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Australasian Health Facility Guidelines

Part B - Health Facility Briefing and Planning

0134 - Adult Acute Mental Health Inpatient Unit

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Australasian Health Facility Guidelines

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01 INTRODUCTION

01.01 Preamble

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.

01.02 Introduction

GENERAL

This HPU outlines the specific requirements for the planning and design of an Adult Acute Mental Health Inpatient Unit (the Unit).

The document should be read in conjunction with the Australasian Health Facility Guideline (AusHFG) generic requirements and standard components described in:

- Part A: Introduction and Instructions for Use;
- Part B: Section 80 - General Requirements & Section 90 - Standard Components;
- 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 being developed and will be available in Part B:

- HPU 132 Child & Adolescent Mental Health Unit;
- HPU 250 Ambulatory (Community/Outpatient) Mental Health Unit;
- HPU 133 Psychiatric Emergency Care Centres (PECC); and
- HPU 135 Older Persons Acute Mental Health Inpatient Unit (MHOPU).

HPUs being developed will address Adult Non Acute Mental Health Unit and Mental Health Intensive Care Unit (MHICU).

TERMINOLOGY

The following terminology conventions are specific to this HPU:

- terminology may vary from jurisdiction to jurisdiction. For example, depending on the jurisdiction, ‘general’ beds may be known as ‘open’ or ‘general acute’ beds and ‘observation / high dependency’ beds may be known as ‘secure’ or ‘acute’ beds. For consistency and clarity, this HPU uses the terms ‘general / open’ and ‘high dependency’ when referring to the different beds and zones;
- Psychiatric Emergency Care Centre (PECC) is a NSW Health term for units developed adjacent to Emergency Departments (ED) for the assessment of patients presenting to, or being brought into, ED with ‘mental health illness/disorders requiring acute intervention’. Similar units are being developed in other jurisdictions and may have different names but PECC has been used in this HPU;

- with regard to the person or persons undertaking review of patients admitted under the relevant Mental Health Act and Regulations, terms for these hearings and those conducting them vary from jurisdiction to jurisdiction, for example, ‘magistrate session’ (NSW), tribunal, board of review. In this HPU the term ‘formal hearing’ has been used;
- in the mental health context, the 'consumer' is the patient and this terminology will be used in this HPU; and
- 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 the consumer and, in the mental health setting, is a recognised member of the multidisciplinary team. For further information see Carers Australia website at www.carersaustralia.com.au

THERAPEUTIC ENVIRONMENT

This HPU reflects advances in the understanding of optimal environments for care, advances in assessment, treatment, rehabilitation / recovery and changing practices in the delivery of mental health services.

Consumers may be agitated, aggressive and potentially a risk to themselves or others. Consequently, 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 and staff safety supporting enhanced client outcomes;
- better staff conditions and satisfaction; and
- reduced recurrent costs.

CONSUMER RIGHTS

Consumer rights include:

- the right to receive care in an environment with the least possible restriction;
- the right to privacy and dignity and appropriate control over their environment, i.e. the ability to lock bedroom doors as well as access to quiet spaces;
- the right to complain and to expect a response to their complaint;
- access to external influences such as email, internet and newspapers; and
- access to local community facilities such as shops, banks and other local amenities as deemed appropriate.

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

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

01.03 Policy Framework

Mental health services in all jurisdictions are underpinned by individual Mental Health Act and Regulations/ Amendments and by the National Mental Health Strategy.

The National Mental Health Strategy is a commitment by the Commonwealth, State and Territory governments to improve the lives of people with a mental illness. It aims to:

- promote the mental health of the Australian community;
- where possible, prevent the development of mental disorders;
- reduce the impact of mental disorders on individuals, families and the community; and
- assure the rights of people with mental illness.

The strategy has been reaffirmed by the Health Ministers a number of times since 1992. In 1998, the Second Mental Health Plan was developed and, in 2003, the National Mental Health Plan 2003-2008 was endorsed. In 2008 the National Mental Health Policy (1992) was revised and a fourth National Mental Health Plan was launched in November 2009.

For more information, refer to:

- Australian Government, 2005, Disability Discrimination Act 1992;
- Australian Government, 2009, Fourth National Mental Health Plan - An agenda for collaborative government action in mental health 2009–2014;
- Australian Government, 2009, National mental health policy 2008; and
- UN, 1991, Principles for the protection of persons with mental illness and the improvement of mental health care.

01.04 Description

DESCRIPTION OF HEALTH PLANNING UNIT (HPU)

This HPU describes the specific requirements for the planning and design of an Acute Adult Mental Health Unit comprising a zone of general / open beds and a zone of high dependency beds. The high dependency zone should be a separate area from the open zone, with the potential to be locked but able also to be used as part of the open zone at other times, depending on clinical need. Each zone requires its own recreation / activity area as well as outdoor areas with weather protection.

The function of the Unit is to provide, in a safe and therapeutic environment, appropriate facilities for the reception, assessment, admission, diagnosis, observation, treatment and recovery of often acutely unwell consumers, presenting with known or suspected psychiatric conditions and behavioural disorders. Consumers may be admitted on a voluntary or involuntary basis. The open zone may have a mix of voluntary and involuntary consumers.

Facilities and amenities are required to meet the needs of carers, families, staff, official visitors and consumer consultants.

Where required or mandatory, Units will comply with all necessary requirements of legislation, policies and accreditation standards with regard to design, equipment, safety and security.

BUILDING STRATEGIES

Architects, designers, engineers and builders should 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 paid to walls, doors, ceilings and glazing, both in terms of acoustic management and the potential for damage by consumers and for consumers to self-harm.

UNIT DESIGN

Mental health facility design requires a conscious balancing of the requirement to provide an effective therapeutic environment for acutely mentally ill consumers with the need to provide consumers, carers, visitors and staff with a pleasant, spacious, light-filled, comfortable and non-threatening facility.

Priorities for a mental health unit 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 - without looking like a prison;
- privacy and safety (including sexual safety) - patients should be able to lock their bedroom doors without preventing staff entry as required;
- comfort and visual satisfaction (domestic furnishings, decor, artworks);
- personal 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 patient and staff safety e.g. no unsupervised blind corners, recessed areas and alcoves;
- space: the need for space cannot be overemphasised as a means of reducing the potential for aggressive behaviour, by way of wide corridors and recreation areas large enough to avoid crowding;
- fixtures and fittings that minimise the opportunity for consumer self-harm or injury to others, with special attention to bathrooms, bedrooms, courtyards, seclusion rooms and formal hearing (magistrates) rooms. Consideration should be given to the type and amount of furniture used;
- acoustic management, particularly of bedrooms;
- access to facilities for carers. These may include overnight bedrooms, toilets and showers and a private lounge, plus a room where a patient may meet with their family in private (NSW does not support this in terms of a specific building of physical space for carers);
- safe and supervised access for visiting family members, including children of parents with a mental illness;
- 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 the mix of staff;
- changes in technology;
- maximising efficiencies in recurrent and/or operating costs; and
- interplay between inpatient and ambulatory care services.

BED NUMBERS

The number of beds will vary according to the service needs identified in the service plan, the model of care and the role of the Unit within the context of other mental health services in the region. A range between 18 and 35 beds is commonly found.

While there will be surge occupancy, there should be sufficient beds to maintain a safe environment and avoid pressure for premature discharge in accordance with local planning guidelines and procedures.

The schedule of accommodation has been developed for a 20 and 30 bed unit.

The proportion of general / open to high dependency beds will vary from project to project. Twenty percent has been used as the basis for this HPU as a starting point only.

BED CONFIGURATION

The configuration of beds should facilitate safety and security, staff observation, allow for changing levels of consumer acuity and models of care (step up/step down), and for a mix of voluntary and involuntary consumers.

Bedrooms should be grouped into clusters or pods for distinct consumer groups e.g. based on gender (for sexual safety), age and/or diagnosis. However, such a configuration should not reduce flexibility of usage nor compromise the ability of staff to supervise consumers.

It may also be useful to locate a small cluster of bedrooms close to, and easily observed from, the Staff Station for consumers who may have special needs or vulnerabilities including, but not limited to; female, indigenous, adolescent, elderly, intellectually and physically disabled consumers, or those consumers recovering from treatment requiring closer nursing observation. Such a cluster should have its own recreation areas, lounge and courtyard.

In addition:

- at least one bedroom should be designed to AS1428 for independent wheelchair users; and
- at least one bedroom should be large enough to cater for bariatric consumers or for the accommodation of a mother and baby.

For more information see the Schedule of Accommodation and Standards Australia, 2010, AS/NZS 1428:2010 Design for Access and Mobility (Set).

ADDITIONAL SPACE REQUIREMENTS

If the proposed unit is to differ from the bed numbers in the Schedule of Accommodation, the guidelines in Table 1 below should be used to allocate space for key areas. These were estimated using benchmarks from past capital planning projects, current standards and guidelines and advice provided by NSW Health regarding the special requirements of persons with a mental illness.
Provision of these spaces should be determined in accordance with local admission guidelines and processes and related models of care and should be amended as appropriate.

Table 1: Space Requirements

Area	Space requirement
Lounge/dining/activity areas - general/open	7.5m2 per person
Lounge/dining/activity areas – high dependency	10m2 per person
Outdoor areas – general/ open	7.5m2 per person
Outdoor areas – general/ open	10m2 per person
Terrace – minimum area	20m2
Consultation rooms (inpatient use only)	1 per 5 beds
Examination/ assessment rooms	Minimum 1 per unit

SHARED FACILITIES

In the planning of the Unit, every attempt should be made to avoid duplication of support areas such as staff amenities and public spaces. However, each zone of the Unit should have its own recreational and outdoor areas.

Where facilities are shared the following considerations need to be taken into account in determining size and number of facilities:

- number of staff occupying or needing access to the room/space (particularly relating to staff stations);
- operational procedures, including the number of clinicians and planned scheduling of clinic sessions. For example, one shared interview room will not be sufficient if two clinicians

simultaneously hold clinics while unplanned admissions also need to be assessed. Access to other space may be required in such a case;

- number and type of consumers; and
- staff and consumer safety requirements.

Depending on the overall size of the Unit, sharing should not compromise the ability of staff to constantly supervise consumers and deliver therapeutic care in either zone. Sharing should never compromise the safety and security of staff and patients. Ensuring staff are not working in isolation is an important consideration.

Treatment and consultation rooms, the designated formal hearings room and meeting rooms may be shared and should have ease of access from, and be in close proximity to, all patient areas.

Encouraging part-time service providers to share common office and treatment spaces also increases utilisation and reduces operating costs.

CONSUMER PROFILE

The service population of consumers for this Unit is assumed to be the 18 to 65 year old group. However, depending on the availability of age-specific facilities in the mental health network (children, adolescents and older people), the age of patients may range from adolescent to frail elderly, particularly in rural and fringe metropolitan areas.

