Australasian Health Facility Guidelines

Part B - Health Facility Briefing and Planning
0132 - Child and Adolescent Mental Health Unit

Revision 6.0
01 March 2016

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Australasian Health Facility Guidelines

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01 INTRODUCTION

01.01 Preamble

PURPOSE OF GUIDELINE

This Health Planning Unit (HPU) has been developed for use by project staff (architects, planners, engineers, project managers and other consultants) and for end users, to facilitate the process of planning and design.

It is intended to assist with the planning and design of a unit that will be fit for purpose in accordance with its designated service delineation / capability and defined catchment population.

It is a revision of the HPU originally developed for NSW Health in 2004 and issued for Australasian use in 2006 with further review in 2011. Its revision has been informed by an extensive consultation process and review of literature.

01.02 Introduction

GENERAL

This HPU outlines the specific requirements for the planning and design of a Child and Adolescent Mental Health Unit.

It should be read in conjunction with the Australasian Health Facility Guidelines (AusHFG) generic requirements and Standard Components described in:

- Part A: Introduction and Instructions for Use;
- Part B, Section 80: General Requirements;
- Part B, Section 90: Standard Components, Room Data and Room Layout Sheets;
- Part C: Design for Access, Mobility, OHS and Security;
- Part D: Infection Prevention and Control; and
- Part E: Building Services and Environmental Design.

RELATED HEALTH PLANNING UNITS

The following related HPUs are available in Part B:

- HPU 133 Psychiatric Emergency Care Centres;
- HPU 134 Adult Acute Mental Health Inpatient Unit;
- HPU 135 Older Persons Acute Mental Health Inpatient Unit; and
- HPU 250 Ambulatory (Community / Outpatient) Mental Health Unit.

The Mental Health Intensive Care HPU is currently being reviewed and a new HPU for Non-Acute Mental Health Inpatient Unit is also being developed.

TERMINOLOGY

The following terminology is applied for the purpose of this HPU:

- consumer: in the mental health context, the patient is referred to as the ‘consumer’ and this terminology will be utilised throughout this document;
- carer: carers provide unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness or who are frail. A carer is intimately

involved with the lives and treatment of consumers. In the mental health context, the carer is a recognised member of the multidisciplinary team;

- young people: jurisdictions will refer to their consumers / patients as ‘adolescents’ or ‘young people’. This Guideline adopts the term ‘young people’ as it gives greater scope for the jurisdiction to define the age group to which they refer;
- voluntary patient: a consumer who elects to remain in a mental health facility for treatment, care or observation, or who is admitted by his or her guardian or person responsible under the relevant jurisdiction’s Guardianship Legislation;
- involuntary patient: a consumer admitted under the relevant jurisdiction’s Mental Health Act. The process of involuntary detention usually includes the steps of request, recommendation, admission and examination by a psychiatrist, and regular review at formal hearings;
- nomenclature of beds: different terminology is used by the different jurisdictions. ‘Acute’ beds may also be known as ‘general’ or ‘open’ beds. ‘High dependency’ may also be known as ‘observation’ or ‘secure’ beds. For consistency and clarity, this HPU uses the terms ‘acute’ and ‘high dependency’ when referring to the different beds and zones; and
- formal hearing: the term used in this HPU for formal reviews of consumers admitted under the relevant Mental Health Act and Regulations. The term for this varies between jurisdictions e.g. magistrate session, tribunal, board of review.

01.03 Policy Framework

GENERAL

Policies for the provision of healthcare services are formulated in accordance with the following principles:

- appropriate service models that ensure a comprehensive service network throughout state and regional health jurisdictions;
- safe and effective care that minimises both staff and patient risks;
- provision of a safe and efficient environment that minimises risk to all users of the facility;
- deployment of resources in a fair and cost effective manner to optimise health outcomes; and
- development and support for enhanced information systems to monitor, plan and evaluate healthcare services.

LEGISLATION AND REGULATIONS

The Commonwealth Disability Discrimination Act 1992 and the New Zealand Public Health and Disability Act 2000 are overarching policies relevant to this HPU. (See References).

Mental health services in all jurisdictions are underpinned by mental health legislation, and by the National Mental Health Strategy.

All child and adolescent units will also be governed by the relevant child protection and education legislation in their jurisdiction.

POLICY DOCUMENTS

The United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care is a key document influencing service provision.

In Australia, the mental health agenda has been set through the National Mental Health Policy 2008 and the Fourth National Mental Health Plan: an agenda for collaborative government action in mental health 2009 - 2014. Together, these documents reflect governments’ commitment to:

“a mental health system that enables recovery, that prevents and detects mental illness early and ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community”.

New Zealand's commitment to mental health is reflected in Tahuhu, T. 2008, Improving Mental Health 2005 - 2015: The Second New Zealand Health and Addiction Plan, New Zealand Health.

The United Nations Convention on the Rights of the Child (1990) is also a relevant policy document in the context of providing inpatient mental health care for children and young people.

DIVERSITY AND SPECIAL GROUPS

Policy frameworks recognise the diversity of our community and special groups that often require specific consideration to meet their needs and to enhance the effectiveness of any services provided. These groups include:

- children and young people of Aboriginal and Torres Strait Islander descent in Australia, and Maori and Pacific Islander descent in New Zealand;
- children and young people with physical and cognitive disabilities including (bariatric) consumers;
- children and young people from cultural and linguistically diverse backgrounds; and
- children and young people from rural and remote areas.

CONSUMER / PATIENT RIGHTS

Consumer rights include:

- the right to receive care in the least restrictive environment;
- the right to privacy and dignity and appropriate control over their environment, e.g. ability to locked bedroom doors, to access quiet spaces;
- the right to complain and expect a response to their complaint;
- access to external influences (email, internet, newspaper, etc); and
- access to local community facilities such as shops, banks and other local amenities as deemed appropriate.

It is recommended that consumer/carer groups be involved in the briefing process.

An official visitor box should be provided in a discrete location to enable consumers, families and friends to provide feedback in a safe and discreet manner.

01.04 Description

DESCRIPTION OF HEALTH PLANNING UNIT (HPU)

This HPU describes a tertiary level service with regional / area and/or statewide responsibility.

This HPU describes facilities for the admission, assessment, treatment of children and young people, generally up to 18 years, who require treatment as inpatients for mental health problems for whom community based approaches have proven, or are likely to prove, inadequate. The Unit will provide consultation, assessment, care planning, acute care management, recovery, discharge planning and outcome measurement.

Admission to a unit of this nature is generally moving away from diagnostic admission criteria towards criteria based on severity, complexity, level of impairment and risk management.

Some areas / jurisdictions may have a need to establish specialist child & adolescent mental health units; to include a eating disorders unit; behavioural intervention unit; forensic mental health unit etc.

In some jurisdictions the child's / young person's whole family will be admitted to the service, whilst in other jurisdictions only the child / young person is admitted. Regardless of the admission policy, the Unit will encourage and facilitate active family involvement by taking into account the needs of a consumer's family / carers.

CONSUMER CHARACTERISTICS

Age of admission is generally four to eleven years of age for children's units, and twelve years up to eighteen years of age for adolescent units. However, consideration is given to the developmental age of the individual to determine the appropriateness of admission to this Unit (The Australian Infant, Child, Adolescent and Family Mental Health Association, 2006). Some young people, especially those sixteen to eighteen years, may be more suited to admission in an adult unit, whilst some young adults (up to 21 years of age) may be developmentally suited to this Unit.

UNIT SIZE

The UK Royal College of Psychiatrists (1998) recommends units of ten to twelve beds to optimise clinical and financial viability. Units smaller than six to seven beds may not be clinically or financially viable, and may limit the level of amenity / range of recreational facilities that can be provided. However in Victoria (Australia), fifteen bed units are favourably reported.

BUILDING STRATEGIES

It is important to recognise and understand that the fabric of a mental health unit is required to be considerably more robust than for other units. Particular attention should be given to walls, doors, ceilings and glazing: giving consideration to acoustic management, the potential for damage by consumers and potential for consumers to self-harm.

THERAPEUTIC ENVIRONMENT

This HPU reflects advances in the understanding of:

- optimal environments for care;
- advances in assessment;
- treatment;
- rehabilitation and/or recovery; and
- changing practices in the delivery of mental health services for children and young people.

Consumers may be agitated, aggressive and a potential risk to themselves or others. Therefore, the environment should be conducive to the management of complex behaviours offering the capacity for observation of consumers by staff, discreet security and, where necessary, temporary containment. However, this should be achieved with a therapeutic focus so that while necessary measures for safety and security are in place, they are non-intrusive and do not convey a custodial ambience.

Optimal physical environments are associated with shorter lengths of stay, lower levels of aggression and critical incidents, improved consumer / patient and staff safety, better staff conditions and satisfaction, and reduced recurrent costs.

UNIT DESIGN

Mental health facility design requires a conscious balancing of the requirement to provide an effective therapeutic environment for acute mentally ill consumers, with the need to provide consumers, carers, visitors and staff with a pleasant, spacious, light filled, comfortable and non-threatening facility. For a child and adolescent mental health unit, priorities include:

- facility design that enables safe and efficient operation in order to optimise consumer outcomes;
- unobtrusive security and access control that can accommodate consumers of all levels of acuity;
- privacy and safety, including sexual safety;
- comfort and visual satisfaction (domestic furnishings, decor, artworks);
- quiet spaces and active indoor and outdoor spaces, for therapy and relaxation;
- maximum penetration of natural light and, where possible, views;
- avoidance of isolated spaces for both consumer and staff safety e.g. no unsupervised blind corners, recessed areas, alcoves;

- the need for space cannot be over-emphasised as a means of reducing the potential for aggressive behaviour by means of wide corridors and recreation areas large enough to avoid crowding;
- fixtures and fittings that minimise the opportunity for self-harm or injury to others, with special attention to bathrooms, bedrooms, courtyards, low stimulus areas and formal hearing rooms;
- acoustic management, particularly of bedrooms;
- access to facilities for carers. This may include overnight bedrooms, toilets and showers, a private lounge and a room where a consumer may meet with their family in private;
- safe and supervised access for visiting family members, including other children and young people;
- sufficient flexibility to adapt over time in response to changes in practice, treatment and the consumer demographic; and
- compliance with fire safety, building regulations and standards.

