

Australasian Health Facility Guidelines

Part B - Health Facility Briefing and Planning
0135 - Older Persons Acute Mental Health Unit

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Australasian Health Facility Guidelines

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01 INTRODUCTION

01.01 Preamble

PURPOSE OF GUIDELINE

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

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

This is a new HPU written for Australasian use in 2011/12. Its development has been informed by an extensive consultation process.

01.02 Introduction

GENERAL

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

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

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

RELATED HEALTH PLANNING UNITS

The following related HPUs are available in Part B:

- HPU 132 Child & Adolescent Mental Health Unit, Australasian Health Facility Guidelines (AHIA, 2012);
- HPU 133 Psychiatric Emergency Care Centres (PECC), Australasian Health Facility Guidelines (AHIA, 2010);
- HPU 134 Adult Acute Mental Health Inpatient Unit, Australasian Health Facility Guidelines (AHIA, 2012); and
- HPU 250 Ambulatory Mental Health Unit, Australasian Health Facility Guidelines (AHIA, 2010).

Other HPUs currently being developed will address Non-Acute Mental Health Inpatient Unit and Mental Health Intensive Care Unit.

TERMINOLOGY

The following terms are used in this HPU:

- 'psycho geriatric services': mental health services for older people are also known as psychogeriatric services; Australasian Health Facility Guidelines Part B - Health Facility Briefing and Planning Page 5/135 - Older Persons Acute Mental Health Unit, Revision 1.0, 31 May 2012
- "Consumer": in the mental health context, the consumer is referred to as the 'consumer'; this document utilises both terminology;

- 'Carer': carers provide unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness or who are frail. A carer is intimately involved with the lives and treatment of consumers / consumers. In the mental health context, the carer is a recognised member of the multidisciplinary team;
- 'voluntary consumer': a consumer who elects to remain in a mental health facility for treatment, care or observation, or who is admitted by his or her guardian or person responsible under the relevant jurisdiction's guardianship legislation.
- 'involuntary consumer': a consumer admitted under the relevant jurisdiction's mental health act. The process of involuntary detention usually includes the steps of request, recommendation, admission and examination by a psychiatrist and regular review at formal hearings;
- 'nomenclature of beds': different terminology is used by the different jurisdictions. 'Acute' beds may also be known as 'general' or 'open' beds. 'High dependency' may also be known as 'observation' or 'secure' beds. For consistency and clarity, this HPU uses the terms 'acute' and 'high dependency' when referring to the different beds and zones; and
- 'formal hearing': the term used in this HPU for formal reviews of consumers admitted under the relevant mental health act and regulations. The term for this varies between jurisdictions e.g. magistrate session, tribunal, board of review.

01.03 Policy Framework

GENERAL

Policies for the provision of healthcare services are formulated in accordance with the following principles: Appropriate service models that ensure a comprehensive service network throughout state and regional health jurisdictions;

- safe and effective care that minimises both staff and consumer risks;
- provision of a safe and efficient environment that minimises risk to all users of the facility;
- deployment of resources in a fair and cost effective manner to optimise health outcomes; and
- development of and support for enhanced information systems to monitor, plan and evaluate healthcare services.

DIVERSITY AND SPECIAL GROUPS

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

- Aboriginal and Torres Strait Islanders in Australia;
- Maori and Pacific Islanders in New Zealand;
- people with physical and cognitive disabilities, including obese (bariatric) consumers;
- people from cultural and linguistically diverse backgrounds;
- people from rural and remote areas;
- children and adolescents; and
- older persons and the frail aged.

SPECIFIC POLICIES

The Disability Discrimination Act 1992, Disability Discrimination Act 1992 (Australian Government, 2005) and the New Zealand Public Health and Disability Act 2000 (New Zealand Government, 2000) are overarching policies relevant to this HPU.

Mental health services in all jurisdictions are underpinned by their individual mental health act and regulations / amendments. The United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (UNHCHR, 1991) is a key document influencing service provision.

In Australia, the mental health agenda has been set through the National Mental Health Policy 2008 (Australian Government, 2009) and the Fourth National Mental Health Plan - an Agenda for Collaborative Government Action in Mental Health 2009–2014 (Department of Health and Ageing, 2009). Together, these documents reflect the Commonwealth Government's commitment to "a mental health system that enables recovery, that prevents and detects mental illness early and ensures that all Australians with mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community" (Fourth National Mental Health Plan - an Agenda for Collaborative Government Action in Mental Health 2009–2014 (Department of Health and Ageing, 2009)).

New Zealand's commitment to mental health is reflected in the document The Second New Zealand Mental Health and Addiction Plan, Improving Mental Health 2005–2015 (Tāhuhu, T, 2005).

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.

01.04 Description

DESCRIPTION OF HEALTH PLANNING UNIT (HPU)

The HPU describes facilities for older persons who require treatment as inpatients, or day patients, for acute psychiatric disorders. Treatment of mental illness in older persons warrants individual consideration because "Biological, social and cultural changes associated with aging may significantly alter the clinical presentation of mental illness in old age" (Psychiatry of the Elderly: A Consensus Statement, Consensus Meeting on Psychogeriatrics (WHO, 1996))

The primary focus of the service is restoring the health of older persons with a psychiatric disorder to an optimal degree of mental function by addressing the consumer's psychological, physical and social needs (WHO, 1996). The Unit will provide:

- consultation;
- assessment;
- acute care management;
- recovery;
- education;
- discharge planning; and
- evaluation of outcomes.

Discharge to the usual place of residence is the primary goal of management, but transfer to an alternative longer term facility such as an aged care facility, extended care facility, specialised residential aged care facility or inpatient unit may be required.

In a gazetted unit consumers may be admitted on a voluntary or involuntary basis.

The Unit may admit and treat older consumers who have the following mental health disorders:

- affective disorders (such as depression or bipolar disorder);
- schizophrenia and other psychoses in old age;
- anxiety disorders (such as post traumatic stress disorder, social phobia, panic disorder or generalised anxiety disorder); and / or
- severe behavioural and psychological symptoms of dementia.

In some settings the Unit may also admit and treat consumers with:

- delirium (acute confusion), where there is a specific mental health indication; and
- substance use disorders (such as harmful alcohol or drug use / dependence).

The HPU may include an outpatient unit from that may be used for:

- aged care psychiatry clinics for new consumers; or
- follow up of discharged consumers.

Facilities for community and outreach services can also be collocated with the HPU.

Admission to this Unit is not appropriate for consumers with acute, unstable medical co-morbidities. When the co-morbidity is stable, the consumer will be eligible for admission to the Unit under the care of a psychiatrist with ongoing input from a geriatrician or physician.

CONSUMER CHARACTERISTICS

The minimum of admission to this Unit is generally defined as 65 years. However, there should be some flexibility for admission based on need and jurisdiction policies (Position Statement 22: Psychiatry Services for Older People (RANZCP, 2009)). Some older people may benefit from admission to an acute adult unit with which they have a long standing relationship. Similarly, some younger consumers may also have disorders that make admission to this unit more appropriate (such as younger onset dementia). Increased longevity impacts the need for the unit because "...increasing levels of physical illness, neurodegenerative diseases and disability are associated with increasing longevity. Anxiety and depression are particular risk issues for older people and can accompany physical illness, dementia, disability or bereavement. People with life-long mental illnesses and related disabilities will experience age-related frailty and diseases." (Specialist Mental Health Services for Older People, NSW Service Plan 2005-2015 (NSW Health, 2006)).

Mobility and balance difficulties as well as vision and hearing impairment are common characteristics of the ageing consumer that should be catered for in facility design.

Consumers may also exhibit a range of challenging behaviours such as:

- shouting;
- physical aggression;
- sexual dis-inhibition;
- undressing;
- intrusive behaviours;

- wandering;
- repetitive noisy behaviours;
- intentional self-harming; and/or
- withdrawn behaviour.

Consumer behaviours may have adverse impacts upon other consumers admitted to the unit (such as the frail and isolated) and this will need to be managed appropriately.

UNIT DESIGN

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

The following principles, originally prepared to guide the design of dementia units, are also applicable to this Unit (Adapting the Ward: for People with Dementia, Fleming, R., Forbes, I. and Bennett, K., 2002):

- provide a safe and secure environment;
- plan for small consumer groups: eight consumers for severe dementia and up to fourteen consumers for moderate dementia;
- provide good visual access so consumers can see everywhere they need to go;
- reduce of unnecessary stimulation;
- highlight useful stimuli;
- provide for planned walking;
- use familiar decor from the consumer's early adulthood;
- provide opportunities for privacy and community;
- provide appropriate facilities for visitors to retain links with the community;
- make the environment as domestic as possible; and
- and encourage consumers to use their abilities.