The cultural diversity, background and linguistic needs of consumers require consideration.

Consumers may be classified as involuntary consumers under the relevant Mental Health Act (also refer to Clause 134.004.050).

VOLUNTARY AND INVOLUNTARY CONSUMERS

A voluntary patient is a consumer who elects to remain in a mental health facility for treatment, care or observation, or a person who is admitted by his or her guardian or person responsible under the relevant jurisdiction’s Guardianship Legislation.

Involuntary patients are 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.

02 PLANNING

02.01 Operational Models

HOURS OF OPERATION

The Unit will operate 24 hours per day, seven days per week.

MODELS OF CARE - FACILITY

The Adult Acute Mental Health Unit may be developed as:

- a unit with its own public entry/ reception but integrated with the general hospital. Where required, ensuring the safe transfer of consumers from the ED to the inpatient unit via a weatherproof, secure, and preferably non-public, corridor to avoid the need to transfer consumers via outside areas. Also avoiding extended travel distances between the ED and the Unit;
- a Unit which may have a secure ambulance/police enclosed entry;
- a discrete Unit as part of a mental health complex. It may share the public reception area with other units and may need a secure entry; and
- a discrete unit within a general hospital with its own public entry, where supported by jurisdictional policy. It may also have a secure entry.

MODEL OF CARE - UNIT

Models of care may address:

- bed numbers and mix;
- provision of seclusion room and/or time-out room. This will be determined on a project-by-project basis and will vary from jurisdiction to jurisdiction; and
- the need for a secure entry suite if consumers are not admitted via ED / PECC.

02.02 Operational Policies

GENERAL

Operational policies, guidelines, procedures and protocols have a major impact on the capital and recurrent costs of healthcare facilities. The cost implications of proposed policies should be fully evaluated to ensure the most cost-effective and efficient design solutions are developed.

Operational policies, guidelines, procedures and protocols will vary from unit to unit depending on a wide range of factors but their development is crucial to defining how the unit will operate within the healthcare facility and the health service, as well as in adjoining health services from where consumers may be referred.

The following sections are policies specific to this unit.

CATERING ARRANGEMENTS - MEALS

Consumers' meals may be pre-plated and delivered to the Unit from the main hospital kitchen on individual trays or delivered in bulk and plated in the Unit kitchen. Consumers in the open Unit may be encouraged to prepare their own breakfasts, assist with barbecues and prepare lunch sandwiches.

The selected method of food delivery and preparation will affect the size and layout of the Unit kitchen. It is not expected that consumers in the high dependency zone will participate in food preparation or utilise equipment.

CATERING ARRANGEMENTS - REFRESHMENTS

Consumers and their carers should have access to self-serve beverage bays outside of meal times for cold drinks and snacks, such as fruit and biscuits. A small beverage bay with a cold drinking water tap, plastic cups and a refrigerator may be provided.

The temperature of hot water, if made available, should be at a safe level to prevent scalds The bays should be recessed and lockable.

ELECTROCONVULSIVE THERAPY (ECT)

ECT and recovery should only be undertaken in a Day Procedure Unit, Operating Unit or dedicated and fully equipped ECT suite either within an acute hospital campus or within a mental health complex dependent on jurisdictional requirements. Facilities for ECT are not addressed in this HPU.

Refer to the following guidelines and position statement, which advise on specific facility needs for ECT and the minimum standard of practice:

- Mental Health and Drug and Alcohol Office, NSW Health, 2011, Electroconvulsive Therapy: ECT Minimum Standard of Practice in NSW; and
- The Royal Australian & New Zealand College of Psychiatrists, 2013, Electroconvulsive Therapy (ECT) Position Statement.

EMERGENCIES

Medical emergencies will be managed in accordance with the healthcare facility’s standard guidelines, procedures and protocols. A resuscitation trolley and portable oxygen and suction should be readily available in a secure area not accessible to consumers such as the Staff Station, Medication Room or Treatment Room, which are not accessible to consumers.

Psychiatric emergencies (such as suicide or violent behaviour) will be managed in accordance with Unit's guidelines, procedures or protocols regarding de-escalation, restraint, seclusion and resuscitation.

FIREARM SECURITY - POLICE

Police officers accessing the Unit should be encouraged to disarm at the entry. However, depending on jurisdiction specific firearm acts and regulations, removal of firearms may be a matter for police discretion and unenforceable by the health service.

When planning services it is important that contact be made with the local police station to ascertain requirements. Each station has a senior officer who can provide advice in the design phase on access requirements and the type of firearm security cupboards/safe, etc. that may be required by police attending the Unit.

Police will not disarm in a public place and a discreet area for disarming should be provided e.g. a small room or concealed recessed bay with an approved firearm safe/s. Generally one safe per gun should be provided.

MEDICAL RECORDS

The introduction of an electronic health record will significantly strengthen the ability of clinicians to access all the necessary information for complex assessments and clinical decision-making across the range of treatment settings. It will also significantly reduce the need for file storage. However, if large quantities of hard copy files are stored in the Unit, consideration may need to be given to secure storage and fire protection.

SECLUSION AND RESTRAINT

National Safety Priorities for Mental Health were endorsed by Health Ministers in October 2005. These priorities include:

- reducing suicide and deliberate self harm in Mental Health Services; and
- reducing the use of and, where possible, eliminating restraint and seclusion.

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”. 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. Generally seclusion will only be implemented for involuntary patients after other de-escalation strategies have failed, i.e. removal of patient from the environment causing concern and ‘talking down’ thus avoiding the need for containment with the focus of management being one of de-escalation. Alternative options to accessing a seclusion room may be a comfortable "low stimulus" area/room.

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.

Seclusion rooms have very specific design requirements that are addressed in an appendix at the end of this HPU.

The usage, or even provision, of a seclusion room will vary from jurisdiction to jurisdiction and from project to project. Where provided, a seclusion room has a crucial impact upon planning and design of the Unit.

Refer to individual jurisdiction policies and legislation on seclusion and restraint.

Also see the following for further information on the use of seclusion:

- Mental Health and Drug and Alcohol Office, NSW Health, 2012, Aggression, Seclusion and Restraint in Mental Health Facilities in NSW;
- National Mental Health Working Group, 2005, National safety priorities in mental health: a national plan for reducing harm; and
- NSW Health, 2007, Aboriginal Mental Health and Well Being Policy 2006-2010.

SMOKING

Smoking policy and provision of smoking areas will be reliant on the policy directive of each jurisdiction. In most jurisdictions, healthcare campuses are designated smoke-free areas. However, the issue of smoking by mental health consumers is complex and the effect of passive smoking on staff and other consumers should also be considered. All jurisdictions should have supportive programmes in place for nicotine substitution and smoking cessation.

STAFFING

Unit staff work as a multidisciplinary team and may include, in a permanent and visiting capacity:

- medical staff;
- nursing staff;
- allied health staff;
- administrative and clerical staff;
- security and other emergency response personnel;
- official legal and mental health advocates; and
- housekeeping, maintenance and catering staff.

Carers, case workers and students should also be considered as part of the staff establishment when assessing staff facilities and amenities.

STAFFING LEVELS

Staffing levels and skill mix will vary depending on the size and configuration of the Unit, service profile, case mix and staff availability

This HPU does not advise on staffing levels or skill mix but when planning the Unit, consideration should be given to the most cost effective number of beds and the need to safely manage psychiatric and other emergencies which can require six or more staff.

Unit design should also consider the use of staff areas by visiting staff including community case managers, support workers, students etc.

02.03 Planning Models

LOCATION

As safe access to outdoor areas is essential, the consumer components of mental health units should ideally be at ground level but not if this compromises outdoor space. Providing units at higher building levels requires careful consideration of safety issues. Railings, enclosures and other barriers may be required to restrict access to roof areas and to prevent people jumping or falling.

Units that are part of a general healthcare facility should be located in a way that supports clinical liaison to/ from other units e.g. paediatrics, geriatrics or access to medical imaging services etc. Unit location should allow discreet transfer of patients from the Emergency Unit and facilitate duress response in emergencies. Dependent upon jurisdictional guidelines, procedures the ease of access to the Operating Unit (for ECT) should be considered.

Location of the Unit needs to ensure that the general public and consumers in other parts of the facility cannot see into the building or outdoor areas. This may be an issue where there are adjoining multi-storey buildings; not only of privacy but also promoting feelings of confinement, blocking of sunlight and creating undesirable levels of shade / shadow.

CONFIGURATION / LAYOUT

The plan for the Unit should reflect specific operational polices, guidelines and procedures related to the endorsed unit-specific model of care.

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

Good sight lines from staff areas (e.g. staff station) to consumer areas are important design criteria, to be balanced against staffing levels and operational guidelines, and procedures of the ward.

For security and fire safety reasons, all exits should have at least six metres of clear external space so that people are not encouraged to congregate outside perimeter doors. All corridors and exits are required to comply with the current requirements of The Building Code of Australia.

In developing the layout, consider circulation issues such as emergency access and egress of consumers and/or the police as well as consumer flow to theatres or day the procedures unit (for ECT or medical imaging).

Dead-end corridors and recesses where consumers may be out of view should be avoided.

All corridors with the exception of those in staff-only areas should have a minimum clear width of 1,800mm.

02.04 Functional Areas

GENERAL

Individual spaces combine to form functional zones or clusters with a similar purpose. These include:

- main entry / reception / booked admissions area;
- consulting / counselling rooms;
- meeting and formal hearing rooms;
- bedrooms and patient amenities;
- high dependency zone;
- secure entry;
- activity and recreation areas;
- outdoor areas including terraces;
- clinical and non-clinical support areas; and

- staff offices and amenities.

MAIN ENTRY / RECEPTION / BOOKED ADMISSIONS AREA

The main entry / reception is the public face of the Unit for arrival and reception of all persons entering the Unit. The exception being those emergency admissions who access the Unit via the secure entry either via police/ ambulance, or as a transfer from the emergency unit. If the Unit is part of a mental health complex, the reception / entry may be the access point to a number of inpatient and outpatient facilities.

The area should have a welcoming waiting space and access to public amenities including an accessible toilet and appropriate signage.

The reception should be safe for staff, with direct access to a safe retreat in an adjacent secure area. Personal and fixed duress alarms will be required.

The area should be designed so that no visitor can directly access other parts of the Unit without either reporting to the reception and reception staff, or having some means of communicating with staff inside the Unit if the reception is not manned. Options include intercom and CCTV both outside the main door and at the entry door to the inpatient area.

Reception desk design solutions should enhance security while maintaining a visually welcoming environment. Security screens are one option, these should be designed so as not to impede communication or visibility. Ensure that:

- ambient noise levels on both sides of the screen are taken into account and provision is made for hearing impaired clients, and
- the need for privacy of conversations is balanced with the need for communication.