Consideration should also be given to the following:

- availability of qualified staff and mix of staff;
- changes in technology;
- maximising efficiencies in recurrent / operating costs; and
- interplay between inpatient and ambulatory care services.

02 PLANNING

02.01 Operational Models

HOURS OF OPERATION

The Unit will provide service 24 hours per day, seven days per week. Where a day hospital is established, it will generally operate during business hours Monday to Friday.

MODELS OF CARE: FACILITY CONFIGURATIONS

Common inpatient unit configurations are:

- stand alone child mental health unit for children aged four to eleven years of age, with flexibility to admit children / youths outside this age range according to an individual's developmental age;
- a stand alone adolescent mental health unit for young people aged twelve to eighteen years, with flexibility to admit children / youths outside this range according to an individual's developmental age; or
- a child and adolescent mental health unit, with services delivered in a single facility, providing there is opportunity for flexible differentiation of zones to meet the specific developmental and health needs of consumer / patient sub-groups.

Collocation of a voluntary child mental health unit with other paediatric services is not recommended. Units of this type have been unsuccessful in NSW.

A common alternative, where an inpatient facility is not available, is admission to a paediatric unit with access to mental health consultation-liaison to support the treating paediatric team. However, this arrangement is intended to be short term only.

A day unit can provide specialist programs and outpatient services for consumers / patients and their carers, who need treatment but who do not require overnight admission. This unit also provides a step down from inpatient admission.

If a day unit is a component of the service model, collocation with an inpatient unit could allow sharing of reception, common consulting / treatment areas and staff, whilst preserving a functional separation from inpatient areas. Operational policies will dictate the extent to which inpatient and day patient activities remain separate such as: meals, education, group therapy, activities etc.

Facilities for community based services may also be collocated with inpatient and/or day units to strengthen continuity of care.

MODEL OF CARE - DELIVERY OF SERVICE

A multi-system, multidisciplinary approach to care is recommended. Queensland Health (1996) summarises service delivery goals as:

- short term treatment and relief of symptoms for consumers, and their families, who present with acute episodes of mental illness;
- a safe and therapeutic environment for the return of health, sufficient to enable the consumer to return to the community with appropriate support;
- medical, psychological and social approaches to managing symptoms and education for the consumer, family and carers about the illness and recovery;
- close observation for consumers experiencing extremely acute phases of illness, and containment for those who are at risk of harming themselves or others;
- participation of family and carers in a consumer's treatment, and access to counselling services for carers and families when necessary;

- culturally sensitive services for Aborigines and Torres Strait Islanders, Maori and Pacific Islanders, and culturally and linguistically diverse consumers;
- linkages with, and specialist liaison to, community and outreach services, crisis teams, acute assessment teams, and provision of services to rural and remote areas using teleconferencing; and
- services located close to families / carers.

02.02 Operational Policies

GENERAL

The development of operational policies is integral to defining how the unit will operate within a healthcare facility or health service, as well as in relation to adjoining health services from where consumers may be referred. They impact on the capital and recurrent costs of a facility and will vary from unit to unit depending on a wide range of factors, such as the clinical characteristics of the consumers and the defined role of the unit. The cost implications of proposed policies should be fully evaluated to ensure the most cost-effective and efficient design solutions are developed in providing therapeutic and high quality physical environments.

Operational policies should be developed for every Unit as part of the project planning process to inform the design process. Refer to Part B Section 80 for further information.

The following operational policies are particularly relevant to this Unit.

CONSUMER / EDUCATION / SCHOOLING

A consumer's participation in education or schooling should be maintained during treatment wherever possible. It is, however, acknowledged that activities such as schooling may be postponed for a short admission if the purpose is to confirm a diagnosis, stabilise the client on medication prior to returning them to their support environment, or they are too unwell to participate.

Facilities and programs should be in place to support age appropriate educational activities (see policies / guidelines from jurisdictional departments of Education and Health). Collocation of this Unit with a Paediatric Unit that has a hospital school does not negate the need for an education room in the Unit, as some consumers / patients will be too high risk to leave the Unit. The room should be readily available, as required, and be appropriately furnished for learning activities.

Facilities for other specialist education staff will be required. Provide lockers for each consumer's personal items and school work.

LOW STIMULUS AREA

Seclusion is "the confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented" (NMHRSP 2009). It is an intervention of last resort that protects the consumer, other consumers, staff and visitors from significant harm through containment, isolation and stimulus reduction in order to allow the consumer to settle (NSW Health 2007a). Generally seclusion will only be implemented for involuntary patients after other de-escalation strategies have failed. Refer to jurisdiction policies on seclusion and restraint, which may differ from jurisdiction to jurisdiction.

Reduction and eventual elimination of seclusion is a recognised goal across contemporary mental health services both nationally and internationally. Appropriate facility design will contribute to this goal, along with a range of other prevention strategies (NSW Health 2007).

Time-out is a different management strategy for voluntary quiet time. Use a comfortably furnished quiet room for this purpose.

Separate rooms for each function are preferred by service providers so that furnishings can be appropriate to the purpose, without constant adjustment according to the situational need.

ELECTROCONVULSIVE THERAPY

Electroconvulsive therapy (ECT) should only be undertaken in a dedicated ECT suite; day procedure; operating unit; or other area designated and equipped for ECT procedures. Facilities for ECT are not addressed in this HPU.

SMOKING

It is not illegal for a person under eighteen years of age to smoke, but local non- smoking policies will apply. However, all jurisdictions will have supportive programmes in place for nicotine substitution and smoking cessation.

BARIATRIC PATIENTS

At least one bedroom and en suite should be large enough to accommodate lifting equipment, and a larger bed for potential bariatric patients. A larger than standard examination couch may be provided in at least one consultation / examination room.

CATERING

Food services need to comply with relevant standards (ISO 22000), legislation and local food authority requirements.

All meals can be prepared and plated outside the unit and delivered ready to eat, however, it is beneficial for capable consumers and carers to be involved in the preparation of their breakfasts and lunches, as a part of activities of daily living. If this operational policy is adopted, the unit kitchen should be sized and equipped to facilitate use by consumers and family / carers. Store dangerous items in locked cupboards and display safe items on open shelves. The kitchen should be lockable after hours. Young people should have use of the kitchen throughout the day under supervision. The kitchen should be able to be locked as appropriate.

A supervised refreshment facility should be available at all times for consumers of all ages, their families and carers.

Where families / carers are staying in the unit with the consumer, catering will need to be extended to them.

USE OF BEDROOMS

Generally, consumers will not be allowed access to their bedrooms except to sleep, for approved time out, or if recovering from sedation or other treatment. Therefore, bedroom doors should be lockable from the outside with access controlled by staff.

Assuming clients are supervised closely at all times and appropriate operational policies are in place, acute units may allow young people to lock their bedroom doors (with staff override). This would not be practiced in a high dependency unit (HDU) setting where clients are at higher risk. The inclusion of bedroom locks allows for changing operational practice over time, and from day to day to meet a wide range of needs. Locking of bedroom doors is not supported in NSW, where lockable space for personal items is to be provided as an alternative.

In units for children, provision should be made for a parent to room-in or, alternatively, provide access to family accommodation close to the unit.

At least one bedroom should be designed to AS1428 (Standards Australia 2010) for independent wheelchair users.

EMERGENCIES

Medical emergencies are to be managed in accordance with the health facility's standard policies. A resuscitation trolley and portable oxygen and suction should be readily available in a secure area not accessible to consumers / patients, such as the staff station or treatment room / clean utility.

STAFFING

Staffing levels will vary for each unit depending on the size of the unit; the operational policies; availability of staff and differing skill mix; levels of supervision required; clinical case mix; and dependency and unit activity levels.

The unit should provide sufficient functional area to support the number of staff in the safe and efficient delivery of care.

The environment should be secure and facilitate effective emergency responses to acute situations on each shift. Designing the unit on this basis will support efficient unit operation without imposing additional costs, whilst enabling compliance with security and occupational health and safety requirements.

STAFF ESTABLISHMENT

A staff establishment by full time equivalent (FTE), category and shift should be prepared to inform staff office accommodation and amenities requirements.

Staff may include the following, working as a multidisciplinary team in a permanent or visiting capacity:

- medical staff;
- nursing staff;
- allied health staff;
- administrative staff;
- education staff;
- housekeeping, maintenance and catering staff;
- security and other emergency response personnel;
- research and evaluation staff; and
- consumer advocates.

Community clinicians and students should also be considered as part of the staff establishment when assessing staff facility and amenity requirements.

Visiting services may include:

- legal officers;
- advocates;
- official visitors;
- representatives from other agencies; and
- community health staff.

FIREARM SECURITY - POLICE

Police officers accessing the unit should be encouraged to disarm prior to entering. A discreetly placed firearm safe should be available for secure storage. Generally one safe per gun should be provided.

Consultation with the relevant jurisdictional agencies should be an essential part of the design process.

02.03 Planning Models

GENERAL PRINCIPLES

The operational model chosen for the Unit will greatly influence the planning model adopted.

LOCATION

A ground floor location for the internal patient areas in the unit is preferred. Where this cannot be achieved, railings, enclosures and other barriers may be required to restrict access to roof areas and to prevent people jumping or falling.

At grade outdoor areas are required.

The public and people in other parts of the healthcare facility should not be able to see into the building or outdoor areas.

The building's orientation needs to maximise sunlight to internal and external spaces in the unit, in particular bedrooms and activity areas.

TRAFFIC FLOWS

Movements external to the unit may be between:

- the unit and a paediatric unit, if consumers / patients are to participate in age appropriate activities with other children; and/or
- the unit and the hospital school.

It is preferable to avoid movements through high traffic public areas.

UNIT CONFIGURATION / LAYOUT

A secure and safe staff-controlled entry is needed.