In addition, the following are important for the Unit's design:

- the need for space cannot be overemphasised as a means of reducing the potential for aggressive behaviour by means of wide corridors and recreation areas large enough to avoid crowding;
- universal access and facilities for the disabled;
- circulation spaces sufficient for staff and carers to assist consumers (e.g. consumers with wheel chairs and mobility aids), particularly in areas such as bedrooms, bathrooms, dining rooms, activity rooms and corridors (A Geropsychiatric Unit without Walls, Issues in Mental Health Nursing, Vol 26, Issue 1, pp101-114 (Nadler-Moodie, M, Gold, J, 2006));
- unobtrusive security and access control that can accommodate consumers of all levels of acuity;
- privacy and safety, including sexual safety;
- comfort and visual satisfaction (domestic furnishings, decor and artworks);
- quiet spaces, plus active indoor and outdoor spaces for therapy and relaxation;
- maximum penetration of natural light and, where possible, views;

- avoidance of isolated spaces for both consumer and staff safety (i.e. no unsupervised blind corners, recessed areas and/or alcoves);
- fixtures and fittings that minimise the opportunity for self-harm or injury to others, with special attention to bathrooms, bedrooms, courtyards, low stimulus rooms and formal hearing rooms;
- acoustic management, particularly of bedrooms;
- safe and supervised access for visiting family members;
- sufficient flexibility to adapt over time in response to changes in practice, treatment and the consumer demographic;
- provision of storage for mobility equipment, easily accessible for consumer use; and
- compliance with fire safety, building regulations and standards.

Consideration should also be given in the Unit design to the following:

- availability of qualified staff and mix of staff;
- maximising efficiencies in recurrent / operating costs; and
- the interplay between inpatient and outpatient services.

BUILDING STRATEGIES

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, giving consideration to acoustic management, the potential for damage by consumers and potential for self-harm.

THERAPEUTIC ENVIRONMENT

This HPU reflects advances in the understanding of:

- optimal environments for care;
- advances in assessment, treatment and rehabilitation / recovery; and
- changing practices in the delivery of mental health services for older persons.

Consumers may be agitated, aggressive and potentially a risk to themselves or others. The environment should therefore be conducive to the management of complex behaviours, offering:

- the capacity for observation of consumers by staff;
- discreet security; and
- where necessary, temporary containment.

These objectives should, however, 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, better staff conditions and satisfaction, and reduced recurrent costs.

02 PLANNING

02.01 Operational Models

HOURS OF OPERATION

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

Where an outpatient unit is collocated with the inpatient unit, the outpatient unit will generally operate during business hours Monday to Friday. However, the operating hours are dependent on local operational needs.

MODELS OF CARE: SERVICE DELIVERY

This HPU describes a secondary or tertiary level acute inpatient mental health service for older persons. The inpatient service may be collocated with an outpatient service or day hospital and will be supported by community based services and outreach services.

Older persons with acute mental illness will often have complicating age related co-morbidities, and social and lifestyle considerations that need to be addressed during their admission. Frailty is also a concern (Position Statement 22: Psychiatry Services for Older People (RANZCP, 2009)), and a well designed service will foster a collaborative approach between carers and health, social and voluntary organisations (Psychiatry of the Elderly: A Consensus Statement, Consensus Meeting on Psychogeriatrics (WHO, 1996)). A multidisciplinary team will contribute to consumer care including nurses, psychiatrists, geriatricians, physicians, allied health personnel and aids.

The generally accepted length of stay for older persons' acute mental health is currently under review. In National Older Person Mental Health Benchmarking Forums (National Mental Health Benchmarking Project (AMHOCN, 2015)) the average length of stay in 2006 / 2007 was 45 days.

CLUSTER / UNIT SIZE

Literature does not explicitly identify the ideal cluster (number of beds that can be functionally separated) or unit size (total number of beds) for an older persons' acute mental health unit, however the following examples from the literature provide helpful guidance:

- a 15 bed inpatient cluster is recommended for adult acute mental health (Council Report CR62: Not Just Bricks and Mortar, Size, Staffing, Structure, Siting, and Security of New Acute Adult Psychiatric In-Consumer Units, Safety for Trainees in Psychiatry (Royal College of Psychiatrists, 1998)). However, as mentally ill older persons tend to be more prone to confusion, smaller clusters are more appropriate;
- an eight bed cluster is suggested for severe dementia consumers (Position Paper 3: Dementia Care and the Built Environment (Alzheimer's Australia, 2004));
- a 12 to 14 bed cluster for moderate dementia consumers (Alzheimer's Australia 2004). It is noted that whilst this HPU will admit some dementia consumers, it is not a dementia unit;
- NSW's Transitional Behavioural Assessment & Intervention Service (T-Basis) Units and Western Australia's High Dependency Units accommodate eight consumers per cluster;
- Victoria's Psychogeriatric Nursing Homes accommodate ten consumers per cluster; and
- building guidelines for Queensland Mental Health Facilities (Queensland Health, 1996) suggest eight to twelve beds per cluster for acute psycho geriatric admission and assessment units.

Bed numbers in this HPU are recommended as between eight to 12 beds per cluster according to local factors.

The total unit size will be determined by local service need, however an 18 to 24 bed unit, made up of multiple clusters, is considered to be efficient from a staffing and budget perspective.

02.02 Operational Policies

GENERAL

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

Operational policies should be developed for every unit as part of the project planning process. Refer to AusHFG Part B: Section 80 General Requirements for further information.

MOBILITY SUPPORT

Frail consumers in this unit will require varying levels of mobility support and assistance with daily activities including:

- assistance to sit and stand;
- assistance with dressing;
- eating; bathing and toileting;
- repositioning in bed; and
- assistance with moving around the unit.

A variety of equipment such as prescribed walking frames, mobile / wheel chairs, lifters and hand rails will be available for these purposes. In addition, an appropriate staff profile including nursing aids or wards-men ensures the physical needs of immobile consumers are met.

LOW STIMULUS AREA

Seclusion is “the confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented” (Seclusion and Restraint in Mental Health Services, NMHCCF Advocacy Brief (NMHCCF, 2012)). The use of seclusion is not common practice for older persons. Victoria is the only jurisdiction that has dedicated seclusion rooms in this Unit. Facilities in other jurisdictions will use seclusion management strategies from time to time, but tend to transfer the consumer to a low stimulus room (quiet room / time-out room) which is more comfortably furnished. It has been scheduled in order to meet the design requirements for a seclusion room in the event that one is required. The low stimulus room would ideally be located in a swing area so that it could be accessed by all consumers in the Unit.

ELECTROCONVULSIVE THERAPY

Electroconvulsive Therapy (ECT) and recovery will only take place in the day procedures unit, operating unit or dedicated and fully equipped ECT suite if available, within the mental health complex or hospital campus.

SMOKING

Local non-smoking policies will apply, however all jurisdictions will have supportive programmes in place for nicotine substitution and smoking cessation.

BARIATRIC CONSUMERS

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

CATERING

It is recommended that meals be prepared for consumers, either in the Unit kitchen or, if collocated in the hospital's main kitchen, as per the hospital's existing arrangements.

It is beneficial for capable consumers to be involved in serving themselves (e.g. breakfasts, lunches, snacks) as a part of activities of daily living (ADL). If this practice is implemented, the Unit kitchen will need a large serving bench accessible from the dining room by consumers.

A cold beverages facility should be accessible to consumers and their visitors at all times. Hot drinks should only be accessible under carer / staff supervision, using appropriate cups and mugs that are easy to grasp, thereby minimising the risk of spills / burns.

The unit may encourage consumers to participate in supervised food preparation activities in an ADL kitchen. Dangerous items would be stored in locked cupboards, safe items displayed on open shelves and the kitchen would be lockable after hours. Cooking groups will need access to a basic food preparation area close to the ADL kitchen.

BEDROOMS

Generally, consumers will not be allowed access to their bedrooms unless it is prescribed as part of their management plan. However, consumers should have as much control as reasonable. Bedroom doors should therefore be lockable from the outside with access controlled by staff.

All bedrooms should be designed to AS/NZS 1428:2010 Design for Access and Mobility (Set) (Standards Australia, 2010) for wheelchair users or other mobility aids.

EMERGENCIES

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

Psychiatric emergencies such as suicide or violent behaviour will be handled in accordance with unit policies.

STAFFING

Levels will vary for each Unit depending on:

- the size of the unit;
- the operational policies;
- availability of staff and differing skill mix;
- levels of supervision required;
- clinical case mix and dependency; and
- unit activity levels.

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

The environment should be secure and facilitate effective emergency responses to acute situations on each shift. Designing the unit on this basis will support efficient unit operation without imposing additional costs while enabling compliance with security and OH&S requirements.

STAFF ESTABLISHMENT

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

- old age psychiatrists;
- geriatricians;
- nurses;
- allied health staff, including an occupational therapist, social worker, psychologist, diversional therapist and/or neurophysiologist with access to a physiotherapist, dietician and speech therapist as required;
- administrative staff;
- housekeeping, maintenance and catering staff;

- security and other emergency response personnel;
- research and evaluation staff; and
- consumer advocates.

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

Visiting services may include:

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

FIREARM SECURITY - POLICE

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

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

02.03 Planning Models

GENERAL PRINCIPLES

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

LOCATION

It is highly desirable to have a ground floor location to support the safety and security of consumers.

The shape of the building and the location of the Unit within the building will affect the overall planning process. However, a number of other issues / planning parameters will need to be evaluated prior to commencing the internal planning of the Unit as described in the following sections.

TRAFFIC FLOWS

Movements external to the Unit may be between the Unit and:

- the emergency department;
- medical imaging;
- theatres; and/or
- the local community.

Consideration should be given to the requirements associated with moving consumers between units to minimise transportation distances and to avoid movement through high traffic, public areas. Mentally ill older persons will experience exacerbated confusion as a result of travel through unfamiliar and busy corridors.

CONFIGURATION / LAYOUT

The main entry and reception can be shared with other mental health services if they are collocated. Public access to this Unit will be via a central reception point.

