level, where you may be just simply attaching things to the outside of the body, whereas cardiac prevention takes into account that you may undertake invasive procedures within the body, so it has a higher level of protection. That's one of the main fundamental differences between that and a standard inpatient room.

Over and above that, generally speaking, all the servicing requirements around power, data, medical gases are all very similar.

**CHAIR** - If I might on that, is it simply a matter that the power system trips at a lower level?

**Mr JONES** - That's correct. It trips at a much quicker rate if it determines that there's an earth leakage problem.

---

<sup>3</sup> *Ibid*, p. 11.

**CHAIR** - So in milliseconds?

**Mr JONES** - It is milliseconds, yes, five milliseconds, from memory, something of that nature.

**CHAIR** - Close to 10?

**Mr JONES** - Yes, something of that nature. The other main difference is also that the number of circuits you are allowed on one RCD [Residual Current Device] is at a much lower level than with body protection or even standard RCD protection.

## **Storage**

4.12 During the site visit, the Committee noted the use of corridors as storage facilities throughout the current D- Block Cardiology inpatient unit, due to a lack of official storage space. Consequently the witnesses were asked to detail the proposed solution to this concern:

**Ms RATTRAY** - Through our site visit, we saw that the hallway is currently a storage area for a number of things. Are there adequate storage facilities in this new redevelopment?

**Ms HODGE** - Yes. We have an equipment storage area. We also have a separate area for our sterile stock and another separate area for our non-sterile stock. That is part of Australasian standards that you separate your sterile stock from non-sterile stock. I have also got contemporary systems of plastic wire baskets, which are from nearly ceiling to floor, and you can put much more equipment in a smaller area. That meets standard.

We do like colour coding of putting certain stock together so it makes it easier for nursing and medical staff when they go to get equipment. It is what we call value stream mapping.

**CHAIR** - That is interesting, you just described about the basket arrangement. Can you describe that a little more, how that works?

**Ms HODGE** - Traditionally, we used to use things like compactors which are big, metal, with solid bottoms and you put your equipment on. But they collect dust and they have to be wiped down. With new contemporary standards, what they have is plastic baskets and they have little inlets all the way through so you keep your sterile stock on those and your non-sterile stock on those. They can pull out and you can colour code, put certain stock together so that it is easy for nurses to manage.

We always separate our sterile from our non-sterile and when equipment comes to the ward, we don't put into that sterile stock until it is unpacked. It is all about infection control standards.

## **Building Services**

4.13 The Committee asked the witnesses to discuss the specifics of selected building services across J-Block. As such, the absence of electronic glass in bedroom doors was queried:

**CHAIR** - .... I was asking a question about electronic glass because this was something put forward as part of the Mersey development. You explained why you are not using electronic glass. Can you expand on that?

**Mr JONES** - Yes, certainly. Our ability to get natural light is twofold. We are replacing all of the existing doors into the bedrooms because they were designed for a previous use. We are replacing them with glazed doors to increase the ability for the nursing staff to observe the

patient in their bedroom. In this particular case we are using interstitial venetian blinds in each door.

**CHAIR** - Can you explain what that is?

**Mr JONES** - It is basically a venetian blind between two layers of glass. A double-glazed unit with venetian blinds inside that has a sliding mechanism to allow the blinds to be either open or closed in varying degrees.

**CHAIR** - Or tilted.

**Mr JONES** - Or tilted, like you do with a normal set of venetian blinds at home. Quite honestly, it is a cheaper alternative than E-glass. If you talk about mitigating factors, it is slightly less in lead time than what it would be with E-glass. The other factor is it allows the nursing staff to adjust the level of privacy to suit how the patient is at any one given time during the course of a day or night on either their need to observe or give the patient privacy.

**CHAIR** - For those watching, you might explain what E-glass is.

**Mr JONES** - E-glass is a glass that is embedded with a chemical that responds to electricity that allows you to switch the power to the glass on or off, and the glass is either transparent or opaque.

**CHAIR** - It is like a liquid crystal.

**Mr JONES** - Almost like a liquid crystal display effectively.

**CHAIR** - Like how a watch works.

**Mr JONES** - Yes, but it only has an 'on' or 'off' function and it is either clear or opaque, whereas going back to the old-fashioned venetian blinds allows the degrees of transparency in between.

#### 4.14 The Committee also sought further information on the function of air-conditioning ventilation on J-Block:

**Mr TUCKER** - With the air-conditioning system in the new isolation room, so I have this clear, the air completely goes back out. It does not recirculate through that room at all?

**Mr JONES** - No. For 98 per cent of the work we're doing we're re-using existing systems because what's there is sufficient for what we're doing. We are just reconfiguring, relocating fresh air supply, return air supply grills and re-balancing. For the new isolation room on Level 3 - one is already existing on Level 2 - it has its own new, stand-alone system, which will exhaust through the roof to the minimum 3 metres separation from any adjoining fresh air -

**Mr TUCKER** - Say if you have someone with COVID-19 in that room and then they get right and they move out of that room, someone else moves in who might have COVID-19, that air supply won't be going through that?