The Unit layout needs to be sufficiently flexible to allow for changing levels of acuity, age mix and models of care over time. The ability to create sub-units / clusters for distinct consumer groups (e.g. based on gender, age, diagnosis or acuity) is desirable.

Unobtrusive observation of patient areas by staff is essential, but needs to be balanced with consumer privacy.

Dead-end corridors and recesses where consumers / patients may be out of view should be avoided. Recent units in Victoria have single loaded corridors around a courtyard, providing access to every room from two directions.

All corridors, with the exception of those in staff-only areas, should be a minimum of 1800mm clear. For security and fire safety reasons, all exits should have at least six metres of clear space so that people are not encouraged to congregate outside perimeter doors. All corridors and exits are required to comply with the current Building Codes Australia (BCA) requirements.

The high dependency zone and low stimulus area should be located away from bedroom and activity areas, so as to maintain the privacy and dignity of consumers and minimise the impact on other consumers in the Unit. The low stimulus area can be located within the HDU.

Views from the Unit into surrounding gardens have a therapeutic benefit. An outlook beyond the Unit is also desirable (Ulrich 1999).

02.04 Functional Areas

FUNCTIONAL ZONES

Functional zones may include:

- main entry, reception, waiting;
- consulting rooms
- therapy rooms;
- interview rooms;
- bedrooms and bathrooms;
- activity and recreation areas - indoor;
- activity and recreation areas - outdoor;
- high dependency zone;
- low stimulus area;

- visitor / family amenities;
- meeting rooms;
- clinical and non-clinical support areas; and
- staff offices and amenities.

MAIN ENTRY / RECEPTION

A secure, and safe, staff controlled entry is needed. The reception can be shared with a day unit, if collocated.

The area will incorporate a welcoming greeting / waiting area for consumers, carers and others. Public amenities will be provided separate from other parts of the Unit.

The area should be designed so that no visitor can directly access other parts of the Unit without either reporting to reception staff or having some means of communication with staff in the Unit if the reception is not attended. Options include intercom and closed circuit television (CCTV) both outside the main door and at the entry door to the inpatient area.

The reception desk should enhance security while maintaining a visually welcoming environment. Security screens can be used, however, they should be designed so as not to impede communication or visibility. Alternatively, the depth of the reception counter can be increased while still meeting occupational health and safety requirements.

A room for interviewing and processing booked consumers should be provided, with direct access from the waiting area where consumers can be received in a private and welcoming environment. This room can also be used for interviewing carers and visitors and undertaking security checks before allowing entry to the Unit. Depending on circumstances, more than one such room may be required.

Small lockers may be provided so that visitors' belongings can be safely stored while they are visiting. Management of this provision would require operational guidelines to support their functionality.

CONSULTATION / THERAPY ROOMS

Consultation / therapy rooms may include rooms for interview, consultation, assessment, treatment and play therapy. Rooms will variously cater for individual and group therapy. The number and specific purpose will be determined by the Unit's size and service profile.

Interviews involving consumers / patients should be restricted to dedicated consultation / therapy rooms, however, some office sizes may need to be enhanced to cater for meetings with multiple family members (Carthey 2008).

Consultation and interview rooms should be large enough to comfortably accommodate up to six people, including the consumer, clinicians and carers Each requires two exits and fixed duress alarms for safety. Family or group therapy involving more than six participants will generally occur in a medium / large meeting room.

An observation room may adjoin one interview room. Alternatively, video recording equipment may be installed for observation and viewing.

CONSUMER BEDROOMS

Children and young people may have differing needs in relation to bedroom and bathroom facilities:

- young people: privacy will be enhanced through provision of single bedrooms with en suites;
- children: where rooming-in is the preferred approach, larger bedrooms should be provided to accommodate a family member. Shared bedrooms may be appropriate in some circumstances i.e. where a parent is not 'rooming in'. For example, Indigenous children are more likely to express a preference for a shared room, however, single bedrooms are preferred as a strategy for maximising consumer safety. A combination of individual en suites and shared en suites with corridor access may be more appropriate for children.

One or more larger single bedrooms should be provided to accommodate bariatric patients.

A secure sub-unit of two bedrooms and shared en suite may be created in the acute zone to achieve age / gender separation, if needed. Such a sub-unit would require a small sitting area which can be easily observed by staff.

Where a bedroom is being set up to accommodate 'rooming in', careful selection of furniture is required to ensure appropriate circulation is maintained and occupational health and safety is addressed. The availability of separate family accommodation on a unit is a factor in determining the number of larger bedrooms required.

Design and decor should permit personalisation of the space, particularly for young people (Queensland Health 2009). Required furniture and fittings include:

- built-in wardrobe (no door or lock);
- built-in desk;
- mirror (impact resistant and non distorting);
- lightweight, flexible chairs;
- pin board;
- door vision panels should be impact-resistant glass: panels should be located high and low, so that a small child can be observed;
- domestic style beds are preferred: mattresses should not be innerspring and should have a high fire resistance rating; and
- blinds to external windows are to be integrated venetians within double glazing.

Services will include:

- body protected power;
- two power outlets;
- optional internet outlet;
- staff alarm system; and
- low wattage night light switched from outside the room.

Medical gases will not be provided.

CONSUMER BATHROOMS

En suites should incorporate a shower, toilet and hand basin.

In the acute inpatient zone, consumers may have direct bedroom access (individual en suites), or corridor access (shared en suites between two consumers). The mix of shared and individual en suites will rely on the ages, requirement for specialling, and number of consumers accompanied by a carer. Note that sharing of en suites impacts on the Unit’s flexibility. In the high dependency unit, shared en suites with corridor access are preferred.

A common bathroom should provide a bath, a raised shower bath to avoid unnecessary bending by carers / staff, a full sized toilet, a small toilet for children and nappy change facilities.

Fittings such as towel rail, clothes hooks etc, require a breaking strain of fifteen kilograms to minimise opportunities for self harm. Avoid other ligature points such as shower curtains through appropriate design e.g. recessed area for garbage bin, recessed toilet roll holders, toilet seats that resist breakage and removal, in-fill moulded hand rails (not in accessible toilets), recessed soap and shampoo shelf.

Ensure doors to en suites open outwards against a wall. They will be lockable from the outside so that staff can deny access, if necessary. If occupancy indicators are used, capability is needed for the doors to be opened by staff in an emergency. In the high dependency unit en suite doors should be able to be locked either open or closed, depending on the particular needs of the consumer / patient.

KITCHEN AND DINING ROOM

The dining room should have direct access to an outdoor area which can be used for outdoor dining. Tables will preferably be square and able to accommodate four trays. There should be ready access to an accessible toilet. This may be the toilet in the bathroom, if appropriately located.

The kitchen should be located to have ready access for delivery of food supplies and meals.

ACTIVITY AND RELAXATION AREAS - INDOOR

A sufficient number of indoor activity areas should be sized and furnished to accommodate a range of concurrent activities, both active and passive, and appropriate to age. These include:. meals; cooking; television; art; games; music; computers; reading; indoor facilities for exercise as part of a consumer therapy program, and telephone contact.

Areas may include:

- quiet lounge;
- television / music / internet area (media room);
- group recreation areas (including lounges, games area);
- multipurpose activity / art and craft / computer facilities;
- activities of daily living (ADL) kitchen - optional. (Access to an ADL kitchen located in another unit is sufficient);
- dining room;
- education room;
- indoor exercise facility; and
- self care laundry - optional.

The main recreation area should open onto an outdoor area and be large enough to cater for all consumers / patients and carers, particularly when outdoor areas are unusable e.g. cold, wet weather.

It may be appropriate for the media room to be a sub lounge, adjacent to the group recreation area, so that internet based activities can be easily supervised by staff.

ACTIVITY AND RECREATIONAL AREAS - OUTDOOR

Outdoor areas for programmed activities, play or relaxation are treated as therapeutic areas. Therefore as much design effort and attention to detail should be given to achieving a tranquil and functional garden as to internal spaces.

Children and young people require larger outdoor areas than adult consumers. The space should be zoned (Coombes and Coombes 2004) to achieve:

- passive areas such as seating in landscaped gardens;
- active areas that encourage games and exercise, such as half basket ball court, walking paths, safe climbing areas etc.; and
- a barbeque area.

Some of the outdoor area should have soft surfaces e.g. 'soft fall', grass. Sun protection and weather protection should be incorporated so that outside recreation is not weather dependent. Outdoor furniture should be fixed.

Landscape features and plantings should be set back from the perimeter wall to avoid breaches of perimeter security. Avoid blind spots in the design to enhance supervision. Provide full and soft lighting to outdoor areas at night.

A minimum outdoor area of 60 metres squared is recommended to achieve active and passive areas. Additional space should be provided if the Unit exceeds ten consumers.

HIGH DEPENDENCY INPATIENT ZONE

A high dependency area, located immediately adjacent to the staff station, may be provided for acute, high risk consumers who need additional observation, or who are a risk to others in the Unit. It should be capable of secure separation from the acute zone, but able to be used as an unlocked facility at other times. Access to the high dependency area will be controlled by staff. Protect consumer privacy by locating this zone so it is separate from other consumers / visitors in the Unit (Victoria 2008).

The Unit comprises single bedroom(s), a secure lounge area with direct access to an external secure courtyard, toilet and shower (either shared facilities or en suite bathroom). An interview room and a low stimulus area (seclusion room and/or quiet room) are optional in the high dependency area, as per local operational policies.

A direct entry to the high dependency area is required for police-assisted admissions or admissions who are highly disturbed.

As an alternative to a high dependency unit, it may be possible to provide the appropriate level of observation to high risk consumers without a dedicated high dependency unit by increasing the staff ratio, or specialling a consumer i.e. one to one nursing care (Carthey 2008).

LOW STIMULUS AREA

A low stimulus area should be provided for agitated and distressed children. The low stimulus area may consist of a seclusion room and/or a quiet room. The area should be located so as to minimise disruption to other Unit activities. The room(s) may be located within the high dependency unit, or alternatively a quiet location away from bedroom and activity areas, depending on the Unit’s management plan (Queensland Health 2009). Toilet and washing facilities should be nearby.