The layout needs to be sufficiently flexible to allow for changing levels of acuity and models of care over time. The ability to create clusters for distinct groups e.g. based on gender, age, diagnosis, acuity, and behaviours is desirable.

It is important that the consumer has good visual access to the whole Unit and as far as possible can see everywhere they are able, or may want, to go. This needs to be balanced against the goal of providing a non-threatening domestic scale rather than a large, imposing or institutional space. Flexible dividers may be used to break up large spaces.

Long corridors are discouraged as they cause echoes and orientation difficulties that confuse the elderly (Adapting the Ward: for People with Dementia (Fleming, R., Forbes, I. and Bennett, K., 2002), Best Practices: Environmental and Therapeutic Issues in Psychiatric Hospital Design: Toward Best Practices, Psychiatric Services, Vol 57, Issue 10, pp1376-1378 (Karlin BE, Zeiss RA, 2006)). 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 be a minimum of width of 1800 millimetres clear.

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

The consumers' / consumers' orientation may be enhanced through:

- consultation;
- connecting consumers to views of surrounding gardens and architectural elements;
- appropriate signage, including consideration of its location (floor level signage may attract downcast eyes), font size, colour, and the use pictorial guides (Improving Services and Support for Older People with Mental Health Problems, UK Inquiry into Mental Health and Well-Being in Later Life, Issue 2nd Report (Age Concern, 2007));
- managing visual stimulation through the application of colour to highlight doors that consumers will use (such as bedrooms and bathrooms) and neutrals to hide doors that they will not use (such as utility rooms and staff areas) (Adapting the Ward: for People with Dementia (Fleming, R., Forbes, I. and Bennett, K., 2002));
- use of distinctive objects as landmarks (Alzheimer's Australia 2004);
- variation in tactile surfaces;
- high visibility of toilets, which reduces incontinence issues amongst older persons with cognitive impairments (Best Practices: Environmental and Therapeutic Issues in Psychiatric Hospital Design: Toward Best Practices, Psychiatric Services, Vol 57, Issue 10, pp1376-1378 (Karlin BE, Zeiss RA, 2006)); and
- prominent display of clocks and calendars to minimise confusion regarding the passing of time (Improving Services and Support for Older People with Mental Health Problems, UK Inquiry into Mental Health and Well-Being in Later Life, Issue 2nd Report (Age Concern, 2007)).

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

The high dependency zone and low stimulus room should be located away from bedroom and activity areas, so as to maintain the privacy and dignity of consumers / consumer and minimise the impact on other consumers in the Unit. The low stimulus room would ideally be located in a swing area so that it could be accessed by HDU and acute consumers.

Views to, and a sense of connection with, gardens and other outdoor spaces are desirable from all parts of the Unit, in particular bedrooms and day rooms, as is an outlook beyond the Unit (Effects of Gardens on Health outcomes; Theory and Research, Healing Gardens, Issue 1st Ed, pp27-86 (Ulrich, R, 1999)). This is an important strategy in reducing aggression and in hastening recovery.

02.04 Functional Areas

FUNCTIONAL ZONES

Functional zones may include:

- main entry, reception, waiting;

- consulting / therapy rooms;
- consumer bedrooms and bathrooms;
- kitchen and dining room;
- activity and recreation areas, both indoor and outdoor;
- high dependency zone;
- visitor / family amenities;
- meeting rooms;
- clinical and non-clinical support areas;
- staff station / clinical resource room;
- medication room and clean utility;
- treatment room;
- storage; and
- staff offices and amenities.

MAIN ENTRY / RECEPTION

A secure, safe, staff controlled entry is needed. There may be one main entry to the Unit and one reception, which can be shared with other mental health inpatient units or a day unit if collocated.

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

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

The reception desk should enhance security while maintaining a visually welcoming environment. The depth of the reception counter can be increased, or security screens can be used, however they should be designed so as not to impede communication or visibility.

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

Small lockers may be provided so that visitors' belongings can be safely stored while they are visiting.

CONSULTATION / THERAPY ROOMS

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

Interviews involving consumers should be restricted to dedicated consultation / therapy rooms; however some office sizes may need to be enhanced to cater for meetings with multiple family members (Reinterpreting the Hospital Corridor: "Wasted Space" or Essential for Quality Multidisciplinary Clinical Care? (Carthey, Jane, 2008)). One room should be equipped with videoconferencing facilities - for both consultation and education purposes.

Consultation and therapy room needs to be large enough to comfortably accommodate up to six people, including the consumer, clinician and where applicable, carers or guardians. Family or group therapy involving more than six participants will generally occur in a medium / large meeting room. Rooms will have two exits and fixed duress alarms for safety.

Consumers will be encouraged to maintain and improve their independent living skills through supervised access to an ADL kitchen and laundry, as is appropriate to their level of acuity (Adapting the Ward: for People with Dementia (Fleming, R., Forbes, I. and Bennett, K., 2002)). An ADL bathroom is optional. These rooms will be lockable when not in use, will have locked cupboards for storage of dangerous objects and open shelves for safe objects (Position Paper 3: Dementia Care and the Built Environment (Alzheimer's Australia, 2004)).

A diversional therapy room for arts, crafts, music therapy and other group activities is required. Sizing will depend on the planned number of consumers to be in the room at a time and proposed equipment / furnishings to support activities e.g. piano.

CONSUMER BEDROOMS

It is highly desirable that bedrooms are oriented to receive morning natural light. All bedrooms should be designed to accommodate consumers using mobility aids / wheelchairs. One or more larger single bedrooms should be provided to accommodate a bariatric consumer.

Single bedrooms with en suites that are easily visible to and accessible by the consumer are preferred for privacy, as well as promoting flexible consumer management. This group tends to exhibit a range of antisocial behaviours or have special needs that can be disturbing to other consumers and which make shared bedrooms difficult to manage. A twin occupancy room in each cluster can satisfy socialisation and cultural needs, however as consumers will generally only enter their bedrooms for rest, sleep or ablutions, adequate supervised socialisation can occur in communal recreation areas.

Medical gases are not required in bedrooms, except where the consumer has a relevant medical condition (Design Guide for the Built Environment of Behavioral Health Facilities , Issue 7.0 (Sine, D, Hunt, JM(ed), 2015)). The design may include two to three bedrooms with fixed gases for this eventuality, as well as fixed gases in a suitable communal area. Consideration can be given to installing the piped gases in high dependency rooms where consumers are under closer observation, although frail consumers might be at risk in the high dependency environment if other high dependency occupants are aggressive. It is preferable to avoid the use of bottled gas as it can be used as a weapon or be a tripping hazard.

It is highly desirable that bedrooms are oriented to receive morning natural light.

In an Older Persons Sub-Acute Mental Health Unit, consideration can be given to inclusion of an independent living unit to assess independent living skills prior to discharge.

Opportunities should be provided to display and store personal memorabilia, in accordance with the Unit's operational policies and the consumer's risk, both outside of bedrooms to increase room recognition, e.g. consumer name and photograph on bedroom door as well as within bedrooms (The Impact of Light on Outcomes in Healthcare Settings, Issue Paper 2 (Joseph, A, 2006)).

Design and decor should permit personalisation of the space to aid recognition.

CONSUMER BATHROOMS

Individual en suites with direct access from the bedroom are preferred, however some shared en suites with corridor access could be considered in the acute zone. Note that shared en suites will limit the flexibility of the Unit in catering for the varied needs of clients, particularly given the age, behaviours and frailty of clients. Large en suites (6m²) will be provided to two larger bedrooms, allocated for bariatric or special needs consumers. Entry to these en suites may be via the corridor to allow ease of access for assisting staff.

En suites will have a shower, toilet and hand basin. The shower will enable use of a showering chair as required.

Avoid white on white in bathrooms as it is difficult for older people to detect changes in surface: instead use contrasting colours.

Fittings (such as towel rails and clothes hooks) will have a breaking strain of 15kg to minimise opportunities for self-harm. Other ligature points such as shower curtains need to be avoided through appropriate design. There should be a recessed area for a garbage bin; recessed toilet roll holders; toilet seats that resist breakage and removal; in-fill moulded hand rails (not in accessible toilets); and, recessed soap and shampoo shelf. Hand rails need to be colour contrasted to cue use, and should have a textured surface for

grip. A hand held shower should be standard, be removable, and have sufficient length to enable staff to shower a consumer safely, with a clip attachment.

Ensure doors to en suites open outwards against a wall. They will be lockable from the outside so that staff can deny access if necessary. If occupancy indicators are used they should be of larger size so that older people can see them. Doors will be able to be opened by staff in an emergency.

In the HDU, en suite doors will be able to be locked either in an open or closed position, depending on the particular needs of the consumer.

Options are required for bathing consumers who require lifting equipment, are resistant to bathing, or require the assistance of multiple staff. An ADL bathroom and consumer bathroom are optional inclusions which may be applicable for meeting these needs.

KITCHEN DINING ROOM

The kitchen will be a 'staff only' area for the receipt and preparation of meals. It should be located so that it has ready access for delivery of food supplies and meals.

Non-institutional, smaller dining rooms have been found to increase food intake in long term care settings for the elderly (The Impact of Light on Outcomes in Healthcare Settings, Issue Paper 2 (Joseph, A, 2006)). Square tables with rounded corners are preferred rather than round tables as they reduce confusion about seating placements (Dementia Care and the Built Environment, Issue Position Paper 3 (Alzheimer's Australia, 2004)). Tables should be able to accommodate four trays. They should be of sufficient height to accommodate wheelchairs. Dining chairs should have armrests.