For alternative solutions, refer to Part C of the Guidelines.

A room for admitting booked patients should be provided either in close proximity to the main public entry or directly from the waiting space, where patients can be received in a more discreet and welcoming environment.

This room may also be used for interviewing visitors and undertaking security checks (for contraband etc.) before allowing access to consumers. Small lockers may be provided so that the belongings of visitors can be safely stored while they are visiting. Depending on circumstances, more than one such room may be required.

CONSULTING / COUNSELLING ROOMS

The number of such rooms and their specific uses will be determined by:

- commitment to involving patients in their own care;
- scheduling and the number of clinicians visiting on the same day; and
- possible use by community mental health if no adjoining ambulatory / community mental health unit exists.

Ad hoc use of offices or consumer bedrooms for consultation purposes may pose a threat to staff safety, and should be prevented by providing an adequate number of spaces available for consultation.

Consultations may be limited to the consumer and the health professional, but at times six to seven people may need to be accommodated e.g. family conferences.

Assuming they are for inpatient use only, the rooms should be located within the envelope of the inpatient zones within reasonable observation of the staff station, but if requiring both consumer and family access, some rooms may be positioned to be accessible from the ward entry.

All rooms should have two exit doors and at least two fixed duress alarms, including one on the path of travel to the second exit door for safety. Furniture arrangement should encourage informal discussion whilst not obstructing staff exit routes, should the need arise. Sound-proofing and robust walls and doors are essential.

MEETING AND FORMAL HEARING ROOMS

Meeting room/s will be required for:

- case conferences where there may be more than a dozen people in attendance, especially if the case is complicated and community staff and other outside agencies are involved;
- group therapy sessions;
- staff meetings, in-service educational sessions for staff, family and other carers;
- formal hearings for review of involuntary patients; and
- after hours use by consumer groups, for education purposes, etc.

The exact use and number of such room/s will vary between units due to the different needs of consumer groups and services provided. Their use should be determined early in the planning process to ensure adequate provision and optimal utilisation of space.

Where used after hours by community groups, consider the location of these rooms including security requirements and design.

For safety reasons two points of access / egress should be provided in all rooms accessed by patients.

Consideration should be given to providing teleconferencing facilities in one room in units that provide telepsychiatry services to other units, or that utilise teleconferencing for education or clinical reviews. Planning for future links to the Law Courts may also require consideration.

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

For specific requirements for the room designated for use for consumer review sessions, refer to Non-Standard Components.

In NSW, a room with video-link facilities will be required for the conduct of Mental Health Inquiries as required by NSW Health, 2010, Transfer of Mental Health Inquiries from Magistrates to the Mental Health Review Tribunal.

SINGLE BEDROOMS

Bedrooms in both the open and high dependency zone will generally be provided as single rooms. This permits gender, age and clinical condition/need in separable accommodation as required; a quiet haven for the consumer and maximum flexibility. However, their use as de facto consulting rooms should be discouraged.

Consumers with mental illnesses need increased personal space. An external outlook coupled with high ceilings adds to the perception of light and space and can be therapeutic.

There should be no blind spots in the rooms, particularly any created behind open doors or by en suite placement.

Acoustic treatments to minimise transference of noise between adjoining bedrooms is of importance.

Consumers in the general/open unit should be able to lock their door with a privacy lock. Staff should be able to override locks with keys if necessary. Refer to individual jurisdiction procedures and guidelines where available.

Bedroom doors should ideally open outwards to prevent consumers attempting to blockade themselves in their bedroom. This is of particular importance in the high dependency bedrooms. However, this has implications for corridor widths. Outward opening doors should be recessed to prevent obstruction of corridors.

Eliminate ligature points such as window latches, door handles, clothes hooks, air conditioning grilles, smoke detectors, fixtures in the ceiling for curtain rails, lights, etc.

Consider low wattage night lights over the bed spaces for night time consumer observation, with switches located in the corridor.

Determine the need for "hi-lo" hospital beds, including electrically operated beds, on a jurisdiction-specific basis. Note that in some circumstances a standard "hi-lo" bed may provide undesirable ligature points.

Whilst consumers may make their own beds on a day-to-day basis, they would not necessarily be expected to change bed linen. The provided beds should be of an adequate height to facilitate bed making by staff with minimal bending.

If not otherwise utilised in all bedroom areas, a standard electric hospital bed should be available in the Unit, albeit in storage or in one of the special bedrooms. All bedroom doors should therefore be wide enough to allow the passage of a hospital bed.

Mattresses should have a high fire resistance rating and should not be innerspring, especially in high dependency areas.

TWO-BED ROOMS

At the discretion of each jurisdiction, a two-bed room may be included in the general / open inpatient zone providing an option for sharing, the accommodation of a mother and child, or to meet cultural needs. Such rooms can however be restrictive e.g. resulting in the disruptive movement of patients to other rooms in order to accommodate new admissions.

Two-bed rooms are generally not recommended and are not suitable in the high dependency zone.

ENSUITE SHOWER / TOILETS

Each bedroom in the general zone should have its own en suite shower and toilet. There are a number of configurations; inboard, outboard and between rooms.

Provision of en suites in the high dependency zone may be decided on a project-by project basis. Individual toilets and showers accessed directly from a corridor may provide better supervision and should be designated ‘male’ and ‘female’.

En suite doors in the open zone should be lockable inside by the consumer but able to be opened by staff in an emergency. They should also be lockable by staff to deny access to consumers as clinically indicated.

All en suite doors should open outwards against a wall. For the outboard option this prevents creation of a barrier behind which a consumer may hide that would increase the risk that self-harm activities may go unobserved. For the inboard option it prevents creation of a barrier and also removes any opportunity for barricading the room using the en suite and main bedroom door entry.

Shower curtains may not be required if shower cubicles have good floor-to-fall drainage to avoid flooding. Narrow shower heads and controlled water flows may also remove the need for shower curtains and tracks whilst also minimising splash contamination of the surrounding area.

Solid surfaces to vanity benches should be resistant to damage by water spray.

If vinyl is used for wall and floor surfaces, weld any joins.

All possible ligature points should be avoided. Considerations for en suites, showers and toilets include:

- recessed area for garbage bins;
- recessed and durable toilet roll holders;
- toilet seats that resist breakage and removal;
- shelves (rather than collapsible hooks) for clothing and towels in a dry area;
- in-fill moulded hand rails (not in accessible toilets); and
- recessed soap and shampoo shelf.

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 and access to live electrical currents, when consumers are considered at extreme risk or not under direct supervision by staff. Also refer to section – Plumbing Fixtures.

BATHROOM

The Building Code of Australia (BCA) requires one bath per floor to be provided in Class 9a buildings - although this may be challenged on a project-specific basis.

Inclusion of a bathroom will depend on the consumer population. However its inclusion in the open zone may be useful for relaxation and diversion and also provides a hygiene option for patients unable to stand comfortably in a shower.

If provided, the bathroom should provide a safe, secure environment for all patients and staff in accordance with OHS guidelines. The room should be lockable so that staff can control access and the design of the bath should be compatible with any existing, or proposed, lifting equipment.

Please refer to ABCB, Building Code of Australia.

SECLUSION ROOM

The usage or even provision of seclusion rooms will vary from jurisdiction to jurisdiction. Where provided, it has a crucial impact upon planning and design of the Unit.

The provision of a seclusion room needs to ensure it provides a safe and secure environment for the patient and meets all OHS guidelines for consumers/patient and staff safety.

DINING ROOM AND KITCHEN

The dining room provides a defined space for consumers to eat at tables, seated as small groups or individually. The use of square tables that may be joined together and used for general activities outside of meal times is preferable to round tables. If meals are plated, tables should be large enough to safely hold four trays.

High ceilings and the use of skylights as well as windows can promote the perception of light and space. Décor should reflect a domestic environment.

There should be direct access to an outdoor area that can be used in all types of weather.

There should be ready access to an accessible toilet that is not an en suite to a bedroom. This may be the toilet in the bathroom if appropriately located.

There should be a direct access from the hospital corridor to the unit kitchen (located in the general / open zone) for delivery of food supplies and meals.

If the Unit kitchen is used by consumers to prepare meals as part of activities of daily living (ADL), ensure that it is appropriately sized and can be locked when not in use.

A small beverage bay may be located in the dining room or separate alcove for general use by consumers outside of mealtimes.

RECREATION AREAS AND LOUNGES

These areas may be used 24 hours a day, catering for a variety of activities and may be categorised as follows:

- quiet lounges for relaxation, time out or to socialise;
- designated lounge/s for special groups based on age, gender and other characteristics as appropriate;
- television / music room with TV, multimedia players etc. in fixed cabinetry; and
- multifunction recreation area used by all consumers in the zone (a secondary use of the dining room).

Recreation areas should open onto an outdoor area and be large enough for the projected population - particularly during wet, cold weather when outdoor areas are unusable. Sufficient space is also vital to avoid crowding that may prevent or minimise violence by consumers who may become disturbed if in too close contact to other people.

Recreation rooms should be clearly observable by staff so that they are able to monitor the flow of passing traffic.

There should be careful selection of comfortable but durable furniture that can be configured for a range of activities and uses and of non-institutional colours to promote a welcoming and safe environment for companionship, the opportunity to be alone, or to be with visitors.

Finishes and soft furnishings should be washable and easily maintained or restored, with a low flame index.

Cupboards should be lockable and extremely durable.

THERAPY AREAS

Space for group occupational therapy that can be shared should be provided. This may be combined with the dining area described above, provided that an additional 0.7m2 per patient is added or a minimum enclosed room area of 21m2 is available. Activities of daily living may also occur in the kitchen and patient laundry.

Depending on length of stay and consumer characteristics, a small gymnasium with exercise equipment may be considered as some medications and lack of physical activity contribute to weight gain and general levels of frustration.

OUTDOOR AREAS INCLUDING TERRACES

Courtyards or terraces, ideally with views, are integral components of a mental health unit and are essential to the consumer's treatment and well-being. As much design effort and attention to detail should be given to these areas as to internal spaces. In this guideline, they are treated as therapeutic areas and are included in the schedules of accommodation.

In designing outdoor areas, address extremes of climate and ensure that indigenous needs for open spaces are met. Such areas should be large enough to allow maximum sun penetration in summer and winter. Covered verandas of at least 2.5m should be part of the overall outdoor area to provide weather protection.

Outdoor areas may be fully enclosed by other buildings that act as perimeter security, or open-ended requiring perimeter walls or fencing. Perimeter fencing is discussed in more detail later in this document.

Whilst views are desirable, also ensure that outdoor areas cannot be overlooked by the general public and other consumers particularly in smaller rural areas where consumers may be recognised.