Seclusion rooms have very specific design requirements that are addressed in HPU 134 Adult Acute Mental Health Unit.

The quiet room should be plain, with comfortable but unbreakable fittings. It should be supplied with activities conducive to voluntary quiet time and be a positive therapeutic space.

VISITOR / FAMILY AMENITIES

Carers and visitors require a comfortable lounge in the unit for time out, private interactions with the consumer, or interactions with other families. Access to a beverage bay is required.

Sleeping facilities for carers should be provided in a children’s unit. 'Rooming in' is applicable across all jurisdictions. In some jurisdictions separate family accommodation may be provided with good access to the Unit.

MEETING ROOMS

Provide at least one multi-purpose meeting room for group therapy, staff meetings, staff education, family meetings and formal hearings. The number of meeting rooms depends on the number and nature of other rooms available in the unit. At least one meeting room should be equipped for video/teleconferencing services.

Meeting rooms used for consumer interactions such as formal hearings or group therapy require two doors and dedicated access from the high dependency zone.

Furniture such as tables and chairs should be appropriate for activities being undertaken in the meeting room, but be heavy enough to eliminate their potential use as weapons.

CLINICAL AND NON-CLINICAL SUPPORT AREAS

Support areas will include:

- staff station and clinical resource room;
- medication room;
- treatment room / clean utility;
- linen store;

- dirty utility; and
- storage: clinical, non clinical, patient.

STAFF STATION / CLINICAL RESOURCE ROOM

It is suggested that these two functions could be combined with an open counter area (staff station) for consumer - visitor interaction, and an adjoining clinical resource room (quieter enclosed office) in which confidential discussions can occur. Functions for these two spaces may be arranged as follows:

Staff station:

- workstation for ward clerk;
- space for computers, telephones, printer, facsimile, copier;
- docking stations for portable phones, pagers and personal duress - alarms; and
- procedure manuals and references.

Clinical resource room:

- staff handovers and case discussions;
- medical records storage; and
- locker storage for staff personal belongings (if separate locker room is not provided).

Ideally, the unit's design would allow a single staff station to monitor all areas (including the high dependency unit) and provide an escape route / safe haven for staff. However, unit location and site footprint may have an impact on the ability to achieve this as part of the design process.

A decision to provide a separate staff station in the high dependency unit should only be reached after serious consideration of planning options and staffing levels, being mindful of compromises to safety and operational efficiency.

The size of staff stations should be based on the number of staff who will occupy the areas, not necessarily the bed numbers.

Note the strength of fluorescent lighting for night duty requirements. Dimmer facility and/or 'down lighting' above work spaces for night duty staff should be installed.

MEDICATION ROOM / CLEAN UTILITY

Medications should be stored in a locked room with no consumer access. Storage of sterile supplies and other medical equipment / trolleys may also occur in this room. Room size needs to allow for this anticipated storage.

If also used for dispensing medications, a medication dispensing hatch is required.

Direct internal access from the staff station or treatment room may be considered.

TREATMENT ROOM

A treatment room may be used for performing examinations and minor procedures, such as dressings and injections, storage of resuscitation equipment and sterile supplies. Sterile stock may be stored in this room. It will require an examination couch, examination light and a second exit.

Ideally, access to the treatment room for consumers from the high dependency zone should not be through the acute zone.

STORAGE

Storage will be required for occupational therapy equipment, and a range of age- appropriate therapy, sport and recreation equipment. Cots may also be stored for very young consumers. Storage areas for general recreational equipment should be accessible to consumers under supervision, either in each inpatient area or in a central shared area. It may also be appropriate to have a store room located in the outdoor recreation area for ease of accessing outdoor equipment.

STAFF OFFICES AND AMENITIES

Staff offices for the unit manager and on-duty registrar should be located in the unit so that they are readily available to support and supervise staff, as well as having ready access to clinical information. Other offices, workstations and staff amenities should be located away from inpatient areas, with no consumer access. This may be on an upper floor that can be secured after hours and at weekends, whilst still giving authorised staff access to amenities, photocopier etc.

As this unit tends to have a relatively large staff establishment and high staff to consumer ratios, a higher proportion of single and shared offices may be required to meet the needs of the various consultants, registrars nursing, allied health and education staff.

The practice of seeing consumers in offices is not supported by jurisdictions and should be discouraged. Sufficient consultation rooms should be provided to avoid this.

Staff amenities should include a staff room and outdoor area, located to provide privacy to staff whilst on breaks. These amenities should be accessible at all times for staff use.

Access and the provision of other staff amenities (e.g. toilets, showers, car parking, lockers etc) in accordance with standard requirements.

02.05 Functional Relationships

EXTERNAL

The Child and Adolescent Mental Health (CAMHS) Unit has a range of functional relationships with the following facilities, services and organisations:

- adult mental health unit;
- paediatric inpatient unit/s;
- hospital school;
- medical imaging unit;
- other specialist services;
- pathology;
- Child Protection Unit;
- departments of education, community services, corrective services;
- early childhood services;
- child and family support services;
- other CAMHS community services including intensive outreach services and day programs;
- drug and alcohol services; and
- police and ambulance services.

INTERNAL

Planning of the Unit is complex and requires the correct relationships to be achieved between the functional zones listed previously.

The central reception zone should feed into the inpatient area and, if applicable, the day hospital. This zone could contain consultation and interview rooms utilised by both inpatient consumers and day patients.

Ideally, and dependent on the Unit's bed numbers and consumer profile, the inpatient area should be zoned to allow for appropriate grouping / separation of inpatients, according to characteristics such as developmental age (child / young person), behaviours (hypoactive / hyperactive), diagnosis and gender.

Locate the high dependency unit in a separate area of the Unit that has direct entry and access to the treatment / clean utility room.

The inpatient area could share central support areas comprising: staff station; therapy areas; meeting rooms; education room; and other activity areas.

Locate recreation areas (indoor and outdoor) in proximity to each group of bedrooms.

Locate staff offices and amenities in a zone not accessed by consumers.

03 DESIGN

03.01 Accessibility

EXTERNAL

The Unit requires a dedicated entry for voluntary consumers and their families / carers.

Provide a separate, secure, entry point for police-assisted and involuntary patients to the high dependency zone.

Ready access is required for support services such as food, linen, supplies and waste disposal. This access will be controlled by staff and not accessible by consumers.

INTERNAL

Provide direct access to the Unit, not through other units. The Unit should not be a thoroughfare to other units.

03.02 Parking

The following provisions should be made:

- all weather drop-off for consumers;
- short term parking for police or ambulance vehicles;
- visitor parking in close proximity;
- some longer term parking options - given that some carers will be present throughout the admission.

For staff parking, refer to Part C Clause 790.

03.03 Disaster Planning

Each component of the Unit will have operational plans and policies detailing the response to a range of internal and external emergency situations. During planning and design phases consider issues such as the placement of emergency alarms, the need for uninterrupted power supply (UPS) to essential clinical equipment and electronic sensor taps, services such as emergency lighting, telephones, duress alarm systems and computers and the emergency evacuation of patients, many of whom will require assistance.

Refer to Part B, Section 80 and Part C for further information.

03.04 Infection Control

GENERAL

The following aspects of planning and design contribute to the implementation of effective infection prevention and control measures and are relevant within the context of this HPU:

- hand hygiene facilities;
- isolation rooms (if applicable);
- linen handling;

- separation of ‘clean’ and ‘dirty’ work flows;
- storage;
- waste management; and
- surface finishes.

Refer to Part D for and to individual jurisdiction policies and guidelines.

HAND BASINS

Hand basins are required in clinical areas e.g. treatment and medication rooms.

Corridor basins may be replaced by alcohol hand wash in dispenser units, dependent on jurisdictions' infection control policies and guidelines.

03.05 Environmental Considerations

ENVIRONMENTALLY SUSTAINABLE DESIGN

Sustainability applies to many areas such as:

- air handling and ventilation;
- thermal integrity (insulation, etc.);
- water management;
- choice of sustainable products e.g. low volatile organic compounds (VOC) floor finishes; and
- support of operational recycling policies.

Many of these issues will be addressed at overall facility level but may have greater or lesser implications for this Unit.

ACOUSTICS

Noise is a constant source of complaint from consumers and may compromise consumer confidentiality as well as comfort and recovery. In particular, noise at night will have a negative impact on the ability of consumers to sleep.

Noise sources may arise both within and from outside the Unit and include:

- sanitary facilities;
- equipment;
- other consumers;
- staff activities e.g. conversations, talking on phone, rounds, meetings, cleaning;
- areas of public movement, lift lobbies, etc.;
- traffic through the Unit including visitors, food, linen and other trolleys, or movement of consumers into or out of the Unit;
- helipad / helicopter, police / ambulance noise; and
- external traffic noise.

Solutions to be considered include:

- location of the Unit;
- use of sound absorbing materials and finishes;

- sound isolating construction. Special acoustic isolation is required for high dependency areas, seclusion rooms, consultation / therapy rooms. General acoustic isolation is required for bedrooms, en suites and recreation areas. In acoustically treated rooms, return air grilles should be acoustically treated to avoid transfer of conversations to adjacent areas. Door grilles to these areas should be avoided;
- separation of quiet areas from noisy areas; and
- changed operational management.

Refer to Part C for further information.

NATURAL LIGHT

Natural light contributes to a sense of wellbeing for all building occupants, including consumers, staff and other users. Research studies suggest a link between greater levels of natural light and improved clinical outcomes, particularly for persons with mental illness (Joseph 2006).

However, too much sunlight can adversely affect consumers with medication related photosensitivity. Therefore, ensure outdoor areas have shaded areas.

Higher levels of natural light may help people better orient themselves in the building thus enhancing wayfinding, however, glare should be minimised.

Greater use of natural light may also reduce energy usage in terms of reducing the need for artificial lighting. For these reasons, the use of natural light should be maximised throughout the Unit. Natural light is required to all bedrooms in accordance with the Building Codes Australia (ABCB 1990).