The utilisation of walking aids or wheelchairs will impact on the circulation space required in the dining room.

There should be ready access to an accessible toilet. This may be the toilet in the bathroom if appropriately located.

The dining room should have direct access to an outdoor area that can be used in all weathers.

ACTIVITY & RECREATION AREAS - INDOOR

Indoor activity areas should be sized and furnished to accommodate a range of concurrent activities, including: cooking and eating meals; watching television; art activities; playing games; computers; library services; music related activities; telephone contact; indoor exercise; and a low stimulus room. Some jurisdictions also support the inclusion of a Snoezelen room.

Areas may include:

- quiet lounge;
- TV / music / computer room (media room);
- group recreation room (including lounges, games area, art / craft facilities);
- dining room;
- indoor exercise facility;
- ADL kitchen; and
- ADL laundry.

At least two lounge areas are suggested to support the management of different consumer groups. A large lounge for people engaged in a range of recreational and group activities should have direct access to a secure outdoor area, and be large enough to cater for all consumers, particularly when outdoor areas are unusable, e.g. during inclement or cold weather.

A small lounge for passive activities will accommodate up to eight people. Consideration may also be given to the provision of a female-only sitting room as one strategy to address personal safety concerns. The arrangement of furniture should seek to enhance social interaction.

Indoor and outdoor recreation areas will have visible disabled toilet facilities in close proximity.

The walking path may include a route through internal recreation areas as well as outdoor areas.

ACTIVITY AND RECREATIONAL AREAS - OUTDOOR

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

The following should be achieved in the design of outdoor spaces:

- visibility from day areas, avoiding blind spots for supervision purposes;
- screened from public view to protect privacy;
- ordered rather than wild gardens are recommended. Plants with soft rather than prickly foliage and non-toxic / low allergy plants (edible advantageous);
- surfaces should be even and non-slip to minimise the risk of falls;
- adequate shaded and weather sheltered areas;
- open / active areas for age appropriate activities such as gardening (e.g. raised garden beds), carpet bowls, a walking path;
- area for a vegetable garden;
- passive areas such as seating in landscaped gardens;
- a mix of fixed and non-fixed outdoor furniture;
- a barbeque area; and
- landscape features and plantings set back from the perimeter wall to avoid breaches of perimeter security.

Pacing should be discouraged by including a planned walking path. Ideally the path will encourage an appropriate, continuous route through indoor and outdoor areas and incorporate points of interest such as a garden vista, seating area or reading area. Incorporate rest stops and handrails while avoid long lengths of corridor and trip hazards.

A minimum outdoor area of 60m² is recommended to achieve active and passive areas. Additional space should be provided if the unit exceeds eight consumers.

HIGH DEPENDENCY INPATIENT ZONE

A high dependency unit (HDU), also known as an observation unit or intensive care unit, may be provided in a discrete area of the Unit, to manage consumers that have special needs for observation, or require physical separation to ensure their safety or that of others. Consumers could be: grossly unwell; exhibiting violent behaviours; suicidal tendencies; prone to falls; vocally disruptive; and / or physically dependent.

The HDU / Observation Unit is recommended to contain four to eight beds, depending on overall Unit size. Facilities should include bedroom / s, lounge, dining, bathroom facilities, interview room (able also to be used as a private observable visitor area), and a secure outdoor courtyard. Bathroom facilities may be shared or en suite with access control, according to local operational policies.

The Unit will require a low stimulus room (quiet / time-out room) for agitated and distressed consumers, or a seclusion room where supported by local policy. The room should be located in an area that minimises disruption to other Unit activities, either within the HDU or other quiet area. It will be plain, with comfortable but unbreakable fittings. Toilet and washing facilities should be nearby.

The HDU should be capable of secure separation from the general / open zone, but able to be used as an unlocked, open facility at other times. Access to the high dependency area will be controlled by staff. Consumer privacy will be protected by locating this zone separately from other consumers / visitors in the Unit (The Gender Sensitivity and Safety in Adult Acute Inpatient Units Project, Issue Final Report (Department of Human Services, Victoria, 2008)).

A direct entry to the high dependency area will be required for police-assisted admissions, or admissions that are highly disturbed.

VISITOR / FAMILY AMENITIES

Amenities for carers and visitors include access to a lounge area for private interactions with the consumer and staff, and a kitchenette. Design of such areas should ensure that children can visit family members safely (Medium Secure Mental Health Inpatient Unit Design Considerations, Issue Draft (Queensland Health , 2009)).

Family interview space is available in the reception area, as well as in meeting rooms located in the Unit.

MEETING ROOMS

At least one large multi-purpose meeting room is required for group therapy, staff meetings, staff education and family meetings. The multipurpose meeting room will also be suitable for formal hearings involving approximately fifteen to eighteen people. At least one meeting room should be equipped for telepsychiatry services.

The number of meeting rooms provided will depend on the number and nature of other rooms available in the Unit, the staff profile and proximity to other hospital meeting facilities.

Meeting rooms used for consumer interactions, such as formal hearings, will have two doors and have separate access from the high dependency zone. These areas may have jurisdictional specific requirements as part of the inclusion and fit-out of this space, and should be considered as part of the planning process to best meet the needs of the planned service.

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

CLINICAL AND NON-CLINICAL SUPPORT AREAS

Support areas are to include:

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

STAFF STATION / CLINICAL RESOURCE ROOM

It is suggested that these two functions be combined.

An 'open' counter area, screened for safety with wire strands or offset laminate glass panels, could be considered for staff and for consumer / visitor interactions. An adjoining clinical resource room (quieter enclosed office) can be provided in which confidential discussions can occur. Functions for these two spaces might be arranged as follows.

Staff Station with:

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

Clinical Resource Room to accommodate:

- staff handovers and case discussions;

- medical records storage; and
- locker storage for staff personal belongings, if a separate locker room is not provided.

Ideally, the Unit's design should facilitate a single, centrally located, staff station with a good line of sight through the Unit, including the lounge and activity areas and to the HDU, while providing an escape route / safe haven for staff. However, the unit location and site footprint may not always allow this. The staff station should be configured in a way that promotes communication amongst staff and between consumer / carer and staff.

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

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

If this Unit is a stand-alone mental health unit, a dedicated staff room, outdoor area and multipurpose meeting facility will be provided. If part of a larger mental health facility, these amenities can be shared.

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

MEDICATION ROOM / CLEAN UTILITY

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

Direct internal access from the staff station or treatment room may be considered, although this may have the disadvantage of creating unnecessary traffic through the staff station.

TREATMENT ROOM

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

Separate access is required for consumers from the high dependency zone.

STORAGE

The Unit will require multiple storage areas for clinical, non-clinical and bulky equipment storage such as wheel chairs, lifters, bariatric beds, special chairs, mattresses, pillows, walking frames or nursing aids, as well as equipment used in allied and diversional therapy. Storage areas should be located next to recreation areas for recreational equipment (indoor and outdoor) as well as in close proximity to therapy rooms and bedrooms.

It will not be acceptable for equipment to be stored in corridors as this will present a trip hazard to consumers, create potential for items to be used as weapons, and is a fire hazard.

STAFF OFFICES AND AMENITIES

The office for the Unit manager / Nurse Unit Manager should be located in the Unit so that they are readily available to support and supervise staff, as well as having ready access to clinical information. Other offices, workstations and staff amenities should be located away from inpatient areas with no consumer access. This may be on an upper floor that can be secured after hours and at weekends while still allowing authorised staff access.

The practice of seeing consumers in offices should be discouraged. Sufficient consultation rooms should be provided to avoid this.

Staff amenities will include a staff room and outdoor area, located to provide privacy to staff whilst on breaks. These amenities will be accessible at all times for staff use. Other staff amenities such as toilets, showers, car parking and lockers will be provided.

02.05 Functional Relationships

EXTERNAL

The Unit has functional relationships (of varying degrees) with the following services:

- police and ambulance services;
- adult mental health units;
- geriatrics / acute medical beds;
- theatres (ECT);
- medical imaging (CT scans);
- neurology unit (EEGs);
- pathology;
- other mental health services for older persons including community teams, intensive outreach services, crisis teams and day programs; and
- drug and alcohol services.

INTERNAL

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

The central reception zone should feed into the inpatient area and, if applicable, the day hospital.

The inpatient area would have a central shared support zone consisting of staff station, therapy areas, meeting rooms, education room and other activity areas.

Ideally, and dependent on the Unit's bed numbers and consumer profile, the inpatient area will be zoned to allow for appropriate grouping / separation of inpatients.

Recreation areas, indoor and outdoor, will be located in proximity to each group of bedrooms.

The HDU will be in a separate area of the Unit that has direct entry and access to the treatment / clean utility rooms.

Staff offices and amenities will be located in a consumer free zone.

03 DESIGN

03.01 Accessibility

EXTERNAL

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

A separate, secure, entry for police assisted and involuntary consumers is required to access the high dependency zone.

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

INTERNAL

Access to the Unit will not be through other units, nor will the Unit be a thoroughfare to any other units.

03.02 Parking

The following provisions should be made:

- all weather drop-off for disabled consumers and carers;
- short term parking for police or ambulance vehicles; and
- ensure visitor parking is in close proximity to the unit.