There should be separate courtyards or terraces for the general / open zone, the high dependency zone and the 'pod' of beds for vulnerable consumers where provided. All outdoor areas need to be secure but a greater level of perimeter security will be required for the high dependency courtyard.

Access will be from the lounge/dining/activity spaces and doors should be visible from the staff station.

A separate and private small outdoor area for staff should also be considered, accessed from the staff lounge.

Access will be required for garden/lawn maintenance without staff having to go through the Unit, and for emergency services access.

The design of outdoor areas should be domestic in nature and should have the following features:

- provide opportunities for activities of daily living to be undertaken in addition to recreational and leisure activities with unobtrusive environmental boundaries and appropriate safety protection;
- provide ready access to a toilet that is not an en suite to a patient bedroom;
- attention should be given to detailing roof overhangs, guttering and drain pipes to minimise means of escape, to eliminate opportunities for self harm as far as possible and access points from which it is possible to jump; and
- night lighting using efficient, long life lamps that are sturdy and do not provide ligature points.

Landscaping is essential for promoting a feeling of space and tranquillity and there are many imaginative solutions available for creating a very special area for consumers and staff within the boundaries of a safe and secure environment.

Consideration needs to be given to grounds maintenance and plantings and lawns need to be in tune with local climate and water restrictions.

Nature and sky should be a priority without exposure to too much sunlight which may adversely affect consumers with medication-related photosensitivity. Overhead shading and seating with protection from heat and glare will ensure that summer will not render courtyards unusable, and in winter will provide protection from winds and rain.

Courtyards should be designed to reduce the consumers' sense of being contained, and provide some form of sensory stimulus. Suggestions include textured ground surfaces, resilient plants, shaded areas and attractive but sturdy fixed seating. It should be noted that plastic furniture becomes brittle over time and can break accidentally or be broken purposefully to cause injury.

Garden equipment should be stored in a small secure shed. Barbecues are beneficial as part of the therapeutic program but should be inbuilt with locked off switch control for piped gas, and weather protection with surrounding that can be easily cleaned. Portable barbecues should not be used on OHS grounds.

HIGH DEPENDENCY ZONE

This zone should be capable of secure separation from the general/open zone and layout, but able to be used as an unlocked facility at other times depending on clinical need. Layout should facilitate controlled movement of staff and consumers between zones.

Bedrooms may open onto a central lounge / dining area that is readily observable by staff. Sound attenuation is important to reduce stimulus.

Depending upon the size of the high dependency zone and its layout the following should be considered:

- secure entry;
- the location of toilets and showers off corridors versus individual en suites;
- the need for a separate staff station;
- ease of access for emergency admissions and assessments;
- careful planning for safe and efficient patient flow; and
- a higher level of attention to building fabric and design of fittings and fixtures.

SECURE EMERGENCY ENTRY

Regardless of whether a healthcare facility provides a mental health assessment unit (e.g. in NSW - Psychiatric Emergency Crisis Centre - PECC) adjacent to the emergency unit, a dedicated and discreet secure entry lobby will be required as a point of access into the high dependency zone of the Unit for safety and consumer privacy. This will also avoid disturbing other consumers or visitors to the hospital. Ambulance and police access may also be required.

Refer to Non-Standard Components for details.

EXAMINATION/ASSESSMENT ROOM

A component of the secure entry zone. This room should be located adjacent to the secure entry and the seclusion room and should have a second egress door and duress alarm point/s. A personal alarm system is also assumed.

Locked cupboards that are keyed alike are required for the storage of clinical equipment, syringes/needles and other possibly hazardous materials. ‘Sharps’ containers need to be securely enclosed for ease of disposal and prevention of their use as weapons or for self-harm.

A hand basin is required.

Doors should be lockable with swipe card or similar restricted access, given the range of possibly hazardous equipment stored within this area.

STAFF STATION / CLINICAL RESOURCE ROOM

It is suggested that these two functions could be combined with an open counter area and quieter enclosed resource area. Functions include:

- workstation for ward clerk;
- staff handovers and case discussions;
- space for computers, telephones;
- space for printer, facsimile, copier - if not provided elsewhere on the Unit;
- docking stations for mobile phones, pagers and personal duress alarm;
- medical records storage of current files. Old files may need a separate storage space;
- procedure manuals and references; and
- locker storage for staff personal belongings (if a separate locker room is not provided).

There should be unobstructed emergency escape routes.

The size of the staff stations in both open and high dependency zones should be based on the number of staff who will occupy the areas and not necessarily the bed numbers. The high dependency zone may need to accommodate almost as many staff as the open zone given the higher staff to patient ratios.

Note that fluorescent lighting is too strong for night duty requirements. Down lighting above work spaces for night duty staff should be considered.

MEDICATION AND TREATMENT ROOMS

These rooms should be planned as two discrete room spaces. Internal, staff-only access between the rooms may be considered, as may direct access from the staff station into the medication room.

There should be no consumer access to the medication room. It should be of sufficient size to enable loading and parking of a medication trolley, if that is the method of medication distribution to consumers. A dispensing counter arrangement may be required if medications are dispensed directly from this room.

Ceiling/roof space of the medication room may need to be secure in accordance with pharmacy regulations. Check with local health authority for state requirements.

The treatment room will require an examination couch and may double as a clean utility room and house the resuscitation trolley and other emergency equipment.

Key lock and/or swipe card with key access to room entry doors is required.

All cupboards are to be lockable. The storage of medication should comply with the requirements of the respective state or territory poisons legislation or medication handling policy for the specific jurisdictions.

STAFF OFFICES

These spaces have been zoned separately in the schedule of accommodation to allow most offices to be located away from patient areas. They may be located on an upper floor that may be secured after hours and at weekends whilst still giving authorised staff the necessary access to amenities, photocopier etc.

The practice of seeing consumers in offices should be discouraged. Sufficient consultation rooms should be provided to ensure that ad hoc consultations do not occur in offices.

The office for the nurse unit manager and the registrars' workroom should be located within the envelope of the patient zones, so they are readily available to support and supervise other staff, and have ready access to clinical information.

The size of the Unit and the staff establishment will determine the number of offices and workspaces. Refer to individual jurisdiction policies re provision and allocation of workstations and offices.

STAFF AMENITIES

Staff amenities comprise staff room, property bay, toilets and shower. The latter is optional depending on proximity to main hospital amenities.

The size of the Unit and the number of staff employed will determine the number and configuration of spaces in this zone.

It should provide a quiet space for staff to withdraw from the patient environment. Access to a courtyard or external space is important for the well-being of staff who work in demanding clinical environments.

The staff room should not double up as a meeting room as this will invariably prevent staff from accessing food and refreshments during their breaks.

Amenities will need to be accessible 24 hours per day, seven days a week and are for the use of all staff – permanent and visiting. Depending on the location of amenities, it may be necessary to provide lockers and toilets within the envelope of inpatient areas for ready access, particularly at night.
Staff-only rooms located in the patient zones should be lockable and accessible via swipe-card or similar. An accessible toilet should be available to staff.

02.05 Functional Relationships

The policy of mainstreaming mental health services requires that mental health units are perceived as an integral and equal part of the health precinct. Unit location should afford easy access to the shared services and facilities that may be used by the consumers, staff, visitors and the general public. These facilities include:

- other units that form part of a mental health precinct;
- emergency department and psychiatric emergency care centre (PECC);
- medical Imaging;
- day surgery unit (DSU) or designated location for ECT;
- security base; and
- site staff and visitor parking.

03 DESIGN

03.01 Accessibility

Points of entry should be kept to a minimum and signposting, screening, circulation pathways, etc. should minimise any ambiguity of entrances with only the main entry having a high profile.

Access will be required for:

- general public and voluntary admissions via the main entry;
- discreet secure entry to the high dependency zone;
- separate staff entry if possible or necessary;
- designated entry for housekeeping, catering, maintenance and security;
- contractors and other staff from the main hospital; and
- designated entry/exit for patients being transferred to the main hospital – whether ambulant, wheelchair or trolley for ECT, imaging etc.

Some of the above entry points may be combined.

03.02 Parking

All-weather drop-off parking is required for consumers.

Discreet secure ambulance and police access and parking at the secure entry will be required and in stand-alone units, general police and ambulance parking should be considered.

Well lit staff parking with swipe card access should be available near the staff entrance, with consideration to maintaining safety particularly for staff working after hours.

Visitor car parking including disabled car spaces is required with good visual links to the main entry. Monitored visitor car park by CCTV and patrols by security to deter crime such as drug exchanges, would be as per specific operational policies and guidelines of the jurisdiction.

Consideration to the erecting of bollards at all entrances to the Unit to prevent ramming for forced entry.

Refer to Part C, Section 790 for further information.

03.03 Disaster Planning

Evacuation plans are required in the event of a fire or other emergency to ensure the safety of staff and consumers. Unit layout needs to identify secure assembly areas should evacuation be required.

Connect essential services such as minimum lighting to allow consumers observation, telephones, duress alarm system the central computer, lighting and electronic locks to the emergency power supply.

Disaster management plans are developed as part of a whole of site disaster management plan as per jurisdictional policies direct.

Refer to local Business Continuity Plans and to Part B Section 80 for further information.

03.04 Infection Control

GENERAL

The following aspects of planning, design and fit-out contribute to effective infection prevention and control and are relevant within the context of the acute adult mental health unit:

- hand hygiene facilities - the selection of hand basins will need to be cognisant of safety aspects;
- provision for the isolation of infectious consumers with infectious conditions;
- linen handling;
- separation of clean and dirty work flows;
- storage;
- waste management; and
- surface finishes.

Refer to Part D Infection Prevention and Control for further information.

HANDBASINS

Handbasins are required in treatment and medication rooms.

Corridor basins may be replaced by alcohol hand wash in dispenser units, dependent on jurisdictional infection prevention and control requirements, with ready access to a hand basin for staff if required.

03.05 Environmental Considerations

ACOUSTICS

Adequate acoustic treatment is essential to reduce stimulus, prevent ‘sound-bouncing’, ensure consumer privacy is maintained and that disruptive incidents do not compromise the operations of the Unit or disturb other consumers.

In terms of room design, ceiling heights, wall and door construction and furnishings need to be addressed. However, do not compromise fire safety through use of acoustic treatments.

Areas requiring special attention are noted in the relevant room data sheets and include consulting rooms. Careful location of toilets relative to surrounding rooms such as offices and consult rooms may help minimise disturbance caused by flushing toilets.

In acoustically-treated rooms, return air grilles should also be acoustically treated to avoid transfer of conversations to adjacent areas. Door grilles to these areas should not be installed.

NATURAL LIGHT

Wherever possible, the use of natural light is to be maximised. Current investigations suggest that increased exposure to natural light improves clinical outcomes and reduces the length of stay, especially for consumers with mental illness.