The quality of darkness should be maximised at night to enhance sleep. Placement of night lights and external security lights should be carefully considered to minimise sleep disturbance to consumers.

PRIVACY

A major conflict in the design of inpatient accommodation often arises due to the need to ensure consumers and staff can see each other, while also ensuring consumer privacy.

Strategies to enhance privacy include:

- single bedrooms;
- en suites;
- acoustic treatment;
- single gender areas;
- discreet location of high dependency unit and quiet rooms; and
- no vision into the Unit from outside the Unit.

Bedrooms and other areas occupied by consumers should be designed and configured to give staff the greatest ability to observe consumers / patients, particularly unstable or vulnerable consumers. Different styles of unit design offer varying degrees of visibility / observation.

INTERIOR DÉCOR

Interior decor includes: furnishings; style; colour; textures; ambience; perception and taste, that can help ameliorate an institutional atmosphere. However, cleaning, infection control, fire safety and consumer / patient care requirements and the consumers' and their families' / carers' perceptions of a professional environment, should always be considered.

Some colours, particularly the bold primaries and green should be avoided in areas where clinical observation occurs such as bedrooms and treatment areas. These colours may prevent the accurate assessment of skin tones e.g. yellow / jaundice, blue / cyanosis, red / flushing. Extremes of colour and pattern such as geometric designs which may disturb perception should be avoided, however, strong colours may assist orienting consumers to their bedrooms and activity areas. Colour should be used to highlight doors / areas that consumers will access (bedrooms, bathrooms, activity areas, therapy areas) and neutral colours used to 'hide' doors that they should not access (utility rooms, staff areas) (Fleming et al 2003).

In this unit design, furniture and interior decoration should be robust, but domestic in style, to create a homelike environment (Devlin & Arneil 2003). Furniture should be sized appropriately to the child and/or young person consumer group (Malkin 1991) and be arranged to promote positive group dynamics. Furniture items should be easily replaceable in case of breakage.

Art work and colour should be a key feature for children (Blumberg & Devlin 2006). Opportunities for personalisation of space will be particularly important for adolescents (Queensland Health 2009).

SIGNAGE AND WAYFINDING

The orientation of people to and within healthcare facilities, and even safety and security issues are greatly assisted or hampered by the quality and location of signage which may be directional, used as a means of identification and/or statutory. Signage should comply with guidelines to promote access for people with disabilities.

All signage should be easily understood by staff and the general public whether consumers or visitors, and where necessary and appropriate, languages other than English should also be used. Alternatively, the consistent use of pictograms / symbols could also be used.

Any signposting, or other initiatives put in place, should be considered from the perspective of out-of-hours use. Certain access points may be locked out of office hours or after visiting hours. Directions indicated through signposting should, therefore, be evaluated in this context.

Refer to Part C Section 750 - Signage and TS-2 - Wayfinding for Health Facilities (NSW Health 2009).

Consideration needs to be given to the system used in the numbering of consumer rooms. These rooms should be given non-permanent functional names for future flexibility.

03.06 Space Standards and Components

HUMAN ENGINEERING

Human engineering covers those aspects of design that permit effective, appropriate, safe and dignified use by all people, including those with disabilities.

As the requirements of occupational health and safety and antidiscrimination legislation will apply, this section should be read in conjunction with Part C Section 790 in addition to relevant OHS legislation.

ERGONOMICS

The design and build of the Unit should such to ensure that consumers, staff, visitors and maintenance personnel are not exposed to avoidable risks of injury.

Furniture, fitting and equipment selections need to be appropriate for use by children and young people, without disadvantaging adults who work in and visit the Unit.

Refer to Part C Section 730 for details.

ACCESS AND MOBILITY

Where necessary, design should comply with AS 1428 - Design for Access and Mobility (Standards Australia, 2010). This would apply to bathrooms, public access toilets and en suites designed for independent wheelchair users.

Wheelchair-bound staff including nursing, clerical, support and management should also be accommodated in accordance with AS 1428. The includes the design of reception desks to allow at least one place is wheelchair accessible on both sides.

Refer to Part C - Design for Access, Mobility, OHS and Security - Section 730 for details.

BUILDING ELEMENTS

Building elements include walls, floors, ceilings, doors, windows and corridors and are addressed in detail in Part C Section 710 - Space Standards and Dimensions - Building Elements.

Building fabric needs to be particularly robust in this Unit to withstand abuse and minimise opportunities for self harm e.g. no ligature points, non-removable fixtures and fittings.

DOORS AND DOORWAYS

Ensure doorways are sufficiently wide and high to permit the manoeuvring of beds, wheelchairs, trolleys and equipment without risk of damage or manual handling injury, particularly in rooms designed for bariatric consumers / patients.

Bedroom doors should open outwards to prevent consumers / patients blockading themselves in their bedroom. Outward opening doors should be recessed to prevent obstruction of corridors.

High dependency unit bedroom doors should have a viewing panel. This may also be desirable for acute bedrooms. Two panels: one high; and one low, may assist in observing small children and young people.

WINDOWS AND GLAZING

In consumer areas, all window frames should be heavy duty (commercial frame) construction and securely fixed to the wall fabric.

In areas where damage to glass may be anticipated, larger pane sizes should be avoided as smaller panes are inherently stronger.

Impact-resistant and shatter-proof Grade A safety glass to comply with AS/NZS 2208 Safety Glazing Materials in Buildings is the recommended choice. Polycarbonate is not recommended as it suffers from surface scratching which obscures vision.

Any windows that open should be designed so that they will not allow consumer escape, with locks under the control of staff. Locks should be flush with surrounding window frames and not provide a ligature point. Fixed fly screens should be attached to opening windows to prevent removal by consumers.

SHUTTERS

If shutters are used to secure servery openings, kitchenettes and linen bays, the following OHS requirements apply:

- they should be within reach of an average sized person, i.e.153cm tall. Hooks on poles are not a safe method of pulling down a shutter in mental health units;
- they should not be too heavy to lift;
- locks on shutters that go to the floor should be placed at waist height rather than at the floor; and
- shutters should be sturdy and impact resistant.

Alternatives that can be considered include doors that can be locked in the open as well as closed position.

03.07 Safety and Security

SAFETY

Design and construction of the facility and the selection of furniture, fittings and equipment should ensure users are not exposed to avoidable risks of injury.

Special consideration should be given to the minimisation of hazards for children for example:

- the location of power outlets above child height, and shuttered;
- service panels out of reach of small children;
- access to hot water units and beverage bays;
- rounded edges on furniture at low levels;
- child proof locks on cupboards;

- barriers and balustrades that allow small children / toddlers to be contained as necessary but can be seen through; and
- door handles out of reach of small children.

Ongoing management and repairs are essential to maintaining a safe environment for children, particularly whilst out of their home setting.

RISK / HAZARD MANAGEMENT

Consideration of safety and security risks critical to mental health units should begin during the planning and design phase of a healthcare facility and should continue to be considered during the construction, use and post occupancy stages.

By adopting a risk management approach, many safety and security related hazards can be eliminated or minimised at the planning stage before work even begins, reducing the likelihood of adverse incidents occurring.

Occupational Health and Safety (OHS) or similar legislation requires planners and designers to identify, assess and control risks in order to provide an optimal ergonomic design, and to do this in consultation with stakeholders.

Safety considerations need to address the health and safety of all end users, including staff, maintenance personnel, consumers and visitors.

Refer to National Mental Health Working Group 2005.

SECURITY

A safe and secure Child and Adolescent Mental Health Unit is more likely to be achieved when good design is allied with appropriate staff levels and operational policies.

Facility planners and designers should enhance security by incorporating the principles of territorial reinforcement, surveillance, space management and access control into design decisions. Security may be physical or psychological, and barriers may be real or symbolic. The least restrictive environment that provides a safe environment should be the aim. Security features may include:

- transfer lobby / airlocks;
- electronic locking;
- intercoms;
- video surveillance;
- personal and fixed duress alarms;
- motion sensors in bedrooms and/or in corridors outside bedrooms; and
- all rooms should be lockable, including corridor cupboard doors and fire hose reel cabinets.

ACCESS CONTROL

The Unit should be designed with controlled entry and exit points so that consumer / patient movements can be supervised, and no consumer should be able to leave the Unit unobserved.

If the Unit is located within a multi-storey building, ensure there can be no unauthorised and unsupervised access to external spaces above ground level such as balconies or roof, unless these are specifically designed for consumer use.

CLOSED CIRCUIT TELEVISION (CCTV) SURVEILLANCE

CCTV may be useful for monitoring areas such as stairways and blind spots, hallways and outdoor perimeters. It is not to be used as an alternative to direct clinical observation by staff.

Consider the following factors in relation to the use of CCTV for security purposes:

- health service policies;

- the rights of consumers to privacy, balanced against the need for observation for safety and security reasons;
- the ability of the staff establishment to manage the level of observation required without the use of CCTV;
- the fact that monitors may not always be able to be manned;
- maintenance costs; and
- the potential to avoid use of video security with improved functional design.

DURESS ALARM SYSTEM

A combination of personal and fixed duress alarms is recommended in the Unit, including outdoor areas. All staff should carry a personal duress alarm with location finder, linked to a real time monitor facility. The charger for personal alarms should be located in a staff-only area accessible 24 hours a day.

Fixed alarms should be installed to areas where staff work in a relatively fixed position, such as reception, but also in high risk areas like consultation / treatment rooms. They should be positioned to ensure that:

- staff can reach them without having to cross the path of the consumer / patient or distressed family member
- they cannot be activated by consumers or children
- they cannot be activated accidentally e.g. by a chair being pushed back.

Refer to Part C for further information.

PERIMETER SECURITY

The Unit requires a secure perimeter. A recommended height for perimeter fencing has not been established. A typical range is 2.7 metres to 4.0 metres, however, fencing should not be to a height as to create a prison-like environment, or to increase the possibility of falling injuries should an escape attempt be made. In determining an appropriate height, consideration will be given to the proximity of the perimeter fence to buildings, the topography of the site and consumer profile. Security is enhanced by installing curved fencing rather than having angled joins.