For staff parking, refer to Part C: Section 790, Safety and Security Precautions for further information.

03.03 Disaster Planning

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

Refer to Part B: Section 80 General Requirements and Part C: Design for Access, Mobility, OHS and Security, Space Standards and Dimensions for further information.

03.04 Infection Control

GENERAL

Refer to:

- Part D: Infection Prevention and Control, Australasian Health Facility Guidelines: and
- jurisdiction policies and guidelines.

HAND BASINS

Hand basins are required in treatment and medication rooms. Corridor basins may be replaced by alcohol hand-wash in dispenser units.

03.05 Environmental Considerations

ENVIRONMENTALLY SUSTAINABLE DESIGN

Sustainability applies to many areas such as:

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

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

ACOUSTICS

The Unit's design needs to manage auditory stimuli to limit distress and confusion for the consumer group, who are particularly sensitive to noise, as well as protecting confidentiality of consumer information. Noise may compromise consumer comfort and recovery, particularly if it is impacting on the ability of a consumer to sleep.

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

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

Solutions to be considered include:

- location of the Unit;
- use of sound absorbing materials and finishes;
- sound isolating construction;
- special acoustic isolation is required for low stimulus rooms, high dependency / observation unit, consultation / therapy rooms, and some bedrooms for consumers prone to screaming;
- general acoustic isolation is required between bedrooms, en suites and indoor recreation areas (Charter for Mental Health Care in NSW (NSW Health, 2000));
- in acoustically treated rooms, return air grilles should be acoustically treated to avoid transfer of conversations to adjacent areas. Door grilles to these areas should be avoided;
- separation of quiet areas from noisy areas e.g. Service rooms located away from bedrooms;
- use of door hardware to prevent slamming; and
- changed operational management.

Hearing loops can be provided for consumers who are hearing impaired.

Playing music in the Unit is associated with a reduction in screaming (The Management and Accommodation of Older People with Severe and Persistent Challenging Behaviours in Residential Care (RANZCP, 2004)).

Refer to AusHFG Part C: Design for Access, Mobility, OHS and Security, Space Standards and Dimensions (AHIA, 2010) for further information.

NATURAL LIGHT

Natural light contributes to a sense of wellbeing for all building occupants including consumers, staff and other users. A limited number of research studies suggest a link between greater levels of natural light with improved clinical outcomes. Exposure to morning light in particular should be maximised throughout the building. It has been shown to reduce length of stay for persons with depression and reduce agitation in dementia consumers (Joseph 2006).

Natural light is required to all bedrooms in accordance with the Building Code of Australia (BCA) (ABCB, 2015). Higher levels of natural light may help people better orient themselves in the building thus enhancing wayfinding. However, glare should be minimised.

Greater use of natural light may also reduce energy usage in terms of reducing the need for artificial lighting.

For these reasons, the use of natural light should be maximised throughout the unit

PRIVACY

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

Strategies to enhance privacy include:

- single bedrooms;
- en suites;
- acoustic treatment;
- single gender areas;
- discreet location of HDU and low stimulus rooms; and
- no vision into the Unit from outside the Unit.

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

INTERIOR DÉCOR

Interior décor includes furnishings, style, colour, textures, ambience, perception and taste. This can help prevent an institutional atmosphere. However, cleaning, infection control, fire safety, consumer care and the consumers' perceptions of a professional environment should always be considered.

Some colours, particularly the bold primaries and green should be avoided in areas where clinical observation occurs such as bedrooms and treatment areas. Such colours may prevent the accurate assessment of skin tones e.g. yellow / jaundice, blue / cyanosis, red / flushing.

Colour contrasts between adjoining surfaces are required (Queensland Health 1999). However extremes of colour, patterns such as geometric designs or highly reflective surfaces which may disturb perception should not be used. Visual stimulation can be managed through the application of colour to highlight doors that consumers will use (bedrooms, bathrooms) and neutrals to hide doors that they will not use (e.g. utility rooms and staff areas) (Adapting the Ward: for People with Dementia (Fleming, R., Forbes, I. and Bennett, K., 2002)). Variation in floor and wall surfaces can assist in wayfinding.

Decor should be domestic in style rather than institutional and be familiar from the consumers' early adulthood rather than reflecting more contemporary design. Furniture should also provide functional

assistance to older people with age-related physical limitations (e.g. seat height, fabrics on chairs for continence issues).

SIGNAGE AND WAYFINDING

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

All signage and wayfinding should be easily understood by staff and the general public whether consumers or visitors, and where necessary and appropriate, languages other than English should also be used.

Signage should comply with guidelines to promote access for people with disabilities.

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

Specific signage considerations for this group are:

- placement of some signage on the floor or lower on the wall / door to attract downcast eyes which are typical of this consumer group;
- use of pictorial guides (Improving Services and Support for Older People with Mental Health Problems, UK Inquiry into Mental Health and Well-Being in Later Life, Issue 2nd Report (Age Concern, 2007)); and
- use of distinctive objects as landmarks (Dementia Care and the Built Environment, Issue Position Paper 3 (Alzheimer's Australia, 2004)).

Refer to Part C: Section 750, Signage and TS-2: Wayfinding for Healthcare Facilities, Issue 5th Ed (NSW Health, 2008).

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. For details refer to Part C: Section 730, Human Engineering, Australasian Health Facility Guidelines.

ERGONOMICS

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

Furniture and fittings should be selected to functionally assist older people with age-related physical limitations. For example:

- chairs with arms and higher seats to assist sitting and standing;
- tap ware / door handles designed with arthritic hands in mind;
- raised toilet seats;
- adjustable beds that can be lowered when consumers are resting to minimise injury resulting from falls, but then raised to assist staff in administering consumer care; and
- firm, secure and steady furniture.

Suicide proof hand rails and grab rails are an essential aid to the frail, particularly in bathrooms, corridors, outdoor areas and activity spaces (Best Practices: Environmental and Therapeutic Issues in Psychiatric Hospital Design: Toward Best Practices, Psychiatric Services, Vol 57, Issue 10, pp1376-1378 (Karlín BE, Zeiss RA, 2006)). However these are to be designed in order to minimise opportunities for self-harm.

Refer to Part C: Section 730, Human Engineering for details.

ACCESS AND MOBILITY

Where relevant, design should comply with AS/NZS 1428:2010 Design for Access and Mobility (Set) (Standards Australia, 2010). This would apply to bathrooms, public access toilets and en suites designed for independent wheelchair users. Note that consumers in this Unit often require mobility aids which need to be accommodated in all consumer areas.

Wheelchair-bound staff including nursing, clerical, support and management should also be accommodated in accordance with AS/NZS 1428:2010 Design for Access and Mobility (Set) (Standards Australia, 2010).

Refer to Part C: Section 730, Human Engineering, for details.

BUILDING ELEMENTS

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

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

DOORS AND DOORWAYS

Ensure that doorways are sufficiently wide and high enough to permit the manoeuvring of beds, wheelchairs, trolleys and equipment without risk of damage or manual handling risks.

Bedroom doors should open outwards to prevent consumers blockading themselves in their bedroom. Outward opening doors should be recessed to prevent obstruction of corridors. Bedroom doors should also have a viewing panel.

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, smaller panes are recommended as they are inherently stronger than larger pane sizes.

Impact-resistant and shatter-proof Grade A safety glass to comply with AS/NZS 2208:1996 Safety glazing materials in buildings (Standards Australia, 1996) Safety Glazing Materials in Buildings is the recommended choice. Polycarbonate is not recommended as it suffers from surface scratching which in turn obscures vision.

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

SHUTTERS

If shutters are used to secure a food and beverage servery, kitchenettes and linen bays, the following Occupational Health and Safety (OHS) requirements apply:

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

An alternative that can be considered includes doors that can be locked in the open as well as closed position.

03.07 Safety and Security

SAFETY

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

Facility planners and designers should enhance safety through choices regarding the design, methods of construction, materials used, and the choice of fittings, fixtures and equipment.

Special consideration should be given to the safety needs of older persons, including:

- medication safety;
- minimisation of the risk of medical deterioration;
- reduction of aggressive behaviour;
- cultural safety of indigenous people;
- reduction of falls;
- safety of staff and visitors in the Unit;
- ability to call for assistance; and
- containment of consumers within the Unit.

Strategies to address these safety concerns include:

- any fitting or fixture capable of supporting a consumer's weight should be avoided, unless it is an item of furniture intended to bear the consumer's weight. Fittings in this Unit require a breaking strain of no more than 15kg;
- rounded edges on furniture;
- even walking surfaces, inside and outside, and avoidance of trip hazards;
- prominent and large call buttons easily accessible and visible to all consumers, including those who are visually impaired or have limited manual ability;
- light switches proximal to beds to assist safe movement to the toilet at night;
- Unit exits or doors to external functional areas (e.g. garbage disposal and loading dock) should be located out of consumer view (Adapting the Ward: for People with Dementia (Fleming, R., Forbes, I. and Bennett, K., 2002));
- consultation, interview, formal hearings room and activity areas should have two doors for locations of egress;
- older persons are particularly prone to burns from hot water, so hot water controls will be in place (Adapting the Ward: for People with Dementia (Fleming, R., Forbes, I. and Bennett, K., 2002)); and
- for units that admit consumers with behavioural and psychological symptoms of dementia (BPSD), or consumers who exhibit aggression, separation of consumers may be required.