However, it should be noted that too much sunlight can adversely affect consumers with medication-related photosensitivity and bedroom windows may require shading.

The inclusion of integral Venetian blinds, or blinds to consumers' bedroom windows assists with managing external light and privacy.

INTERIOR DECOR

Decor relates to colour, furnishings, style, textures, ambience, perception and taste. The individual response to decor can often be personal and subjective.

Decor can be used to prevent an institutional atmosphere but cleaning, infection control, fire safety, consumer care and the consumer's and public's perception of a professional, caring environment need to be considered.

Interpretations and research on the use and value of colour in the clinical area differ. Some issues appear obvious, others less so, and many are not backed up by empirical evidence.

Consider the following:

- some colours, particularly the bold primary colours and green should be avoided as many people find them disturbing;
- extremes of colour and pattern, such as geometric designs which may disturb perception, should be avoided. However, strong colours on floors may assist in orienting consumers to their bedrooms and activity areas;
- colours and interior decor should be chosen to reflect the tastes and age of consumers/patients who will use the Unit;
- re-decoration is not a budgetary priority, so care in selection of materials and colour is important in the first instance;
- wall colour should be different to floor colour to define the floor plan. Staff-only doors may be coloured to blend into the surrounding walls;
- lighting should be appropriate to the use of the room/area; and
- inclusion of art on walls for enhanced ambience.

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. It includes occupational ergonomics, which aims to fit the work practices, furniture, fittings and equipment (FF&E) and work environment to the physical and cognitive capabilities of all persons using the building.

As the requirements of occupational health and safety and antidiscrimination legislation will apply. This section needs to be read in conjunction with the section on Safety and Security below, in addition to other OHS related guidelines.

ERGONOMICS

The build and design of the Unit should not expose consumers, staff, visitors and maintenance personnel to risks or injury.

Poorly designed recurring elements such as height, depth and design of workstations and counters, shelving and the layout of critical room's impact on the occupational health and safety of staff as well as the welfare of consumers.

Refer to Part C Section 730 for more details.

ACCESS AND MOBILITY

In line with the Commonwealth Disability Discrimination Act 1992, at least one bedroom and en suite should be provided for independent wheelchair users.

Reception desks should be designed so that at least one place is wheelchair accessible on both sides.

Ramps and turning circles need to address anticipated traffic including movement of large heavy items such as occupied beds and heavy trolleys.

Refer to Part C Section 730 for details.

For more details refer to Australian Government, 2005, Disability Discrimination Act 1992.

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.

Carefully consider the fabric of the building, particularly wall construction, to ensure it is robust enough to withstand abuse and appropriate use of materials such as impact-resistant glass and low maintenance / resilient surfaces.

Minimise opportunities for self harm, e.g. no ligature points and wherever possible/available, provide non-removable fixtures and fittings. Refer to Fixtures and Fittings below.

The ceiling should be higher than normal (3300m) and constructed so as to be escape proof (ceiling material plus escape proof construction over).

Wall construction should be solid with non scratchable, cushioned vinyl finish (steel float cement render rather than plaster finish).

Flooring should be cushioned welded sheet vinyl with continuous vinyl skirting. Vinyl skirting should be made secure at top edge to prevent removal (special detail).

Provide heavy duty windows (observation and external) fitted with non-breakable glass. Any fixing beading should be reinforced and outside the room to prevent it being pushed out or damaged. The window sill inside the room should be splayed.

All construction should be acoustically treated for noise isolation.

All electrical controls (e.g. light switches, lighting level controls), air-conditioning thermostats and controls for blinds should be external and controlled by staff.

As a minimum, provide the room with:

- adequate light / natural light and calming external view where possible;
- comfortable temperature;
- dedicated ventilation and exhaust system with air conditioning vents that cannot be reached or removed (newly admitted consumers / patients may have excessive body odour due to alcohol excess or poor hygiene); and
- no inward jutting edges e.g. windows and door frames should be flush with wall on the inside of the room, no inward jutting wall joins, no internal door handles.

DOORS

Provide solid core doors and door frames that meet all relevant BCA and fire regulation standards. Doors in the high dependency zone and seclusion room require higher levels of performance specification.

High dependency bedroom doors should have a viewing panel. The installation of viewing panels to bedroom doors in the open unit may be determined on a project by project basis.

All bedroom, bathroom and toilet doors should be able to be opened in an emergency without the use of special tools.

Aluminium acoustic door seals should not be used in doors in consumer areas as they can be removed and used as weapons.

Care needs to be taken with the design of inward opening doors. If double-hinged with removable stops to enable outward opening in an emergency, the room acoustics may be compromised.

Doors to high dependency bedrooms and seclusion rooms should be single leaf and outward opening.

Bedroom doors in the open unit may be single or one and a half leaf, the latter able to accommodate the moving in and out of a mental health electric hospital bed. However, it should be ensured that the half leaf is able to be unlocked easily and rapidly in an emergency.

Refer to Part C Section 710.30 - Space Standards and Dimensions.

Ensure that the main seclusion room door opens outwards and is wide enough to admit a consumer with at least two escorts. A second door should be provided as a staff egress if design permits.

Provide single leaf doors (minimum 1,270mm opening) of solid construction with metal reinforcing fixed to the outside of the door. Door frames should be made of metal and be sturdy enough to resist considerable force. There should be at least three door hinges, which should be recessed and pins protected to prevent removal (piano hinges could be considered).

Ensure that door locks are heavy duty, quickly secured, able to withstand a considerable amount of force and resist breakage. Locks should be electronic (key and swipe care) so that they lock automatically on closure as manual key locking increases the risk of injury to staff. Regularly maintain locks to ensure that they are always operational and ensure that the locking mechanism is on the emergency power supply although key access should still be available.

The inclusion of a swipe card reader should be located on the inside of the room to provide a rapid means of escape for staff.

SHUTTERS

If shutters are used to secure servery, kitchenettes and linen bays, they should comply with the following OHS requirements:

- to be within reach of the majority of the population, for example by a 153 cm person. Hooks on poles are not a safe method of pulling down shutters in acute mental health environments;
- they should not be too heavy to lift e.g. wide shutters that need to be lifted from the floor;
- locks on shutters that go to the floor should not be at floor level as stooping to unlock shutters puts the staff in a vulnerable position such as at risk of assault; and
- shutters should be sturdy and impact resistant.

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 for a given thickness than larger panes.

Impact-resistant and shatter-proof Grade A safety glass to comply with AS/NZS 2208 Safety Glazing Materials in Buildings (Standards Australia, 1996) is the recommended choice.

Polycarbonate is not recommended as it suffers from surface scratching and deteriorates, thus reducing vision.

Where provided, opening windows should be designed so that they will not allow consumer escape, with locks under the control of staff. Locks should be flush with the surrounding frames and not provide any ligature points. See Fixtures & Fittings - Safety Principles.

Fly screens should be attached to open able windows and secured so that they cannot be removed by consumers but they should be removable by staff to allow window cleaning.

Double-glazed viewing panels with integral venetian blinds should be provided in bedroom doors in the high dependency zone. Their installation in the general bedrooms may be a decision made on a project-by-project basis by consultation with consumer representatives, as this style of light control reduces the risk of cords and potential as a hanging points. Integral venetian blinds also allow observation without disturbing the patient. Their positioning and construction should ensure that the glazing cannot be broken or removed.

External windows in consumer bedrooms should allow a consumer in bed to see the outside world.

03.07 Safety and Security

RISK MANAGEMENT AND HARM MINIMISATION

By adopting a risk management and harm minimisation approach, many safety and security related hazards can be eliminated or minimised at the planning and design stages, thus reducing the likelihood of adverse incidents occurring.

Consideration of safety and security risks, critical to mental health units, should begin during the planning and design phases, and continue to be addressed and reviewed during the construction, commissioning and post occupancy stages.

Under OHS legislation, it is mandatory that at all stages of the design cycle (particularly when undertaking risk assessments) facility designers consult with relevant qualified and experienced staff and other stakeholders.

Refer to Part C Section 790 and National Mental Health Working Group, 2005, National safety priorities in mental health: a national plan for reducing harm.

GENERAL PRINCIPLES

A safe and secure environment in mental health units is more likely to be achieved when good design is allied with appropriate staffing levels and operational policies.

The Unit should not only be safe but feel safe. Security may be physical or psychological and barriers may be real or symbolic, but all should be unobtrusive. Within this context, the least restrictive environment that still provides a safe environment should be the aim.

The design layout should assist staff to carry out their duties safely and to supervise consumers by allowing or restricting access to areas in a manner which is consistent with consumers' needs/abilities. Staff should be able to view consumer movements and activities as naturally as possible, whenever necessary.

The following aspects need to be considered:

- safety of consumers , staff and visitors;
- consumer and carer legal rights; and
- the status of the hospital or part thereof under the relevant Mental Health Act.

ACCESS CONTROL

As consumers may be a mix of voluntary and involuntary inpatients, the Unit should be designed with controlled entry and exit points so that consumer movements can be supervised. No consumer should be able to leave the Unit unobserved. Security features may include:

- transfer lobby with an airlocks;
- electronic locking;
- intercoms and
- CCTV video surveillance.

All rooms should be lockable, including all corridor cupboard doors and fire hose reel cabinets.

All meeting rooms used by consumers , including counselling and review hearing rooms, require two means of egress and duress alarms . Duress alarms should be fixed, personal or a combination of these.

When the Unit is located within a multi-storey building, ensure that 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 use by consumers.

OBSERVATION AND COMMUNICATIONS

Ensure ease of observation to permit continuous monitoring via:

- vision panels;

- closed circuit cameras (monitored at the staff station) to ensure blind spots are viewable, but only if absolutely necessary;
- parabolic mirror; and
- one-way observation window from adjoining staff station or staff corridor to permit continuous monitoring.

A personal duress alarm system locator should be provided outside the room.

An intercom to staff station is not recommended. It is vital that when a consumer is in seclusion that they have human face to face contact for clear communication and assurance. It is not therapeutic for a consumer to hear voices over an intercom and difficult for a very disturbed consumer trying to communicate through an intercom with staff.

The issue of providing built-in television should be well considered. Most seclusion rooms are very low stimulus environments, i.e. without television.

CLOSED CIRCUIT TELEVISION (CCTV) SURVEILLANCE

The use of patient surveillance via closed circuit TV (CCTV) is a very contentious issue. CCTV may be useful for monitoring areas such as stairways and blind spots, hallways, entrances and outdoor perimeters. It is not to be used as an alternative to direct clinical consumer observation by staff as this may have a deleterious impact on therapeutic rapport and contravene a consumer's right to privacy.