Attention should be given to detailing roof overhangs, guttering and drain pipes, which may provide a means of escape.

Refer to:

- AS/NZS ISO 31000: Risk Management (Standards Australia 2009);
- Part C Section 790 - Safety and Security Precautions;
- individual jurisdiction policies and OHS legislation;
- NSW Health TS-11 Engineering Services & Sustainable Development Guidelines, New South Wales Department of Health, Sydney (NSW Health 2007b); and
- NSW Health TS-7 Floor Coverings in Healthcare Buildings, V1.1, NSW Health Department, North Sydney (NSW Health & CHAA UNSW 2009).

03.08 Finishes

GENERAL

Finishes in this context refers to walls, floors, windows and ceilings.

Refer to Part C Section 710 - Space Standards and Dimensions.

WALL FINISHES

Adequate wall protection should be provided to areas that will regularly be subjected to damage. Particular attention should be given to areas where bed or trolley movement occurs, such as corridors, bed head walls, treatment areas, equipment and linen trolley bays.

FLOOR FINISHES

Floor finishes should be appropriate to the function of the space. Consider acoustic performance, slip resistance, consequences of consumer falls, infection control, movement of beds and trolleys, maintenance and cleaning protocols.

The selection of floor finishes should take into account manual handling issues, including the impact on the flooring on push / pull forces for wheeled equipment, and be adequate to avoid the potential for slips and trips caused by joints between flooring.

Refer to Part C Section 710 Space Standards and Dimension and to TS-7 Floor Coverings in Healthcare Buildings (NSW Health & CHAA, UNSW 2009).

CEILING FINISHES

Ceiling finishes should be selected with regard to appearance, cleaning, infection control, acoustics and ability of consumers to access roof space via the ceiling.

Refer to Part C Section 710 - Space Standards and Dimensions.

03.09 Fixtures, Fittings & Equipment

DEFINITIONS

The Room Data and Room Layout Sheets in the Australasian Health Facility Guidelines define fixtures and fittings as follows.

- fixtures: items that require service connection (e.g. electrical, hydraulic, mechanical) that include, but are not limited to hand basins, light fittings, medical service panels etc. but exclude fixed items of serviced equipment; and
- fittings: items attached to walls, floors or ceilings that do not require service connections such as curtain and IV tracks, hooks, mirrors, blinds, joinery, pin boards etc.

Refer to Part C Section 710 and to the Standard Components (Room Data Sheets (RDS) and Room Layout Sheets (RLS)) for further detailed information.

Also refer to Part F Section 680.

GENERAL PRINCIPLES

The potential suicide of consumers is of particular concern in a mental health unit. Therefore, fixtures and fittings should be assessed for potential use for self-harm or as a weapon.

Any fitting or fixture capable of supporting a consumer’s weight should be avoided, unless it is an item of furniture intended to bear the consumer’s / patient’s weight. Fittings in this Unit require a breaking strain of no more than fifteen kilograms (15kg).

In addition, fittings should be safe, durable, tamperproof and concealed where possible. They should be flush with the surfaces to which they are attached, or designed in a way that prevents attachment of anything around them.

ARTWORK, SIGNAGE AND MIRRORS

Artwork, signage and mirrors are to be rigidly fixed to walls with concealed, flush, tamper-proof mountings. Where possible include consumers, particularly young people, in the selection of art works. Opportunities should also be given for young people to contribute to the artwork on display.

Ensure that mirrors are made from safety glass or other appropriate impact-resistant and shatterproof construction; are scratch proof; and are free from distortion. Fully glue mirrors to a backing to prevent loose fragments of broken glass.

PLUMBING FIXTURES

All exposed plumbing fixtures should be tamper-proof and resistant to breakage and removal, particularly plumbing fixtures accessible to consumers / patients. The following considerations are recommended:

- shower heads should be flush with the wall, and be downward facing;
- taps should not be able to be used as ligature points; and
- sink and basin wastes, and toilet cisterns should be concealed.

It is suggested that water and electrical supply shut-off systems be installed in the staff station to reduce risk of inappropriate use of showers and consequent flooding, or access to live electrical currents if the consumer / patient is considered extreme risk.

RAILS, HOOKS AND HANDLES

Where used, provide rails and hooks that collapse under a breaking strain of 15 kilograms.

The use of horizontal grab rails in toilets and showers should be avoided. Solid, vertical rails with moulded hand grip are preferred. (Note that this does not apply to accessible toilets).

Alternative arrangements for towel storage, such as a bench or shelf, should be considered to avoid use of towel rails or hooks.

Door and cupboard handles/knobs should be designed to avoid ligature points.

Consider using fittings moulded to incorporate hand pulls, to avoid the use of handles.

SHOWER CURTAINS AND TRACKS

Ideally, the use of shower curtains and tracks should be avoided. This can be achieved if the shower cubicle has appropriate floor grading to the drain, and the water flow rate is controlled to prevent excessive splashing.

Where installed, shower tracks should be plastic and mounted flush to the ceiling. It is critical to ensure that the entire track plus hooks has a 15 kilogram breaking strain, so that if the curtains are gathered into a single cluster the aggregate does not exceed fifteen kilograms. Do not install a track which allows the hooks to be pushed together, as this will significantly increase the breaking strain.

WINDOW TREATMENTS

Curtains, Holland blinds or other types of blinds / curtains with cords should not be used in consumer bedrooms. Integrated Venetian blinds within double glazed windows with flush controls, or electronic controls in the staff station, are suggested.

If curtains are selected for consumer recreational areas, provide tracks that are flush to the ceiling with a breaking strain of 15 kilograms.

Consider the fabric type with respect to weight / thickness and ease of tearing.

OTHER

Light fittings and CCTV cameras should be vandal-proof and incapable of supporting a consumer's weight.

03.10 Building Service Requirements

GENERAL

In addition to topics addressed below, project staff may also refer to:

- Part E - Building Services and Environmental Design;

- TS-11 - Engineering Services and Sustainable Development Guidelines (NSW Health 2007); and
- Western Australian Health Facility Guidelines for Engineering Services (WA Health 2006).

AIR HANDLING SYSTEMS

Provision of natural ventilation to consumer care areas should be approached with caution. The management of airflows and the creation of a stable environment are essential to the control of the spread of infection, so generally, air conditioning should be provided.

Refer to Part D and HB260 - Engineering down the risk (Standards Australia 2003c).

Special consideration should be given to ventilation outlets and equipment used:

- provide air grilles and diffusers that prevent the insertion of foreign objects;
- provide tamper-resistant fasteners where these are exposed;
- construct all convector or HVAC enclosures expressed in the room with rounded corners and with closures fastened with tamper-resistant screws;
- use HVAC equipment that minimises the need for maintenance within the room; and
- vents should be fixed to the ceiling to prevent access to the roof cavity.

Refer to TS-11 (NSW Health 2007c) for further information.

ELECTRICAL SERVICES

It is essential that services such as emergency lighting, telephones, duress alarm systems (including the central computer) and electronic locks are connected to the emergency power supply.

Protect power outlets in bedrooms from consumer abuse by using residual current devices that will trip should a consumer attempt to insert a metal object. Treatment rooms should be body protected.

FIRE SAFETY

Fire requirements are covered by relevant building codes and standards.

Smoke and thermal detectors should be tamper-proof or be located so as to be inaccessible to consumers. Fire mimic panels should be installed in staff stations.

Ensure that all fire exit doors are lockable to control consumer movement. Fire hose reels should be located in recessed cabinets with lockable doors. Locking of fire services will require consultation with local fire services and involve staff managing an evacuation situation.

All fabrics, soft furnishings and items such as mattresses should have a low flame index.

INFORMATION TECHNOLOGY AND COMMUNICATIONS

Systems may include:

- wireless technology;
- radiofrequency identification (RFID) for access control, locks etc.;
- duress alarm systems - fixed and personal as required;
- CCTV;
- voice / data (telephone and computers);
- videoconferencing capacity / telemedicine;
- electronic medical records;
- clinical point of care;;
- picture archiving communication system (PACS);
- patient administration systems (PAS);

- paging and personal telephones replacing some aspects of call systems;
- patient multimedia devices including bedside monitors that function as televisions, computer screens for internet access, etc.;
- bar coding for supplies and X-rays / records;
- patient information screen integrated with menu ordering, nurse call and other modalities;
- server and communications rooms;
- e-learning and simulation; and
- e-medication management and e storage systems e.g. automated dispensing systems.

STAFF AND EMERGENCY CALL SYSTEM

Installation of a patient call system in bedrooms and en suites may not be necessary. Most consumers in the Unit are ambulant and capable of asking for assistance. Children and young people in particular may be tempted to abuse the call system.

If a system is installed, it should be compatible with systems throughout the facility and capable of staff override. Call systems should be designed and installed to comply with AS 3811 - Hard wired Patient Alarm Systems (Standards Australia 1998).

Staff assistance and psychiatric emergencies can be handled via personal duress alarms. Medical emergencies will need access to the hospital's cardiac arrest system.

HYDRAULIC SERVICES

Warm water systems will be required.

MEDICAL GASES

Oxygen, suction and medical air are not required in bedrooms. Provision should be made for bottled oxygen and suction as required in the Unit.

04 COMPONENTS OF THE UNIT

04.01 Standard Components

Rooms / spaces are defined as:

- *standard components* (SC) which refer to rooms / spaces for which room data sheets, room layout sheets (drawings) and textual description have been developed;
- *standard components – derived rooms* are rooms, based on a SC but they vary in size. In these instances, the standard component will form the broad room 'brief' and room size and contents will be scaled to meet the service requirement;
- *non-standard components* which are unique rooms that are usually service-specific and not common.

The standard component types are listed in the attached Schedule of Accommodation.

The current Standard Components can be found at: www.healthfacilityguidelines.com.au/standard-components

04.02 Non-Standard Components

Non-standard components are unit-specific and are described below

- interview room - family /large;
- bathroom - domestic;
- store - drugs / 'clean' utility;
- consultation room - large;
- recreation / day area;
- dining room;
- pantry / kitchen;
- lounge - consumer / patient / 'quiet room';
- media room;
- play therapy room;
- indoor exercise facility;
- lounge / dining / activity (HDU); and
- courtyards (various).