**Mr JONES** - No. It's a fully-compliant isolation room, with an antechamber, its own air supply, own exhaust. It's not shared between any other room.

**CHAIR** - Is that a positive or a negative pressure?

**Mr JONES** - Negative pressure.



4.15 The Committee asked the witnesses to detail the extent of information, communication and technology infrastructure which is to be installed throughout J-Block:

**CHAIR** - Information, communication and technology infrastructure - is there major work being done in that area or is just bringing up old buildings to new standards?

**Mr JONES** - First of all, the comment around the budget - that principally covers the active equipment, that line item there, because the infrastructure is included in the construction cost. As far as this particular refurbishment, some of it is already in place. There is an existing Coms room on each floor that has, from memory two racks in it already. We are looking to add a third one to each floor and it is just a matter - I say it is just a matter - but we are upgrading to include some additional data outlets in each room to take into, particularly from a cardiology point of view, the additional monitoring requirements.

**Ms HODGE** - In the last two years we have spent about \$2 million on monitoring equipment for cardiology and we have 26 new monitors.

**CHAIR** - A lot of that is through needing networks.

**Ms HODGE** - Absolutely. It's all within current contemporary practice and we will probably just need a couple of additional monitors.

**CHAIR** - Is that wireless or hardwired?

**Ms HODGE** - They are wireless. Patients can walk around and be monitored and can be linked if someone has a cardiac arrest. We can push a button to get an exact cardiac reading. It has the capacity to store up to a week. We can download that into the digital medical records. It has a lot of capacity.

...

**Ms RATTRAY** - What does other client costs cover?

**Mr CLASENER** - A new sleep study centre has been put in with subscriptions and things to go in and that is an allowance for those types of costs.

**CHAIR** - Are you talking about software?

**Mr CLASENER** - Yes, software subscriptions and equipment associated with that. There are those costs that come up as you get to the end of the project that need to be capitalised over that first year of service.

4.16 The Committee was interested to understand the installation of hydraulics for the proposed works:

**CHAIR** - ..... Hydraulics goes from page 9 over to page 10:

Works include alterations to existing hot-cold water and drainage pipework to connect new ensembles and other fixture locations. Where necessary TMV wall boxes are relocated to suit room layout changes additional tundishes.

**Mr JONES** - ..... Because we're constructing new bedrooms, each bedroom gets an ensuite. We have new hydraulics, new plumbing that services the new bathroom. We are also going through both areas that we are refitting and introducing more handbasins in the public

spaces, from an infection control point of view. Previously it was a mental health ward, which basically just had bedrooms.

The infection control requirement is substantially less compared to an inpatient unit, so we are retro-fitting. As part of the works, each bedroom now has to have a clinical hand basin for handwashing plus there are additional handbasins out in the corridors for nursing staff. That's required additional waste and water works, so therefore additional water outlets and waste outlets. With every hand basin we put in we put in a TMV, a thermostatic mixing valve, a temperature control point.

The tun dishes pick up waste water drainage from fan-coil units. A fan-coil unit is there to heat and chill water, which then provides the air temperature control. If you want to cool air you run cold water through the fan coils. If you want to warm air, you run heated water through the fan coils. Given that you have temperature there that generates condensation, the condensation gets picked up in a tun dish and goes into the waste water system.

### **Fire protection and procedure**

#### **4.17 The Committee inquired into the nature of fire protection and escape procedures in the refurbishment of J-Block:**

**Ms BUTLER** - Can I ask about that fire protection, can you run through where the fire escape areas are for those areas?

**Mr JONES** - Yes. Between Levels 3 and 2, because you're coming down, there's a central stair that's fire protected on Level 2 to allow people on Level 3 to come down to Level 2. There's also the linkway that we came across that brings us from C Block into the building. That's also a designated path of travel back into C Block and then through the relevant evacuation pathways in C Block.

You may not have noticed, but if you're standing on Liverpool Street there are two stairwells on the outside of the building. Both of those are fire-rated stairwells that are used principally as the main means of egress and evacuation from the building, accessible only from inside the building to go down. Each floor is also subdivided into different fire compartments and smoke compartments to enable refuge and transfer of patients, depending upon where the fire source may be.

**Ms BUTLER** - I was going to say those lifts today were pretty -

**Mr JONES** - Slow. Those lifts aren't set-up for any form of -

**Ms BUTLER** - Fire evacuation -

**Mr JONES** - No.

**Ms BUTLER** - What's the process if you had to evacuate that cardiac area because of fire, given people are in beds?

**Mr JONES** - That's principally the reason why we have fire compartments set up. Once it's identified where the fire is we can move patients from compartment to compartment. Each compartment is set up to offer a minimum of 90 minutes up to a two-hour fire separation. In theory it means that a fire can be burning in one compartment for up to two hours before it moves through, which gives adequate time for hospital staff, with the assistance of hospital emergency management, to evacuate patients, particularly bed patients from one building to another. It gives the fire department plenty of time to access the building and extinguish the fire as well.