When considering the use of CCTV security, the following factors should be considered:

- health service policies, guidelines and protocols;
- 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 CCTV;
- the fact that monitors may not always be able to be constantly manned;
- the maintenance costs involved; and
- the ability to negate the need for video security with improved functional design.

DURESS ALARM SYSTEM

A system of personal duress alarms with location finders should operate throughout the Unit and in all outdoor areas, so that there is limited need for fixed duress alarm points with a 5m2 radius of position.

The optimum approach is a combination of personal alarms with location finders linked to a real time monitor facility and some fixed alarms particularly in areas where staff work in a relatively fixed position such as reception, to ensure there is a back-up system if one system fails.

Visiting officers and staff such as magistrates and Visiting Medical Officers (VMOs) should be provided with, and trained in, the use of personal duress alarms. An appropriate response mechanism should be in place. There should be sufficient number of personal alarms to ensure all staff and relevant visiting staff can carry one while in the Unit.

Locate the charger for these personal alarms in a staff-only area accessible 24 hours per day.

Location of fixed duress call points is critical to ensure that:

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

Refer to individual jurisdiction safety and security policies.

PERIMETER FENCING AND SECURITY

Fencing design and height should not create a custodial environment nor increase the possibility of falling injuries should an attempt be made by a consumer to abscond.

Design should avoid purchase points (hands and feet) to prevent scaling and incorporate barriers to the exchange of contraband such as illicit drugs, weapons etc. from public areas outside the Unit. Set back landscape features, plantings and outdoor lighting from the perimeter wall or fence to avoid purchase points. Avoid blind spots to facilitate good observation of consumers by staff and vice versa.

There are no precise guidelines recommended for fence height and this may vary from 2.7m to 6m. A height of 4m may be considered appropriate, as this cannot be scaled by two average height consumers by one standing on the other’s shoulders.

The client profile and topography of the area should be taken into account e.g. young and fit or elderly, land sloping away and the degree of security required etc. Fencing for the high dependency courtyard would tend towards the higher end of the range with escape proof detailing at the top.

03.08 Finishes

CEILING FINISHES

Construct ceiling linings from solid sheet i.e. do not use ceiling tiles. In the high dependency zone and seclusion room, ensure that ceilings are resistant to breakout. Pay attention to detailing of ceiling air conditioning outlets, lights and fire detectors.

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

FLOORING

Non-slip flooring is required in wet areas and all flooring should be easily cleaned.

Consider the use of cushioned vinyl in patient corridors, activity rooms and areas where large groups gather.

Carpet is not recommended in patient bedrooms and recreation areas but may be used in staff offices and with discretion in meeting rooms.

WALL FINISHES

Ensure that wall linings are washable, extremely robust and resistant to physical impact. Welding of any vinyl joins is required.

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

03.09 Fixtures, Fittings & Equipment

DEFINITIONS

Within the context of the Guidelines room data sheets (RDS) and room layout sheets (RLS), fixtures and fittings are defined as follows:

- fixtures: fixed items that require service connection (e.g. electrical, hydraulic, and mechanical) and includes hand basins, light fittings, etc. They should not be confused with serviced equipment such as CCTV cameras; and
- fittings: fixed items attached to walls, floors or ceilings that do not require service connections such as curtain tracks, hooks, mirrors, blinds, joinery and pin boards.

Also refer to Part C Section 710 Space Standards and Dimensions, Part F Section 680 – Furniture Fixtures and Equipment and to the RDS and RLS for further detailed information.

The items discussed below refer specifically to fittings and fixtures in mental health units and is to be applied to all types of units from community mental health centres to non acute and acute inpatient settings. They

do not negate the need for close observation of patients deemed at risk, or for the provision of clinical care appropriate to the acuity of the patients.

GENERAL PRINCIPLES

The potential suicide of consumers is of particular concern in mental health units, and hanging is the most common method. Hanging may involve suspending the body from a high ligature point although many deaths also occur through asphyxiation or strangulation without suspension of the body, using a ligature point below head height. Due to the impossibility of observing all consumers at all times, when selecting fixtures and fittings care should be taken to assess their 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 a consumer's weight.

Fixtures and fittings selected for mental health units should also be assessed to ensure that they do not create any additional safety hazards for consumers or staff.

They should be safe, durable, tamperproof and concealed where possible. Ensuring they are flush with the surfaces to which they are attached or are designed in a way that prevents attachment of anything around them e.g. cords or belts. It is critical to ensure that if anything is or can be attached to the fitting or fixture it will break away when a weight of fifteen kilograms is applied.

Fixtures and fittings should be kept to a minimum and be non-breakable. They should also minimize any potential for self harm or use as a weapon:

- no ligature points;
- no accessible electrical wires;
- shatterproof glass windows which cannot be removed or damaged by the consumer; and
- secured ceiling-mounted fittings and fixtures.

The mattress is usually the only piece of furniture in the room. Ensure that it is fire-proof with tear-proof covering and welded seams. The thickness and strength of the mattress when turned on its side should not support a consumer and thus give access to ceiling fittings. Provision of any comfort items such as bedding will be controlled by staff and should be dependent on the condition of the consumer.

ARTWORK, SIGNAGE AND MIRRORS

Artwork, mirrors and signage should be rigidly fixed to walls with concealed, flush, tamper-proof mountings. Artwork based on non-tear able fabric may be considered. Consideration should be given to involving the consumer and their carers in the selection of art works.

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

FURNITURE

Furniture should promote a domestic, home-like atmosphere but loose furniture should be sturdy enough to prevent use as a weapon. Where possible, built-in furniture should be considered.

Design of beds should minimise any risk of use as a low ligature point.

Mattresses should have a high fire resistance rating and should not be inner sprung, especially in areas accommodating highly acute patients.

PLUMBING FIXTURES

All exposed plumbing fixtures should be tamper-proof and resistant to breakage and removal. This should apply to consumer toilets and to all staff and visitor toilets that may be accessible to consumers.

Shower heads should be flush with the wall and be downward facing.

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. This may result in consequent flooding and undesirable access to live electrical currents when clients considered at extreme risk are not under direct supervision by staff.

Taps should not be able to be used as ligature points.

Services such as sink and basin wastes which may be easily damaged or used as ligature points should be concealed.

Toilet cisterns should be enclosed behind the wall.

RAILS, HOOKS AND HANDLES

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 collapsible hooks, should be considered to avoid use of towel rails.

Where used, provide rails or hooks that collapse under a breaking strain of fifteen kilograms.

Door and cupboard handles/knobs should be designed to avoid ligature points. Consider using fittings moulded to incorporate hand pulls in order to avoid 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 is appropriately sited, floors graded appropriately and water rate is controlled to prevent excessive splashing.

Provide non-slip flooring in and around the cubicle.

Where installed, shower tracks should be plastic and mounted flush to the ceiling to prevent the possibility of attaching anything such as cords or belts. It is critical to ensure that the entire track plus hooks has a fifteen kilogram breaking strain to ensure that if curtains are gathered into a single cluster the aggregate does not exceed fifteen kilograms. For example, if curtain hooks are able to be pushed together, they should not be installed as this will increase the breaking strain far beyond the fifteen kilograms, as outlined.

WINDOW TREATMENTS

Curtains, Holland blinds or any other type of blinds or curtains with cords should not be used in consumer bedrooms. However, alternative means of providing privacy should be considered. Enclosed integral venetian blinds with flush controls or electronic controls in the staff station are an option where privacy and sun shading are required.

Ideally external shading of windows (eaves, awnings, etc.) addressing environmental considerations should be the preferred option while applying the same safety principles for fittings and fixtures.

If curtains are selected for use in consumer recreational areas, provide tracks flush to the ceiling with a breaking strain of fifteen kilograms (as for shower curtains). Consideration should also be given to fabric type, with respect to weight/thickness and ease of tearing.

OTHER

Light fittings, smoke and thermal detectors and incapable of supporting a consumer’s weight.

03.10 Building Service Requirements

ELECTRICAL SERVICES

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.

Body protect in all inpatient clinical areas – refer to Department of Health, NSW, 2013, Technical Series TS11 - Engineering Services and Sustainable Development Guidelines.

FIRE SAFETY

Despite no smoking rules, consumers will often try to smoke in secret. Smoke detectors should therefore be installed in en suites. Detectors should be tamper-proof or 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 (no exposed fire hose reels). Locking of fire services will require consultation with local fire services and involve staff in managing an evacuation situation.

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

In general, fire requirements are covered by:

- ABCB, Building Code of Australia; and
- Standards Australia, 1997, AS 1603: Automatic Fire Detection and Alarm Systems.

INFORMATION AND COMMUNICATION SYSTEMS

Communication systems may provide for:

- alarm systems where necessary;
- duress alarms – personal and fixed;
- telephone services for staff, patients and visitors. The extent of provision, location, and type i.e. fixed or portable with charging docking stations will need to be addressed in the planning stage to identify space for attaching of charging docking stations;
- fixed and cordless telephones for use by patients should be considered;
- computer and internet access for patients and staff;
- teleconferencing, videoconferencing and telepsychiatry facilities that are used for staff education, management and patient services;
- CCTV at entrances, corridors, courtyards and seclusion rooms in consultation with staff; and
- intercoms at inpatient entrances and in seclusion room as required.

Make adequate provision for cabling and power outlets for computers and consideration for wireless technology.

MEDICAL GASES

Medical gases are not required in acute inpatient units but the provision of (lockable) gases in the PECC treatment / assessment area should be considered. Portable oxygen and suction will, however, need to be available for any medical emergencies and to support patients recovering from a procedure if necessary.

MOTION SENSORS

Motion sensors over bedroom doorways can be a useful adjunct to observation of consumers at night between nursing rounds. They can be used to alert staff to consumers who have left their bedroom and who may be in distress, or who may try to gain access to another consumer’s room.

STAFF AND EMERGENCY CALL SYSTEM

The need for a consumer call system in bedrooms and en suites should be assessed. Call buttons may not always be in easy reach of the consumer, systems can be abused and most consumers are ambulant and capable of asking for assistance. If installed, the system should allow staff override.

Staff assistance and psychiatric emergencies can be handled via personal duress alarms. Medical emergencies will need access to the hospital’s cardiac arrest system as part of the organisation's operational guidelines and protocols.

Refer to Part C for further information.

VENTILATION AND AIR HANDLING

Consideration should be given to the type of heating and cooling units, ventilation outlets and equipment installed in patient-occupied areas of mental health units. Special purpose equipment designed for psychiatric use should be used to minimise opportunities for self harm. The following is applicable:

- provide air grilles and diffusers that prevent the insertion of foreign objects;

- provide tamper-resistant fasteners where these are exposed;
- construct all convector or heating, ventilation, and air conditioning (HVAC) enclosures exposed in the room with rounded corners and with closures fastened with tamper-resistant screws; and
- use HVAC equipment that minimises the need for maintenance within the room.