INTERVIEW - FAMILY / LARGE

Description and Function

This room is used to interview and assess consumers and their carers. The size of the room has been enlarged for the purposes of this HPU to reflect the potential for a group of people to be involved in the consultation, rather than a single clinician and consumer.

Location and Relationships

The interview room may be located in the reception area or with other consultation / therapy rooms.

Considerations

The room should be furnished for comfort in a domestic style, using lounge chairs. Furniture should be sufficiently heavy that it cannot be used as a weapon. It will have two points of egress.

BATHROOM - DOMESTIC

Description and Function

A common domestic style bathroom may be advantageous for small children who require assistance with bathing. It should contain a standard bath, a raised shower bath to avoid unnecessary bending by carers / staff, a full sized toilet, a small toilet for children, and nappy change facilities.

Location and Relationships

The bathroom should be located in the acute zone. It may be located near recreation and dining areas so that the toilet and hand washing can be used by consumers and carers using these areas.

Considerations

Supervision is recommended when young children are using the bathroom. If children under five years of age are in the Unit, it may be appropriate to lock the bathroom door to prevent unsupervised access.

STORE - MEDICATION ROOM / CLEAN UTILITY

Description and Function

This is a room in which medications, a medication trolley, medical equipment and sterile stock, if desired, can be securely stored. Medications may be dispensed directly from the room, in which case provide a dispensing hatch. Refer to the Standard Component Room Data Sheet for a Clean Utility, which performs a similar role, but is larger than that proposed for this Unit.

Location and Relationships

Consumers are not permitted to enter this room - however it is located in the consumer zone so that it is accessible for dispensing. It should also be convenient to the HDU. Direct internal access from the staff station or treatment room may be considered, however traffic / circulation routes should be carefully considered to avoid congestion.

Considerations

The room should be sized to allow sufficient space for storage of trolleys and other medical equipment. It may be preferable for operational reasons for the Unit’s sterile stock to be stored in the treatment room.

Schedule drugs should be stored in accordance with the relevant legislation. Other medications may be stored on open shelving (sloping pharmacy style preferred).

CONSULTATION ROOM - LARGE

Description and Function

This room is for the consultation and examination of consumers, with or without a support person present. In this Unit it is common for more than two people to participate in consultations, so 2m2 more than a regular consultation room has been allowed.

Location and Relationships

As per a standard consultation room, it may be located in the consumer therapy / treatment zone, or, if attached to a day hospital, in a shared therapy area.

Considerations

A second egress point is required.

RECREATION / DAY AREA

Description and Function

This is an indoor area in which a wide range of activities can occur including: watching television, indoor games, use of computer and group activities.

Location and Relationships

The area requires ready access to a secure outdoor area and should be able to be supervised from the staff station. Proximity to the dining area is desirable.

Considerations

As this is the main living space for consumers and their carers, every effort should be made to create a domestic environment. The layout should ensure whole group activities are possible, however, provision of a sub-lounge or sectioning some of the space through furniture placement assists in creating a more intimate atmosphere. Furniture should be suitable for children, young people and their carers / visitors.

Lockable storage for activities should be incorporated in this area. Lockers for consumer possessions and school work may also be placed in this room.

Provide a consumer telephone in the vicinity, located so as to avoid disturbance to other consumers and vice versa.

DINING ROOM

Description and Function

This is an area for consumers, carers and visitors to eat meals and snacks.

Location and Relationships

Directly adjacent to the pantry / kitchen, preferably with a serving counter between the two areas that can be secured. Views over a garden / outdoor area are desirable.

Considerations

A hand washing bay should be included. Square or rectangular furniture is preferred, as is allows flexibility in table arrangement. Selection of furniture should give consideration to ease with which it can be moved if different configurations are required.

PANTRY / KITCHEN

Description and Function

A room / space for the receipt and serving of meals. It will also be used by older capable consumers, and carers of children, to prepare their own simple meals e.g. breakfast (cereal and toast etc) and sandwiches etc, according to local operational policies. As such it will have a pantry and refrigerator stocked with a range of groceries.

Design will depend on the method of service delivery i.e. plated or bulk meals, and the management of used crockery and utensils.

Location and Relationships

The pantry / kitchen should be adjacent to dining spaces in the acute zone. If design and layout permit, there may be hatch access to the high dependency lounge / dining / activity areas for the transfer of plated meals. Counter access, with a grille, is an option for the acute zone main dining area.

Considerations

The kitchen should be a safe, secure environment for staff and consumers in compliance with occupational health and safety, and infection control guidelines. There should be: ample bench top area; open shelving; lockable cupboards; secure storage for food and equipment; space to store food trays; and distribution trolleys. A dedicated power outlet for heating / cooling good trolleys may be required.

Consumer access to power supply controls and hot water systems should be restricted by placing these in keyed compartments.

MEDIA ROOM

Description and Function

This is an area in which consumers can use the internet, listen to music and watch television, without disturbing other consumers and/or carers in the unit.

Location and Relationships

It may be appropriate for this area to be a sub-lounge of the recreation / day area to promote supervision of internet based activities.

Considerations

Sufficient desk space should be provided for a computer and a printer, to be used under supervision. A small sound system, television and a lounge to sit on should also be included.

PLAY THERAPY ROOM (CHILD UNIT ONLY)

Description and Function

A play therapy room may be provided for individual ‘regressive’ therapy sessions, using activities such as artwork, doll play and clay modelling. The room should be designed with children aged eight to twelve years in mind.

Location and Relationships

This room should be located within the consumer treatment / therapy zone.

Considerations

Furniture will be suitable for children up to twelve years of age. Storage for materials and a stainless steel sink are required.

INDOOR EXERCISE FACILITY

Description and Function

This space is included as an option for a unit accommodating young people. Regular physical exercise is acknowledged as an important strategy in managing mental illness and weight gain associated with some treatment medications.

Location and Relationships

This room should be located in a space clearly observable from recreational and therapy areas. Transparent barriers and 'passing traffic' will enhance supervision. The room should overlook, and preferably open onto, accessible outdoor space.

Considerations

Careful consideration should be given to the type of equipment installed, given the consumer profile and the therapy goals. All equipment should be secured to the floor or walls. Supervision and appropriate training should be considered as part of the operational policies. The room would be locked when supervision is not available.

SECURE ENTRY ZONE

Description and Function

In circumstances where consumers are brought directly to the unit by police or ambulance, secure entry facilities should comprise:

- fully enclosed parking zone for police and ambulance vehicles that can be secured by a lockable roller door. This reduces the risk of a consumer escaping when the van doors are opened;
- an entry lobby capable of accepting an ambulance trolley and at least two emergency personnel with ease;
- consideration of electronic doors;
- separate area for police to disarm and for gun storage;

- examination / assessment room with optional en suite shower and toilet; and
- a small work space for use by escorting officers to complete required paperwork.

Location and Relationships

The Entrance should be capable of direct approach by ambulance/ police vehicles and should provide weather protection for consumer transfer.

There should be easy access to the examination / assessment room and to the seclusion room.

Considerations

A video and intercom system between the secure entry and the staff station should be provided.

This area should have adequate soundproofing so that noisy incidents do not disrupt the usual operations of the remainder of the unit.

LOUNGE / DINING / ACTIVITY (HIGH DEPENDENCY UNIT)

Description and Function

A shared area for high dependency unit (HDU) consumers to dine, watch television or participate in other activities.

Location and Relationships

It should be immediately adjacent to HDU bedrooms and with direct supervision from the staff station. Direct access to an outdoor courtyard is preferable.

Considerations

Furnished to maximise comfort, being mindful that consumers in the HDU have a higher level of acuity and are therefore more ‘at risk’.

COURTYARDS - VARIOUS

Description and Function

These are secure outdoor areas for programmed activities, play or relaxation. Functional requirements include: passive areas, such as seating in landscaped gardens; active areas that encourage games and exercise; and some weather protection and sun shade.

Location and Relationships

Outdoor areas are accessible from the recreation / day area and visible from the staff station. Garden views from other parts of the Unit should also be maximised.

Considerations

The courtyard perimeter should be screened: if screening is achieved by planting trees or shrubbery, these should subsequently not compromise security.

AX APPENDICES

AX.01 Schedule of Accommodation

A schedule of accommodation is shown below. The following schedule of accommodation assumes a twelve (12) bed unit. Quantities and sizes of spaces will need to be determined in response to the service needs of each unit on a case by case basis.

The 'Room/ Space' column describes each room or space within the Unit. Some rooms are identified as 'Standard Components' (SC) or as having a corresponding room which can be derived from a SC. These rooms are described as 'Standard Components –Derived' (SC-D). The 'SD/SD-C' column identifies these rooms and relevant room codes and names are provided. All other rooms are non-standard and will need to be briefed using relevant functional and operational information provided in this HPU.

In some cases, Room/ Spaces are described as 'Optional' or 'o'. Inclusion of this Room/ Space will be dependent on a range of factors such as operational policies or clinical services planning.