Limiting the risk of suicide through design needs to be balanced with the need for older consumers to maintain independence, through provision of appropriately designed handrails, taps, door handles etc.

SECURITY

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

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

Security features may include:

- transfer lobby / airlocks;
- electronic locking;
- intercoms;
- CCTV / video surveillance;
- personal and fixed duress alarms;
- movement sensors / floor sensors in bedrooms / en suites;
- all rooms should be lockable, including corridor cupboard doors and fire hose reel cabinets; and
- perimeter fencing height to be between 2.7m and 4.8m.

RISK AND HAZARD MANAGEMENT

The physical environment has a significant impact on the health and safety of end users. A risk management approach ensures risks are managed systematically utilising a process that supports the anticipation, identification and avoidance of risks that may have an impact on users and services.

Broad consultation with all stakeholders (as well as other recognised processes) to identify risks should ensure security, and health and safety risks are proactively managed.

Individual jurisdictions should refer to their local legislation for further requirements for plant and buildings.

OHS legislation requires designers to identify, assess and control risks in order to provide an optimal ergonomic design, and to do this in consultation with stakeholders.

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

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

Refer to National Safety Priorities in Mental Health: a National Plan for Reducing Harm (National Mental Health Working Group, 2005) for more information.

ACCESS CONTROL

The Unit should be designed with controlled entry and exit points so that consumer movements can be supervised and no consumer should be able to leave the Unit unobserved. Public access to the Unit will be via a central reception point.

If the Unit is located within a multi-storey building, it should be ensured that there is no unauthorised and unsupervised access to external spaces above ground level such as balconies or the roof.

CLOSED CIRCUIT TELEVISION (CCTV) SURVEILLANCE

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

The following factors should be considered in relation to the use of CCTV for security purposes:

- health service policies;
- the rights of consumers to privacy, balanced against the need for observation for safety and security reasons;
- the ability of the staff establishment to manage the level of observation required without the use of CCTV;
- the fact that monitors may not always be able to be manned;

- maintenance costs; and
- the potential to avoid use of video security with improved functional design.

DURESS ALARM SYSTEM

A combination of personal and fixed duress alarms is recommended in the Unit, including outdoor areas. They should be provided in accordance with jurisdiction health policies.

All staff should carry a personal duress alarm with location finder, linked to a real time monitor facility. The charger for personal alarms should be located in a staff-only area accessible 24 hours per day.

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

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

Refer to Part C: Design for Access, Mobility, OHS and Security, Space Standards and Dimensions, for further information.

PERIMETER SECURITY

The Unit requires a secure perimeter. A recommended height for perimeter fencing has not been established. A typical range is 2.7m to 4m, however fencing should not be so high as to create a prison-like environment or to increase the possibility of injuries due to falling, should an escape attempt be made. In determining an appropriate height, consideration should be given to the proximity of the perimeter fence to buildings, the topography of the site and consumer profile. Attention should be given to the visual interest (such as different panelling), the visual interest privacy and opportunities for longer distance views. Security is enhanced by installing curved fencing rather than having angled joins.

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

For further information refer to:

- AS/NZS ISO 31000:2009 Risk management - Principles and guidelines (Standards Australia, 2009);
- Part C: Section 790, Safety and Security Precautions;
- individual jurisdiction policies and OHS legislation; and
- TS11 - Engineering Services and Sustainable Development Guidelines (NSW Health, 2013).

03.08 Finishes

GENERAL

Finishes in this context refers to walls, floors, windows and ceilings. Refer to Part C: Section 710, Space Standards and Dimensions, Australasian Health Facility Guidelines (AHIA, 2010).

WALL FINISHES

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

FLOOR FINISHES

The selection of floor finishes should be appropriate to the function of the specific area. Furthermore, the acoustic performance, slip resistance, consequence of consumer / consumer falls, and infection control

issues should also be considered. Consideration should be given to manual handling issues including the impact of the flooring on push / pull forces for wheeled equipment, including trolleys and beds.

The selection of flooring should be adequate to avoid the potential for slips and trips to occur, including as a result of joints between flooring.

This consumer group is easily disoriented by surfaces which reflect light. Shiny floor coverings which reflect glare are a barrier to consumers moving comfortably around the Unit (glare on floors can be interpreted as water) and may cause falls. Plain colours rather than patterns should be considered.

The use of both carpet and vinyl will be applicable to this Unit because of its status as an acute unit caring for older people. Soft floor coverings such as carpet and padded vinyl are desirable as they minimise injuries incurred as a result of falls. Variation in floor surfaces will also delineate functional areas, thus assisting consumer orientation.

Refer to:

- Part D: Infection Prevention and Control, Australasian Health Facility Guidelines (AHIA, 2015);
- TS7 - Floor Coverings in Healthcare Buildings, Issue V1.1 (NSW Health, 2009); and
- Part C: Section 710, Space Standards and Dimensions.

03.09 Fixtures, Fittings & Equipment

DEFINITIONS

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

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

Refer to Part C: Section 710, Space Standards and Dimensions and to the Standard Components - Room Data Sheets (RDS) and Room Layout Sheets (RLS) for further detailed information.

Also refer to Part F: Section 680 Furniture Fittings and Equipment.

GENERAL PRINCIPLES

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

Any fitting or fixture capable of supporting a consumer's weight should be avoided, unless it is intended to be weight bearing furniture intended. Fittings in this Unit require a breaking strain of no more than 15kg.

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

ARTWORK, SIGNAGE AND MIRRORS

All artwork, signage and mirrors should be rigidly fixed to walls with concealed, flush, tamper-proof mountings. The involvement of consumers in the selection of art works is preferable, where possible.

Mirrors should be made from safety glass or other appropriate impact-resistant and shatterproof construction, scratch proof, and free from distortion. Mirrors should be securely glued to a backing to prevent loose fragments of broken glass.

PLUMBING FIXTURES

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

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

Water and electrical supply shut-off systems should be installed, preferably in the staff station, to reduce the risk of inappropriate use of showers and consequent flooding, or access to live electrical currents if the consumer is considered extreme risk

RAILS, HOOKS AND HANDLES

Where used, rails and hooks that collapse under a breaking strain of 15kg should be provided.

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

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

All door and cupboard handles / knobs should be designed to avoid ligature points. Fittings moulded to incorporate hand pulls should be considered where possible, to avoid the use of handles.

SHOWER CURTAINS AND TRACKS

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

Floor barriers (screen tracks or hobs) should be avoided as they are trip hazards and also decrease manoeuvrability for consumers with mobility aids.

Where installed, shower tracks should be plastic and mounted flush to the ceiling. It is critical to ensure that the entire track plus hooks has a 15kg breaking strain, so that if the curtains are gathered into a single cluster the aggregate does not exceed 15kg. Tracking which allows the hooks to be pushed together, should not be installed, as this increases the breaking strain far beyond the 15kg limit.

WINDOW TREATMENTS

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

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

When selecting the fabric types give consideration to the weight / thickness and ease of tearing.

LIGHTING

High levels of illumination are required for older consumers, particularly those with dementia (Best Practices: Environmental and Therapeutic Issues in Psychiatric Hospital Design: Toward Best Practices, Psychiatric Services, Vol 57, Issue 10, pp1376-1378 (Karlin BE, Zeiss RA, 2006)).

Variable lighting in the evening, rather than on / off lighting, can reduce aggression. The quality of darkness should be maximised at night to enhance sleep. Night lights are required as a fall prevention strategy, so positioning should be carefully considered so as not to disturb sleep. Low wall lighting with light projected towards the floor should be considered in bedrooms and corridors to illuminate the floor and maintain low levels of lighting at night for consumers and staff.

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

03.10 Building Service Requirements

GENERAL

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

- Part E: Building Services and Environmental Design;
- TS11 - Engineering Services and Sustainable Development Guidelines, Technical Series TS11 - Engineering Services and Sustainable Development Guidelines (NSW Health, 2013); and
- Health Facility Guidelines for Engineering Services (Department of Health, WA, 2006).

AIR HANDLING SYSTEMS

Provision of natural ventilation to consumer care areas should be approached with caution. The management of airflows and the creation of a stable environment are essential to the control of the spread of infection, so generally air conditioning should be provided. Project staff may refer to Part D: Infection Prevention and Control and AS/HB 260-2003: Hospital acquired infections - Engineering down the risk (Standards Australia, 2003).

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

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

Refer to TS11 - Engineering Services and Sustainable Development Guidelines, Technical Series TS11 - Engineering Services and Sustainable Development Guidelines (NSW Health, 2013) for further information.

ELECTRICAL SERVICES

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

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

FIRE SAFETY

Fire requirements are covered by relevant building codes and standards.

Smoke and thermal detectors should be tamper-proof or be located so as to be inaccessible to consumers.

Fire mimic panels should be installed in staff stations.

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

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

INFORMATION TECHNOLOGY AND COMMUNICATIONS

Systems may include:

- wireless technology;
- radiofrequency identification (RFID) for access control, locks etc.;
- duress alarm systems - fixed and personal as required;
- nurse / emergency call systems;
- voice / data (telephone and computers);
- videoconferencing / telepsychiatry capacity;
- electronic medical records;

- consumer administration systems (PAS);
- paging and personal telephones replacing some aspects of call systems;
- bar coding for supplies and X-rays / records;
- consumer information screen integrated with menu ordering, nurse call and other modalities;
- server and communications rooms; and
- e-medication management and e storage systems e.g. automated dispensing systems.