Newly admitted, very disturbed patients may have little regard for bodily hygiene and may emit alcohol fumes etc. The ventilation systems in the high dependency zone and seclusion room should be designed to render the environment more comfortable for staff working in the area, other consumers and visitors by increasing air changes and ensuring fresh rather than recycled air handling systems.

Showers need to be able to drain quickly and should be very well ventilated.

Provide adequate ventilation and air exhaust from the consumer laundry. Consider providing commercial dryers with external venting where dryers are used extensively by consumers.

Air conditioning vents should be fixed to the ceiling to prevent access to the roof cavity. Refer to Department of Health, NSW, 2013, Technical Series TS11 - Engineering Services and Sustainable Development Guidelines.

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 listed and described below:

- kitchen;
- gymnasium (optional area);
- meeting/review hearings room;
- multifunctional activity space;
- secure entry zone;
- store – clean lundry; and
- seclusion room.

KITCHEN

Description and Function

A room/space for the receipt and serving of meals. The design will depend on the method of service delivery i.e. plated or bulk meals and the management of used crockery and utensils.

The kitchen may be used by consumers for the support and upgrading of daily living skills. Any stoves or other appliances to be used by patients should have controlled power supply for management by staff.

Consumers in the high dependency zone are usually too unwell to be allowed access to stoves and other appliances.

Location and Relationships

The kitchen should be located adjacent to dining spaces in the general / open 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 general / open zone main dining area.

Considerations

The kitchen should be a safe, secure environment for staff and patients in compliance with OHS and Infection Control Guidelines with ample bench top area, open shelving and lockable cupboards for sharp

utensils, supplies, etc., adequate secure storage for food and equipment and sufficient space to store food tray and distribution trolleys. A dedicated power outlet for heating/cooling food trolleys may be required.

Patient access to power supply controls and hot water systems should be restricted to by placing these behind keyed doors.

GYMNASIUM (OPTIONAL ADDITIONAL AREA)

Description and Function

Many medications used in mental health, plus generally low levels of physical activity, can lead to weight gain and frustration for consumers. This space is included as an optional inclusion, as the use of programmed physical exercise as an adjunct to treatment is being included in many facilities both in Australia and overseas. Careful consideration should be given to the degree of supervision required to safely provide these services and optimal utilisation.

Location and Relationships

This room should be located in a space clearly observable from the recreational and therapy areas. Transparent walling and the flow of passing traffic can also be used to aid in the monitoring of supervised activities within this room. It should overlook, and preferably open onto, accessible outdoor space.

Considerations

Provide a safe and secure environment for all staff and consumers and comply with OHS guidelines. Careful consideration should be given to the type and size of equipment and the degree of supervision required. Equipment should be carefully selected to provide appropriate activities for therapy and/or recreation without affording opportunities for injury to self or others. The bolting of non freestanding equipment securely to the floor and walls should be considered as part of a risk assessment review for this area. This facility would be used only under supervision and be able to be locked at other times.

MEETING / REVIEW HEARINGS ROOM

Description and Function

This room may serve several functions but in the Unit, one room needs to be able to be arranged specifically for review hearings when tribunal hearings are scheduled.

Location and Relationships

The room used for review hearings needs to be easily accessible by consumers from the high dependency zone.

Considerations

There should be two doors, one of which should be behind the magistrate and not blocked by furniture.

Personal duress alarms are assumed but there should also be two fixed duress buttons.

Heavy duty furniture is required. The arrangement of tables for magistrate sessions should ensure that the distance between magistrate and consumer does not allow the latter to reach across the table to the magistrate. A round table may be seen as less intimidating.

Provide video/teleconferencing facilities as required.

MULTIFUNCTIONAL ACTIVITY SPACES

Description and Function

These rooms may be used for television viewing, listening to music, using computers or other activities as determined by the nature and service needs of the Unit. There should be at least one noisy/active area and one quiet/passive area.

Location and Relationships

Observation of activities undertaken within this room should be considered and enhanced by the unit layout.

The room should have access to internal or external courtyards, or terraces with weather protection.

Considerations

Surfaces should be washable and finishes and furnishings easily maintained and restored.

Bulletin boards and wall spaces for posters etc., may reduce maintenance costs.

Colours and finishes should be carefully selected, the décor reflecting a domestic environment conducive to continued participation in community life and activities of daily living (ADL).
Provide:

- hand-washing facilities;
- workbenches;
- lockable storage; and
- access to toilet facilities.

SECURE ENTRY ZONE

Description and Function

Where consumers arrive via the emergency unit of the main hospital, an entry lobby leading directly into the high dependency zone will be sufficient.

In circumstances where consumers are brought directly to the Unit by police or ambulance, facilities will 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 violent patient absconding when the van doors are opened;
- an entry lobby capable of accepting an ambulance trolley and at least two emergency personnel with ease;
- electric doors, where required;
- discrete area for police to disarm and for gun storage;
- examination / assessment room with secured gases and 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 seclusion room(s).

Considerations

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

This area should have a level of soundproofing so that noisy incidents do not disrupt the usual operations of the remainder of the Unit.

DECONTAMINATION SHOWER

Description and Function

A decontamination shower is provided to shower consumers who arrive in the Unit contaminated with toxic and /or infectious substances. The inclusion of a flexible water hose, floor drain and contaminated water trap should be included this may be provided in the ambulance/police secure entry.

Storage for personal protection equipment (PPE) equipment and a lockable cupboard for linen with the decontamination shower should be considered.

Location and Relationships

Should be directly accessible and part of the secure entry zone.

STORE – CLEAN LAUNDRY

Description and Function

This room provides lockable storage for clean linen trolley(s) and extra blankets, pillows and bed linen.

Location and Relationships

This space may be a corridor alcove with lockable doors. Electrically operated roller shutters may be considered.

Considerations

A cupboard with adjustable shelving wide enough to take sheets, towels, blankets, pillows, etc. may be used as part of the activities of daily living (ADL) whereby consumers may assist in transferring laundry from delivery trolley to the shelves.

Where linen is delivered by trolley and/or stored on trolleys, storage space or adjustable shelving for clean linen decanting should be considered.

SECLUSION ROOM

Description

The seclusion room should ideally be square in shape and a minimum of fifteen metres2 in size (exclusive of an en suite), sufficient to accommodate the mattress and enough space to allow for safe medication of a consumer while being restrained (consumer plus up to six or seven staff). The inclusion of an en suite or separate toilet and shower should be considered as part of the design development.

If the seclusion room is also to act as a voluntary quiet room, the project should consider the inclusion of two rooms, one in the open zone and one in the high dependency unit. If a single seclusion room is to be shared, ensure it is accessible from both sides of the Unit while maximising consumer privacy and dignity.

The inclusion of a sitting area as part of the seclusion space should be considered with access to a secure weather protected outdoor space. Entry and exit point doors from and to the seclusion area should not reduce the functional space available.

The width of corridor space outside the seclusion room should be wide enough to safely accommodate a consumer being escorted by a number of staff as well as the space taken up by outward opening doors.

Location and Access

Locate the seclusion room in close proximity to, and observable from, the staff station but away from common areas such as lounges, dining and activity areas, and away from the direct line of sight of other consumers and visitors, to protect the secluded consumer’s privacy.

A shared seclusion room may be located off a corridor between the two zones with a swipe card entry at each end of the corridor. Locating the seclusion room in a corridor, not accessible to consumers, means that staff observation of the secluded consumer can be discreet while preventing other consumers from looking into the seclusion room.

AX APPENDICES

AX.01 Schedule of Accommodation

A generic schedule of accommodation for an adult mental health inpatient unit with twenty or thirty beds is shown below.

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.

MAIN ENTRANCE / RECEPTION

AusHFG Room Code	Room / Space	SC / SC-D	Qty x m2 20 Beds	Qty x m2 30 Beds	Remarks
AIRLE-10	Airlock - Entry, 10m2	Yes	1 x 10	1 x 10	Wind protection/security.
RECL-10	Reception / Clerical, 10m2	Yes	1 x 10	1 x 12	
WAIT-10	Waiting, 10m2	Yes	1 x 10	1 x 15	
WAIT-SEC	Waiting - Secure, 6m2	Yes	1 x 6	1 x 6	
WCAC	Toilet - Accessible, 6m2	Yes	1 x 6	1 x 6	
WCPU-3	Toilet - Public, 3m2	Yes	1 x 3	2 x 3	Optional.
INTF	Interview room	Yes	2 x 14	2 x 14	Added 2m2 for second door.

(The above facility is required only in a stand alone unit)

GENERAL / OPEN ZONE

AusHFG Room Code	Room / Space	SC / SC-D	Qty x m2 20 Beds	Qty x m2 30 Beds	Remarks
1BR-MH	1 Bed Room - Mental Health, 14m2	Yes	14 x 14	22 x 14	
2BR-MH	2 Bed Room - Mental Health, 28m2	Yes	1 x 28	1 x 28	Optional. May be 2 extra single rooms or may be modified for family care.
ENS-MH	Ensuite - Mental Health, 5m2	Yes	15 x 5	23 x 5	
	1 Bed Room - Mental Health - Special, 18m2		18	18	Adjust number of standard bedroom numbers as necessary. For bariatric consumers or mothers with baby.
	Ensuite - Mental Health - Special, 6m2		6	6	1 per 1 Bed Room - Special.
BHWS-B	Bay – Handwasing, Type B	Yes	2 x 1	3 x 1	Optional recessed bays in corridors - 1 per 8 beds. May be replaced with alcohol-based hand rubs - see Part D
	Kitchen		1 x 10	1 x 12	Sized for consumer use.
SSTN-14	Staff Station, 14m2	Yes	1 x 14	1 x 18	Dependent on staffing level.
OFF-CLW	Office - Clinical Workroom	Yes	1 x 15	1 x 25	
DINR	Dining - Patients	Yes	1 x 40	1 x 60	Overall size of dining and recreational areas based on 7.5m2 per person - refer to Note 2.
LNPT-10	Lounge - Patient / Family, 10m2	Yes	2 x 10	3 x 10	One may be designated for a special group.
	TV / Music Room		1 x 20	1 x 30	
	Multifunction Activity Area		1 x 40	1 x 60	
	Occupational Therapy Room		1 x 21	1 x 21	Refer to Note 1 - Multifunction Activity Area. Lockable store to be included in room.
	Gymnasium		1 x 20	1 x 30	Optional.
WCPT	Toilet - Patient, 4m2	Yes	1 x 4	1 x 4	For consumer use from activity areas.
	Courtyard		1 x 120	1 x 180	Based on 7.5m2 per person and 100% utilisation / occupancy - refer to Note 3.
LAUN-MH	Laundry - Mental Health	Yes	1 x 8	1 x 8	May be used for ADL as per POE OH&S reviews.
BLIN	Bay - Linen	Yes	1 x 2	2 x 2	Lockable. Additional space may be needed for blanket, bedspread and pillow storage.
STPP	Store - Patient Property	Yes	1 x 6	1 x 8	
	Discounted Circulation (%)		32%	32%	

Notes:

- Note 1: 0.7m2 per bed with minimum area of 21m2. Optional area. This area may be added to the Multifunction Activity Area or Dining Area.
- Note 2: Lounge/dining/activity areas – 7.5m2 per person.
- Note 3: Outdoor areas – 7.5m2.
- Note 4: Terrace – minimum area 20m2.
- Note 5: Consult rooms/Interview (inpatient only use) 1 per 5 beds.
- Note 6: Examination/assessment rooms – minimum 1 per unit.