ENTRY / RECEPTION

AusHFG Room Code	Room / Space	SC / SC-D	Qty	m2	Remarks
AIRLE-10	Airlock - Entry, 10m2	Y	1	10	
PLAP-10	Play Area - Paediatric, 10m2	Y	1	10	Optional
RECL	Reception / Clerical, 10m2	Y	1	10	
WAIT-10	Waiting, 10m2	Y	1	10	
WCAC	Toilet - Accessible, 6m2	Y	1	6	Includes baby change facilities
	Gun Safe Alcove		1	2	Concealed from public view and secure area
INTF	Interview Room	Y	1	14	Up to six (6) participants. One in reception, second in patient zone. Access to outdoor are beneficial.
	Discounted Circulation %			32%	

CONSUMER - FAMILY AREAS

AusHFG Room Code	Room / Space	SC / SC-D	Qty	m2	Remarks
1 BR-MH	1 Bed Room - Mental Health, 14m2	Y	4	14	
	1 Bed Room - Special, 18m2		2	18	To accommodate rooming in, physically disabled and bariatric patients.
2 BR-MH	2 Bed Room - Mental Health, 28m2	Y	1	28	Optional. Not recommended for adolescent units.
	Bathroom - Domestic		1	10	
ADLL	Laundry - ADL	Y	1	8	Optional
BBEV-OP	Bay - Beverage, Open Plan, 4m2	Y	1	4	Lockable. Located close to meeting rooms, carer loounge, as alternative to dining and staff rooms.
BHWS-B	Bay - Handwashing, Type B	Y	2	1	1 per 4 beds
	Courtyard - Acute		1	60	A minimum recommended size. Additional space should be provided for units that exceed ten (10) consumers.
ENS-MH	Ensuite - Mental Health, 5m2	Y	4	5	Maybe bedroom access, corridor access, or combination. Reduce en suites to obe per two consumers for corridor access.
	Ensuite - Special, 6m2		2	6	To accommodate rooming in, physically disabled and bariatric patients.
	Ensuite - Shared, 6m2		1	6	Optional. Not recommended for adolescent units.
LNPA-12	Lounge - Parent	Y	1	12	
TRMT	Treatment Room	Y	1	14	Includes spatial allowance for resuscitation trolley (1m2) and exam couch (3m2)
MEET-L-30	Meeting Room, 30m2	Y	1	30	Patient education, group therapy, computer terminals.
MEET-L-30	Meeting Room, 30m2	Y	1	30	Formal hearings, staff meetings, in-service, family conferences, group/ family therapy.
OVBR	Overnight Stay - Bedroom	Y	1	14	On ward accommodation. Optional.
OVES	Overnight Stay - Ensuite	Y	1	5	On ward accommodation. Optional.
STPP	Store - Patient Property	Y	1	8	
CLUR-12	Clean Utility / Medication Room, 12m2	Y	1	10	
INTF	Interview Room	Y	1	14	
	Observation Room		1	6	One way observation window. Adjoins interview room. Optional.
	Recreation / Day Area		1	56	TV, lounges, telephone bay, lockers for personal items/ school work etc.
	Play Therapy Room		1	12	Applicable in a Child Unit only
DINBEV-25	Dining Room / Beverage Bay (Mental Health)	Y	1	25	Assumes 8 consumers plus 4 family members. Includes refreshments bar.
	Pantry / Kitchen		1	14	Collocate with dining room. Parent and consumer access as appropriate.
MEET-L-20	Meeting Room, 20m2	Y	1	20	Activity room, includes sink for wet activities and storage.
LNPT-10	Lounge - Patient, 10m2	Y	1	10	May be located with seclusion room as part of low stimulus area.
	Media Room		1	14	TV, music, internet room
WCPT	Toilet - Patient, 3m2	Y	2	3	Carers, consumers and visitors.
	Indoor Exercise Room		1	20	Optional
	Discounted Circulation %			32%	

HIGH DEPENDENCY UNIT X 4 BEDS

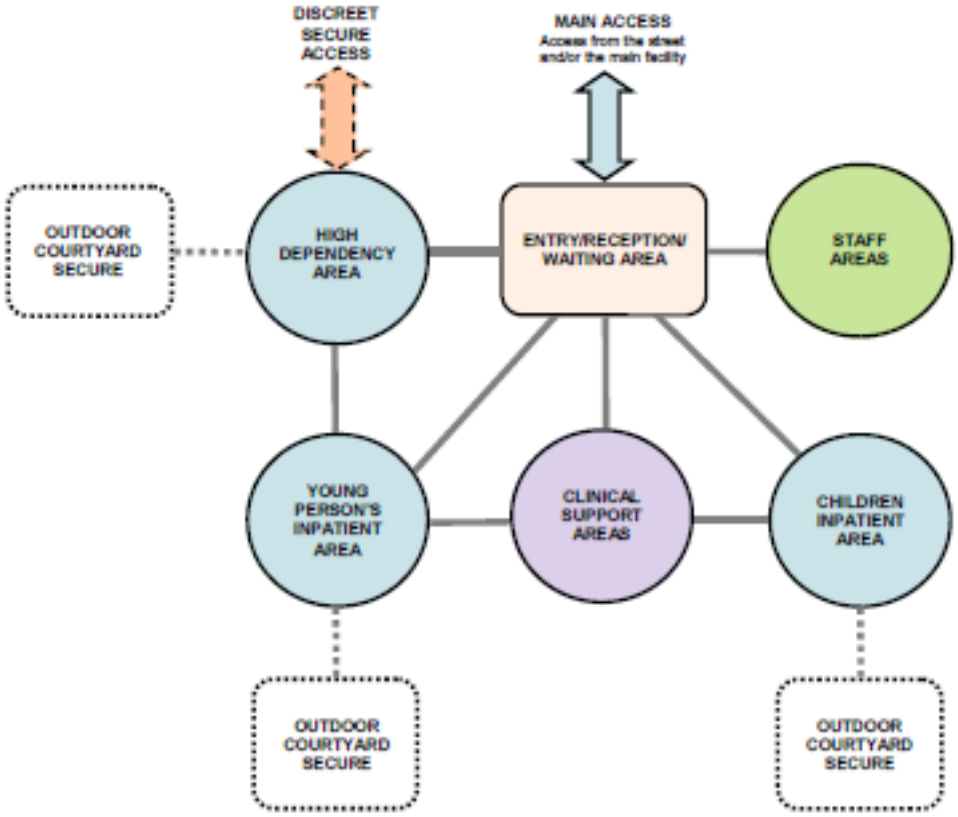
AusHFG Room Code	Room / Space	SC / SC-D	Qty	m2	Remarks
1 BR-MH	1 Bed Room - Mental Health, 14m2	Y	4	14	
BHWS-B	Bay - Handwashing, Type B	Y	1	1	
	Courtyard - HDU		1	40	10m2 per consumer
ENS-MH	Ensuite - Mental Health, 5m2	Y	1	5	Optional - adjoining Interview Room (Exam Assessment)
ENS-MH	Ensuite - Mental Health, 5m2	Y	2	5	Ensuite shared between two consumers with corridor access. Alternatively, provide: toilet - 2 x patient; shower - 2 x patient.
INTF	Interview Room	Y	1	12	
SECL	Seclusion Room	Y	1	15	Optional. Maybe located with Lounge - Patient (Quiet Room) as part of low stimulus area.
SSTN-14	Staff Station, 14m2	Y	1	14	Optional - depending on whether planning allows a shared Staff Station with acute zone.
STGN-9	Store - General, 9m2	Y	1	9	
WAIT-SEC	Waiting - Secure, 6m2	Y	1	6	
	Police/ Ambulance Enclosed Transfer Area		1	20	Area requires secure access and egress
	Secure Entry Lobby		1	10	
	Toilet - Patient		1	4	Carers,To service Seclusion Room
	Lounge/ Dining/ Activities		1	30	7.5m2 per person
	Discounted Circulation %			32%	

CLINICAL SUPPORT AREAS

AusHFG Room Code	Room / Space	SC / SC-D	Qty	m2	Remarks
BLIN	Bay - Linen	Y	1	2	Enclosed and lockable
CLRM-5	Cleaner's Room, 5m2	Y	1	5	
DTUR-10	Dirty Utility, 10m2	Y	1	10	Includes disposal, dirty linen storage
OFF-2P	Office - 2 Person Shared, 12m2	Y	1	12	Worstations for registrars.
OFF-2P	Office - 2 Person Shared, 12m2	Y	1	12	Clinical Nurse Consultant, Educator, Psychologist. Actual number depends on staff establishment.
OFF-3P	Office - 3 Person Shared, 15m2	Y	1	15	Consultants/ Registrars. Actual number depends on staff establishment
OFF-CLW	Office - Clinical Workroom	Y	1	15	In main unit
OFF-S12	Office - Single Person, 12m2	Y	1	12	Clinical Director
OFF-S9	Office - Single Person, 9m2	Y	1	9	Nurse manager. In main unit.
	Office - Workstation, 4.4m2		4	4.4	Clerical, Education, Nursing & Allied Health. 4.5m2 per person. Actual number depends on staff establishment. Office accommodation reference should be made to the relevant jurisdictional operational policies.
PROP-2	Property Bay - Staff	Y	1	2	
SHST	Shower - Staff, 3m2	Y	1	3	
SRM-18	Staff Room, 18m2	Y	1	18	With beverage bay
SSTN-10	Staff Station	Y	1	10	In main unit
STEQ-14	Store - Equipment, 14m2	Y	1	14	Occupational therapy storage
STGN-9	Store - General, 9m2	Y	2	9	Educational resources; sports/ recreation equipment; general storage
STPS-8	Store - Photocopy / Stationery, 8m2	Y	1	8	
WCST	Toilet - Staff, 3m2	Y	2	3	
	Courtyard - Staff		1	15	
	Discounted Circulation %			32%	

AX.02 Functional Relationships / Diagrams

Figure 1: Functional Relationship Diagram in Child and Adolescent Mental Health Unit



AX.03 Checklists

For planning checklists, refer to Parts A, B, C and D of the Guidelines.

AX.04 References

GENERAL POLICIES

- Policies that occur in most HPUs are presented in a separate document.
- The references below are specific to child and adolescent mental health and related services.
- United Nations 1990, Convention on the Rights of the Child.
- United Nations High Commissioner for Human Rights 1991, Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, United Nation.

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- ACT Mental Health (Treatment and Care) Act 1994
- New Zealand Public Health and Disability Act 2000

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- NSW Mental Health Act 2007
- Queensland Mental Health Act 2000
- South Australian Mental Health Act 2009
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- Victorian Mental Health Act 1986
- West Australian Mental Health Act 1996
- Jurisdiction specific Child Protection Acts
- Jurisdiction specific Education Acts

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- NSW Health 2007, PD 2007_059: Aboriginal Mental Health and Well Being Policy 2006-2010, NSW Health.
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