STAFF AND EMERGENCY CALL SYSTEM

Healthcare facilities should provide a call system that allows consumers and staff to alert other staff in a discreet manner at all times. These systems should be compatible throughout the facility.

Call systems should be designed and installed to comply with AS 3811 - Hard wired Patient Alarm Systems (Standards Australia, 1998).

The call system should:

- allow change of the call notification between end users and the system;
- operate within acceptable noise levels; and
- provide sufficient capacity in terms of the anticipated level of use.

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

HYDRAULIC SERVICES

Warm water systems will be required.

MEDICAL GASES

Two to three bedrooms may be fitted with fixed medical gases to cater for those consumers with a relevant medical condition (Design Guide for the Built Environment of Behavioral Health Facilities, Issue 7.0 (Sine, D, Hunt, JM(ed), 2015)). The HDU may be the appropriate venue for these fixed gases given that HDU occupants are under higher levels of observation, however, the higher level of psychiatric acuity in this Unit may be counterproductive to consumers who have a medical co-morbidity requiring medical gases. Fixed gases in a suitable communal area can also be beneficial.

It is preferable to avoid bottled gas in this Unit as it can be used as a weapon or be a trip hazard.

Consideration may be given to recessed or covered service panels enclosing oxygen, suction, and air outlets to minimise the risk of injury to or damage by consumers with dementia. Project staff should refer to Standard Components - Room Data Sheets (RDS) and Room Layout Sheets (RLS) for consumer bedrooms for further advice.

04 COMPONENTS OF THE UNIT

04.01 Standard Components

Rooms / spaces are defined as:

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

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

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

04.02 Non-Standard Components

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

- Interview Room - Family / Large;
- Store - Medication Room / Clean Utility;
- Consultation Room and Interview Room - Exam Assessment;
- Dining Room / Beverage Bay;
- Pantry;
- Recreation / Day Area;
- Indoor Exercise Facility;
- Courtyard - general;
- Police / Ambulance Enclosed Transfer Area;
- Low Stimulus Room; and
- Lounge / Dining / Activity – HDU.

INTERVIEW / FAMILY ROOM - LARGE

Description and Function

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

Location and Relationships

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

Considerations

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

STORE - MEDICATION ROOM / CLEAN UTILITY

Description and Function

This is a room in which medications, a medication trolley, medical equipment and sterile stock (if desired) can be securely stored. Refer to the Standard Component Room Data Sheet for a Clean Utility, which performs a similar role, but is larger than that proposed for this Unit.

Location and Relationships

Consumers are not permitted to enter this room. It should be located centrally in the staff support area and be convenient to the HDU. Direct internal access from the staff station or treatment room may be considered, however traffic / circulation routes should be carefully considered to avoid congestion.

Considerations

The room should be sized to allow sufficient space for storage of trolleys and other medical equipment.

It may be preferable for operational reasons for the Unit's sterile stock to be stored in the Treatment Room.

Schedule drugs should be stored in accordance with the relevant act and regulations. Other medications may be stored on open shelving. Sloping pharmacy style shelving is preferred.

CONSULTATION ROOM - LARGE AND INTERVIEW ROOM / EXAMINATION / ASSESSMENT ROOM

Description and Function

This room provides for the consultation and examination of consumers. In this Unit it is beneficial for potentially agitated consumers to have sufficient personal space. For this reason a larger than standard consultation room has been allowed.

Location and Relationships

It should be located in the therapy / treatment zone. The HDU may incorporate an interview room / examination and assessment room that can also be used for private family visits.

Considerations

A second egress point is required.

DINING ROOM

Description and Function

This is an area for consumers to eat meals and snacks, accompanied by staff and visitors.

Location and Relationships

The dining room should be located directly adjacent to the pantry / kitchen, preferably with a serving counter between the two areas that can be secured. Views over a garden / outdoor area are desirable.

Considerations

A hand washing bay should be included. Square or rectangular furniture is preferred, as it allows flexibility in the arrangement of tables. Furniture should be selected that can easily be moved if different configurations are required. Circulation spaces should take into account the use of mobility aids.

RECREATION / DAY AREA

Description and Function

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

Location and Relationships

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

Considerations

As this is the main living space for consumers, every effort should be taken to create a domestic environment. The layout should ensure whole group activities are possible, however, provision of a sub-lounge or sectioning some of the space through furniture placement assists in creating a more intimate atmosphere.

Lockable storage for activities should be incorporated in this area.

Provide a consumer telephone in the vicinity, located to avoid disturbance to, or by, other consumers.

PANTRY

Description and Function

A room for the receipt and serving of meals. It will have a large servery counter that allows capable consumers to serve themselves at meal / snack times.

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

Location and Relationships

The pantry should be 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.

Considerations

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

INDOOR EXERCISE FACILITY

Description and Function

This space is included as an option. Regular physical exercise is acknowledged as an important strategy in managing mental illness.

Location and Relationships

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

Considerations

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

SECURE ENTRY ZONE

Description and Function

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

- a fully enclosed parking zone for police and ambulance vehicles that can be secured by a lockable roller door. This reduces the risk of an escape when the van doors are opened;
- an entry lobby capable of accepting an ambulance trolley and at least two emergency personnel with ease;
- consideration of electronic doors;
- separate area for police to disarm and for gun storage;
- examination / assessment room with en suite shower and toilet (optional); and
- a small work space for use by escorting officers to complete required paperwork.

Location and Relationships

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

There should be easy access to the examination / assessment room, and to the low stimulus room.

Considerations

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

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

LOUNGE / DINING / ACTIVITY ROOM

Description and Function

This is a shared area for HDU consumers to dine, watch television or participate in other activities. Noise, when concurrent activities are being undertaken in a shared space, should be considered as this may

contribute to the confusion of these consumers. The design of this space will require careful consideration as part of the design development process.

Location and Relationships

Preferably it should be located immediately adjacent to HDU bedrooms, and with direct supervision from the staff station. Direct access is required to an outdoor courtyard.

Considerations

Furnishings for this area should be for maximum comfort and function, while being mindful that consumers in the HDU have a higher level of acuity and are therefore more at risk.

LOW STIMULUS ROOM

Description and Function

This is a room where consumers who are agitated and / or require some 'time-out' may go voluntarily for brief periods.

Location and Relationships

This room is best placed in a quiet area of the Unit that affords occupants privacy from other consumers, ideally located so that it can swing between the open / general zone and the HDU.

Considerations

Size as for a standard seclusion room, but furnish more comfortably to support the therapeutic goals of low stimulation.

AX APPENDICES

AX.01 Schedule of Accommodation

A schedule of accommodation is shown below. It lists generic spaces for this Unit, and assumes a 12 bed unit comprised of 1 x 8 bed cluster and 1 x 4 bed HDU. The quantities and space sizes will need to be determined for individual units on a case by case basis.

The 'Room/ Space' column describes each room or space within the Unit. Some rooms are identified as 'Standard Components' (SC) or as having a corresponding room which can be derived from a SC. These rooms are described as 'Standard Components –Derived' (SC-D). The 'SD/SD-C' column identifies these rooms and relevant room codes and names are provided.

All other rooms are non-standard and will need to be briefed using relevant functional and operational information provided in this HPU.

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

ENTRY / RECEPTION

AusHFG Code	Room	Room / Space	SC / SC-D	Qty	m2	Remarks
AIRLE-10		Airlock - Entry, 10m2	Yes	1	10	
INTF		Interview Room	Yes	1	14	Access to enclosed outside courtyard is beneficial
RECL-10		Reception / Clerical, 10m2	Yes	1	10	
WCAC		Toilet - Accessible, 6m2	Yes	1	6	Includes baby change facilities
WAIT-10		Waiting, 10m2	Yes	1	10	
		Discounted Circulation %			32%	

CONSUMER / PATIENT AREA - 8 BED CLUSTER

AusHFG Code	Room	Room / Space	SC / SC-D	Qty	m2	Remarks
1 BR-MH		1 Bed Room - Mental Health, 14m2	Yes	6	14	
		1 Bed Room - Special, 18m2		2	18	Bariatric patients and support increased mobility equipment.
ADLB		ADL Bathroom	Yes	1	12	Optional
ADLBR		ADL Bed Room	Yes	1	15	Optional - for assessment prior to discharge
ADLK-ENC		ADL Kitchen	Yes	1	12	
ADLL		ADL Laundry	Yes	1	8	
BATH		Bathroom	Yes	1	15	Optional. May be fitted with lifting equipment or require use of mobile equipment.
BHWS-B		Bay - Handwashing, Type B	Yes	2	1	1 per 4 beds
		Consult Room		2	14	
		Courtyard - General		1	60	A minimum recommended size. Additional space should be provided for units that exceed 8 consumers/ patients.
DINBEV-25		Dining Room / Beverage Bay (Mental Health)	Yes	1	30	Assumes 8 consumers plus 2 family members. Includes refreshments bar. Use for activities at other times.
ENS-MH		Ensuite - Mental Health, 5m2	Yes	6	5	Some individual ensuites may be substituted with shared ensuites with corridor access
		Ensuite - Special, 6m2		2	6	Bariatric patients and support increased mobility equipment.
		Indoor Exercise Facility		1	20	Optional
LNPT-10		Lounge - Patient / Family	Yes	2	15	Reading, reflection, gender specific area, quiet music room etc.
LNPT-10		Lounge - Patient / Family	Yes	1	15	Private family visits. Includes lockable beverage bay.
MEET-L-30		Meeting Room, 30m2	Yes	1	30	Activities, group music, occupational therapy. Includes wet area.
MEET-L-30		Meeting Room, 30m2	Yes	1	30	Formal hearings, staff meetings, in-service, family conferences.
		Multifunction Area		1	40	Includes areas for consumer telephone, computer, television, lounges. Note: 1.7m2 per bed may be added if shared space.
PTRY		Pantry	Yes	1	12	Collocated with Dining Room. Includes serving bench
STGN-9		Store - General, 9m2	Yes	1	9	Activity equipment
CLUR-12		Clean Utility / Medication Room, 12m2	Yes	1	10	
STPP		Store - Patient Property	Yes	1	8	
WCAC		Toilet - Accessible, 6m2	Yes	1	6	Access from recreation areas.
TRMT		Treatment Room	Yes	1	14	Includes spatial allowance for resuscitation trolley (1m2) and exam couch (3m2)
		Discounted Circulation %			32%	

The above refers to an 8 bedded unit.
Note that 0.7m2 is added per bed, and is shared space.