## **Repurposing of existing infrastructure**

4.18 During the site visit, the Committee toured the existing mental health care facilities on Level 2 and Level 3, J-Block. The Committee understood that much of the infrastructure from this ward would be stored for later repurposing opportunities:

**Ms RATTRAY** - Part of the site visit we saw there was going to be some redevelopment on a much newer part of the current hospital. There was going to be some opportunity to reuse some products into the future. Would you like to talk about that? I like reuse.

**Mr JONES** - The previous function of where we are relocating to was the mental health ward on both Level 2 and Level 3. As you may be aware, the mental health ward now occupies Levels 2 and 3 of K Block. It uses - I will not say similar - the same hardware on doors and the ensuites - that sort of thing - all the anti-ligature self-harm hardware. We have identified in our documentation the contractor is to remove all the door hardware and also the observation panels from the doors, because they are a specialist piece of equipment that has a long lead time, hand those back to the hospital so the hospital has them as a readily-available supply for maintenance of the same bedrooms in K Block.

**CHAIR** - Those observation panels would have toughened glass?

**Mr JONES** - They do. I will not say ballistic standard, but they are certainly assault-standard and take quite a physical punch to break.

**Ms RATTRAY** - I think that's very useful. So the hospital has a supply area -

**Mr JONES** - They'll have a readily available supply in storage

## **Tasmanian Art Scheme**

4.19 The Committee sought to understand the potential utilisation of the Tasmanian Art Scheme for the proposed works:

**Ms RATTRAY** - I am always interested in the Tasmanian arts scheme and how that might be reflected in the development. Are there any thoughts about how that might be accommodated this time around?

**Mr JONES** - Certainly, during the user meetings for both the cardiology users plus also the user group the hospital put together for the decant ward, we had a lot of discussion regarding how we might incorporate the art into the process. Because I was personally involved in some of the consultation directly with the sleep studies users, there was a thought process and discussion that there are several public areas of the wards we may look at incorporating some artwork into those zones. We still have to formally engage through Arts Tasmania and it will be further into the process to run an arts engagement process with them.

**Ms RATTRAY** - There will not be anything in a practical sense you might be able to accommodate - a feature wall of some special timber?

**CHAIR** - That is what he might be saying.

**Mr JONES** - Yes, what we are suggesting is it might be some sort of artwork that may be incorporated.

**Ms HODGE** - ... .. We have also asked consumers who have been accessing the sleep service about what type of artwork they would like to see. I have also asked cardiology patients about

*colours and things so we meet the needs of patients. That is what we are there for at the end of day - to meet patient need.*

### **Does the Project Meet Identified Needs and Provide Value for Money?**

4.20 In assessing any proposed public work, the Committee seeks assurance that each project is a good use of public funds and meets identified needs. The Committee questioned Mr Clasener who confirmed that the project met an identified need in the community, which will successfully be met in a cost effective manner through the appropriate use of public funds:

**CHAIR** - ... *With these submissions we always ask some standard questions and we need a clear answer for them.*

*Do the proposed works meet an identified need or needs or solve a recognised problem?*

**Mr CLASENER** - Yes.

**CHAIR** - *Are the proposed works the best solution to meet identified needs or solve a recognised problem within the allocated budget?*

**Mr CLASENER** - Yes.

**Ms RATTRAY** - *There was no hesitancy there, Chair.*

**CHAIR** - No.

*Are the proposed works fit for purpose?*

**Mr CLASENER** - Yes.

**CHAIR** - *Do the proposed works provide value for money?*

**Mr CLASENER** - Yes.

**Ms RATTRAY** - *This is the big question.*

**CHAIR** - *Are the proposed works a good use of public funds?*

**Mr CLASENER** - Yes.

## 5 DOCUMENTS TAKEN INTO EVIDENCE

5.1 The following documents were taken into evidence and considered by the Committee:

- *Royal Hobart Hospital (RHH) J-Block Refurbishment*, Submission to the Parliamentary Standing Committee on Public Works, Department of Health, November 2021; and
- Attachment B – Architectural Drawings.

## **6 CONCLUSION AND RECOMMENDATION**

- 6.1 The Committee is satisfied that the need for the proposed works has been established. The Committee recognises that the refurbishment of J- Block will increase the standard of care given to cardiology patients on the Cardiology/Cardiothoracic Inpatient Unit, as well as those seeking aid from the Sleep Studies Unit. Additionally, the formation of the decant ward will add great strategic and functional purpose in relation to the Royal Hobart Hospital Masterplan 2020-2050.
- 6.2 The proposed works will provide:
- A 37 bed Cardiology/Cardiothoracic Inpatient Unit, increasing the current number from 32 beds;
  - A Sleep Studies Unit with 3 inpatient beds and additional day testing facilities. This unit will provide Tasmania's only such public facility, offering a number of tests for the first time in the state; and
  - A 22 bed decant area to be used as a space for patient relocation throughout the remaining redevelopment of the Royal Hobart Hospital.
- 6.3 Accordingly, the Committee recommends Royal Hobart Hospital (RHH) J-Block Refurbishment, at an estimated cost of \$12.331 million, in accordance with the documentation submitted.

**Parliament House  
Hobart  
24 January 2022**

**Hon Rob Valentine MLC  
Chair**