HIGH DEPENDENCY ZONE

AusHFG Room Code	Room / Space	SC / SC-D	Qty x m2 20 Beds	Qty x m2 30 Beds	Remarks
	Secure Entry Lobby		1 x 10	1 x 10	If no Secure Entry Zone.
1BR-MH	1 Bed Room - Mental Health, 14m2	Yes	4 x 14	6 x 14	
ENS-MH	Ensuite - Mental Health, 5m2	Yes	4 x 5	6 x 5	Optional.
	Toilet - Patient, 4m2		2 x 4	2 x 4	If not ensuite, 2 male, 2 female.
	Shower - Patient, 4m2		1 x 4	2 x 4	
SSTN-14	Staff Station, 14m2	Yes	1 x 14	1 x 18	Depending on staff numbers.
BHWS-B	Bay - Handwashing, Type B	Yes	1 x 1	1 x 1	
	Lounge / Dining / Activities Room		1 x 40	1 x 60	Based on 10m2 per person. May be sub- divided / partitioned. Refer to Note 1.
SECL	Seclusion Room	Yes	1 x 15	1 x 15	Optional. Shared with General / Open Unit. Additional space for a sitting area as part of the seclusion space and access to a secure courtyard – see clause 134.021.023.
	Secured Courtyard		1 x 40	1 x 60	Based on 10m2 per person. Refer to Note 2.
	Discounted Circulation (%)		32%	32%	

Notes:

- Note 1: Lounge/dining/activity areas – 10m2 per person.
- Note 2: Outdoor areas – 10m2 per person.
- Note 3: Consult rooms/Interview (inpatient only use) 1 per 5 beds.
- Note 4: Examination/assessment rooms – minimum 1 per unit.

SECURE ENTRY ZONE

AusHFG Room Code	Room / Space	SC / SC-D	Qty x m2 20 Beds	Qty x m2 30 Beds	Remarks
	Police / Ambulance Enclosed Transfer Area		1 x 20	1 x 20	
AIRLE-10	Entry - Airlock, 10m2	Yes	1 x 10	1 x 10	Needs to accommodate a consumer and escort staff on a trolley.
	Gun Safe Alcove		1 x 2	1 x 2	Within police/ambulance area.
CONS	Consult Room	Yes	1 x 14	1 x 14	
ENS-MH	Ensuite - Mental Health, 5m2	Yes	1 x 5	1 x 5	Optional.
CONS	Consult Room	Yes	1 x 14	1 x 14	Consistent with other consult/assessment spaces.
SHDEC	Shower - Decontamination, 8m2	Yes	1 x 8	1 x 8	As per local authority requirements – could be added space to Police/ambulance secure area.
	Discounted Circulation (%)		32%	32%	

SHARED CLINICAL SUPPORT AREAS

AusHFG Room Code	Room / Space	SC / SC-D	Qty x m2 20 Beds	Qty x m2 30 Beds	Remarks
STPS-8	Store - Photocopy / Stationery, 8m2	Yes	1 x 8	1 x 8	Unless located in reception zone.
STFS-10	Store - Files, 10m2	Yes	1 x 8	1 x 10	
INTF	Interview Room	Yes	4 x 14	6 x 14	Added 2m2 for second door. Based on 1 per 5 beds. For inpatient services only. May also be used as a family room.
MEET-12	Meeting Room, 12m2	Yes	1 x 15	1 x 30	Staff and Group / Family Therapy.
MEET-L-20	Meeting Room, 20m2	Yes	1 x 20	1 x 20	
OFF-S9	Office - Single Person, 9m2	Yes	1 x 9	1 x 9	Nursing manager
OFF-2P	Office - 2 Person Shared, 12m2	Yes	1 x 12	1 x 12	5.5m2 per registrar.
STDR-10	Medication Room	Yes	1 x 6	1 x 8	
TRMT	Treatment Room	Yes	1 x 16	1 x 16	Includes spatial allowance for Resuscitation Trolley (1.5m2).
DTUR-10	Dirty Utility, 10m2	Yes	1 x 10	1 x 10	
STEQ-14	Store - Equipment, 14m2	Yes	1 x 12	1 x 16	
STGN-9	Store - General, 9m2	Yes	1 x 9	1 x 12	
CLRM-5	Cleaner's Room, 5m2	Yes	1 x 5	1 x 5	
DISP-8	Disposal Room, 8m2	Yes	1 x 8	1 x 8	Includes recycling bins.
WCST	Toilet - Staff, 3m2	Yes	2 x 3	2 x 3	Optional if main amenities too remote.
	Discounted Circulation (%)		32%	32%	

STAFF OFFICES & AMENITIES (DETERMINED BY STAFF ESTABLISHMENT)

AusHFG Room Code	Room / Space	SC / SC-D	Qty x m2 20 Beds	Qty x m2 30 Beds	Remarks
OFF-S12	Office - Single Person, 12m2	Yes	1 x 12	1 x 12	Director
OFF-S9	Office - Single Person, 12m2	Yes	9	9	Number determined by staff establishment. Staff Specialists.
	Office - Single Person, 9m2	Yes	1 x 9 (o)	1 x 9	Mental Health Service Manager.
	Office - Workstation, 5.5m2		5.5	5.5	Number determined by staff establishment and workstation size. For a range of Medical, Nursing, Allied Health and Administrative staff.
STPS-8	Store - Photocopy / Stationery, 8m2	Yes	1 x 8	1 x 8	May be incorporated as open plan space allocation.
MEET-L-20	Meeting Room, 20m2	Yes	1 x 20	1 x 30	
SRM-15	Staff Room, 15m2	Yes	1 x 15	1 x 20	
BHWS-B	Bay - Handwashing, Type B	Yes	1 x 1	1 x 1	
PROP-2	Property Bay - Staff	Yes	1 x 3	1 x 3	
SHST	Shower - Staff, 3m2	Yes	1 x 2	1 x 2	
WCST	Toilet - Staff, 3m2	Yes	2 x 3	2 x 3	
	Courtyard		1 x 20	1 x 30	
	Discounted Circulation %		20 - 25%	20 - 25%	Depending on unit size.

The above are examples of spaces only – reference should be made to individual jurisdictions specific staff office accommodation policies.

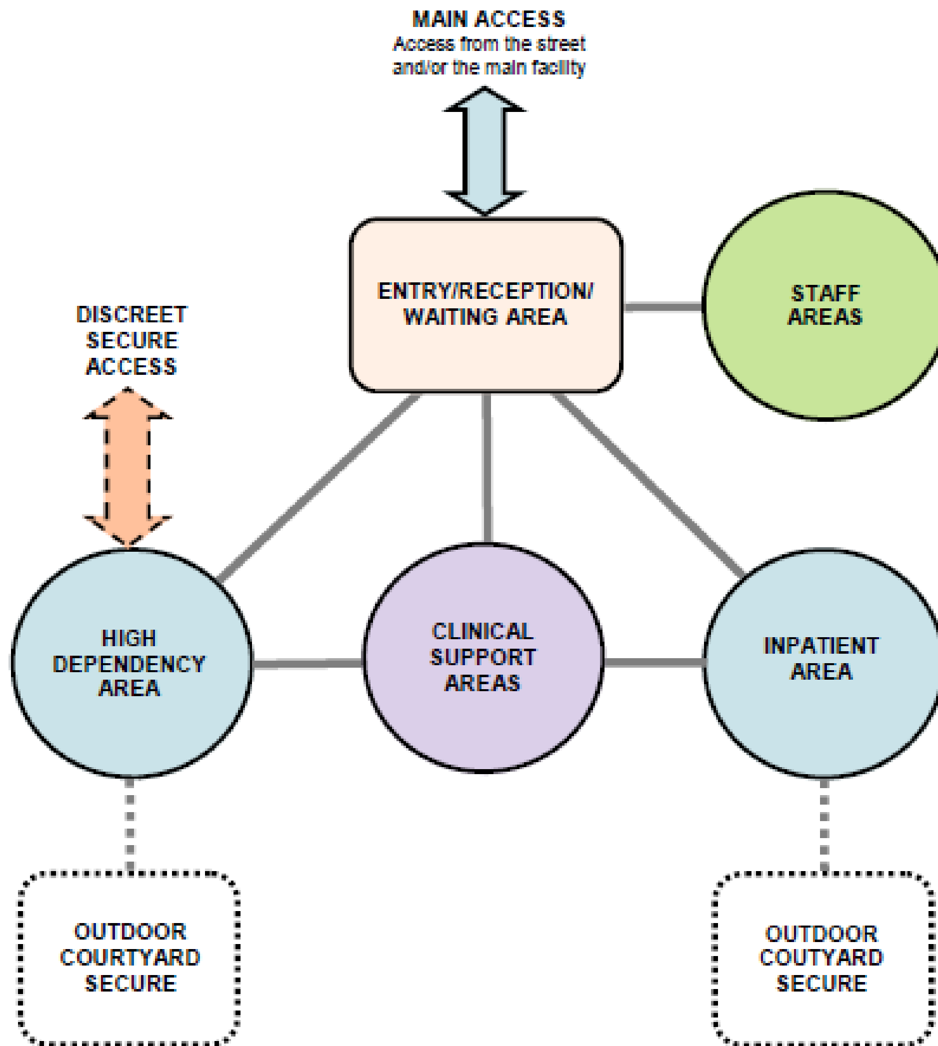
The discounted circulation allowances are recommended as a starting point for briefing a typical unit. Refer Part C for a Schedule of Circulation Areas for other parts of a health facility.

Circulation percentages will vary as a result of the configuration of the unit, including the use of a racetrack arrangement or double loaded corridors. The actual spatial allocation will depend on the role delineation of the service, the re-use of existing buildings and the skill of the individual designer.

The provision of appropriate areas for circulation requirements should be tested during the preliminary design phases.

AX.02 Functional Relationships / Diagrams

A diagram showing the functional relationship between the zones of the Adult Acute Mental Health Inpatient Unit is shown below.



AX.03 Checklists

For Planning Checklists refer to Parts A, B, C & D.

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