Australasian Health Facility Guidelines

HIGH DEPENDENCY UNIT - 4 BEDDED

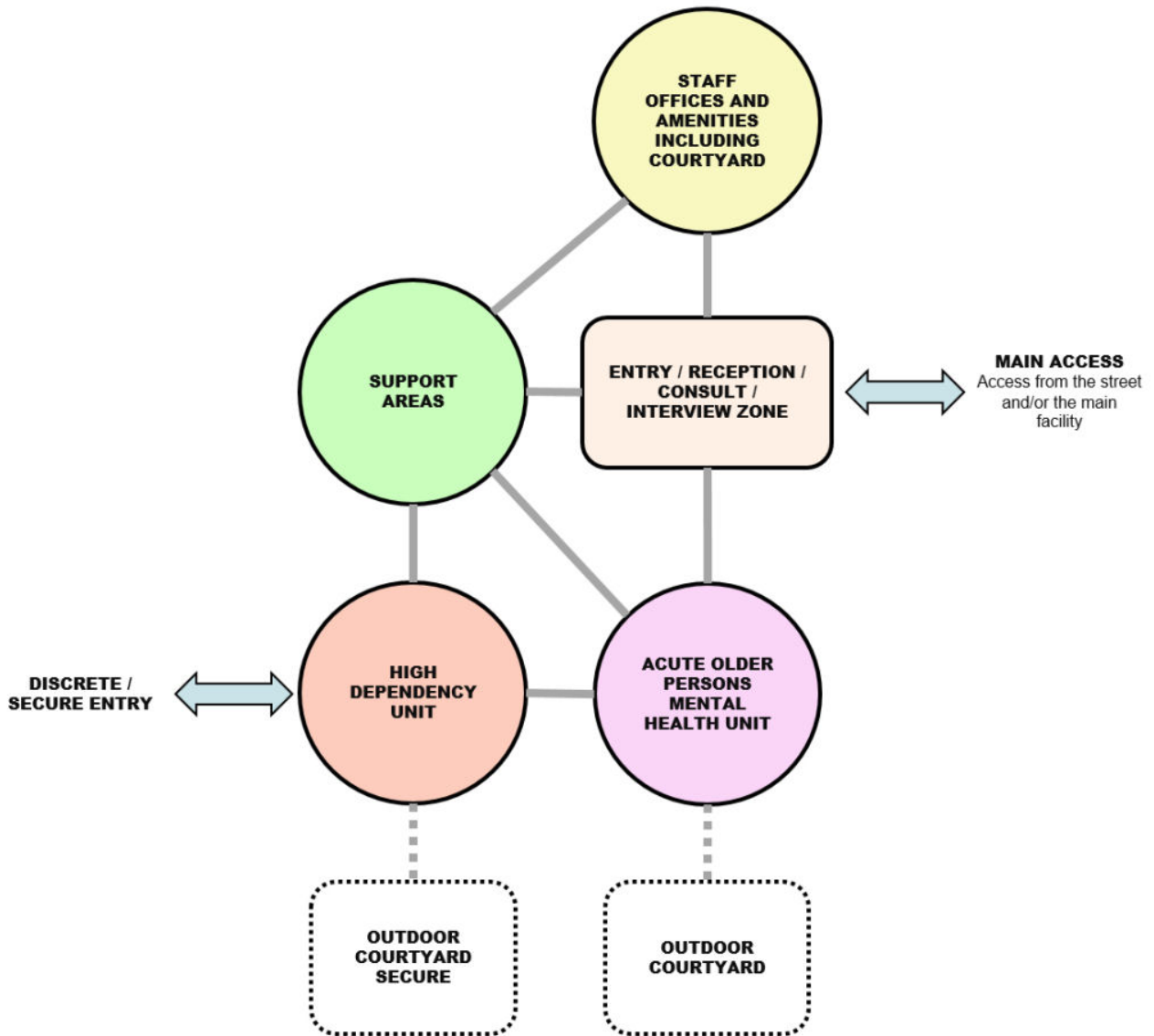
AusHFG Code	Room	Room / Space	SC / SC-D	Qty	m2	Remarks
		Police / Ambulance Enclosed Secure Transfer Area		1	20	Gun safe - Allow additional 1m2 per gun safe when included. This is to be a secure area concealed from public view. The number of gun safes that would be required is a jurisdictional specific requirement e.g. x 2
1 BR-MH		1 Bed Room - Mental Health, 14m2	Yes	4	14	
AIRLE-10		Airlock - Entry, 10m2	Yes	1	10	Secure for involuntary or aggressive consumers
BHWS-B		Bay - Handwashing, Type B	Yes	1	1	
		Courtyard - HDU		1	40	10m2 per consumer - weather protection provided
ENS-MH		Ensuite - Mental Health, 5m2	Yes	1	5	Optional - adjoining Exam Assessment
ENS-MH		Ensuite - Mental Health, 5m2	Yes	4	5	Alternatively, provide: Toilet - Patient x 2; Shower - Patient x 1
INTF		Interview Room	Yes	1	14	Optional. Also used for visitors.
		Lounge/ Dining/ Activity		1	30	7.5m2 consumer
		Low Stimulus Room		1	14	Built to seclusion room specification, but furnished more comfortably. Preferably able to swing between HDU and General zones.
SECL		Seclusion Room	Yes	1	15	Optional: Maybe located with lounge - Low Stimulus Room to replace 'seclusion' room as part of low stimulus area = 10m2.
SSTN-14		Staff Station, 14m2	Yes	1	14	Optional - depending on whether planning allows a shared Staff Station with General/ Open zone.
STGN-9		Store - General, 9m2	Yes	1	9	General storage needs
WCPT		Toilet - Patient, 4m2	Yes	1	4	Available for consumers in low stimulus or seclusion room.
WAIT-SEC		Waiting - Secure, 6m2	Yes	1	6	
		Discounted Circulation %			32%	

CLINICAL SUPPORT AREAS

AusHFG Code	Room	Room / Space	SC / SC-D	Qty	m2	Remarks
BLIN		Bay - Linen	Yes	1	2	Enclosed and lockable
CLRM-5		Cleaner's Room, 5m2	Yes	1	5	
		Courtyard - Staff		1	15	
DTUR-10		Dirty Utility, 10m2	Yes	1	10	
DISP-8		Disposal Room, 8m2	Yes	1	8	
MEET-12		Meeting Room, 12m2	Yes	1	12	Larger meeting room scheduled in consumer/ Visitor Areas
OFF-2P		Office - 2 Person Shared, 12m2	Yes	1	12	Clinical Nurse Consultant, Educator, Psychologist
OFF-3P		Office - 3 Person Shared, 15m2	Yes	1	15	Consultants, Registrars
OFF-CLW		Office - Clinical Workroom	Yes	1	15	In main unit
OFF-S12		Office - Single Person, 12m2	Yes	1	12	Clinical Director
OFF-S9		Office - Single Person, 9m2	Yes	1	9	Unit Manager or NUM. In main unit.
		Office - Workstations, 4.4m2		4	4.4	Education & Allied Health, ward clerk, students. 4.5m2 per person. Refer to staff establishment.
SHST		Shower - Staff, 3m2	Yes	1	3	
SRM-18		Staff Room, 18m2	Yes	1	18	
SSTN-14		Staff Station, 14m2	Yes	1	14	In main unit
STEQ-14		Store - Equipment, 14m2	Yes	1	14	Mobility aid and medical equipment storage. Maybe located on ward.
STGN-9		Store - General, 9m2	Yes	1	9	General storage
STPS-8		Store - Photocopier / Stationery, 8m2	Yes	1	8	
WCST		Toilet - Staff, 3m2	Yes	2	3	
		Discounted Circulation %			32%	

Office areas are given as a guide only. This plan is dependent on the staff profile and staff accommodation policy directives of individual jurisdictions.

AX.02 Functional Relationships / Diagrams



AX.03 Checklists

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

AX.04 References

- ABCB, 2015, Building Code of Australia (BCA) (ABCB, 2015), Building Code of Australia (BCA), Australian Building Codes Board, Canberra ACT
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