Australasian Health Facility Guidelines

Part B - Health Facility Briefing and Planning
0136 - Non Acute Inpatient 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 for end users, to facilitate the process of planning and design.

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

It is a new HPU issued for Australasian use in 2013. 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 a Non Acute Inpatient Mental Health Unit.

It should be read in conjunction with AusHFG generic requirements including Standard Components described in:

- Part A: Introduction and Instructions for Use;
- Part B: Section 80 - General Requirements & 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 mental health HPUs are also available in Part B:

- HPU 132 Child & Adolescent Mental Health Unit;
- HPU 133 Psychiatric Emergency Care Centres (PECC);
- HPU 134 Adult Acute Mental Health Inpatient Unit;
- HPU 135 Older Persons Acute Mental Health Inpatient Unit;
- HPU 137 Mental Health Intensive Care Unit; and
- HPU 250 Ambulatory (Community/Outpatient) Mental Health Unit.

TERMINOLOGY
Consumer: in the mental health context, the patient is referred to as the ‘consumer’ in this document.

Carer: carers provide unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness or who are frail. A carer is intimately involved with the lives and treatment of consumers. In the mental health context, the carer is a recognised member of the multidisciplinary team.

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

Involuntary patient: a consumer admitted under the relevant jurisdiction’s Mental Health Act. The process of involuntary detention usually includes the steps of request, recommendation, admission and examination by a psychiatrist and regular review at formal hearings.

Forensic: this term applies to consumers who overlap the criminal justice and mental health systems. Forensic patients are categorised under the Mental Health Act as not fit to be tried, or not guilty by reason of mental illness. (A third category of forensic patients is those consumers who become mentally ill whilst in prison, however this HPU does not directly deal with this group, although facility design principles may be applicable).

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).

Co-morbidity: this term refers to the presence of two or more mental health conditions occurring at one time. Management of the range of health issues can significantly improve treatment outcomes. End user: in the context of this document, end users refer to those who are accommodated (consumers), work in (staff) and visit (such as carers, friends and family) the Unit.

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Recovery: the recovery philosophy recognises that mental illness may/will be persistent, but aims to maximise a person's quality of life. This term refers to "the lived or real life experience of persons as they accept and overcome the challenge of the disability" - Deegan 1988, as quoted in Queensland Health, 2005, Sharing Responsibility for Recovery: creating and sustaining recovery oriented systems of care for mental health.

SCOPE OF NON-ACUTE MENTAL HEALTH HPU

Non acute mental health units can vary significantly in their target patient group (e.g. forensic, extended care, mental health rehabilitation), as well as clinical goals, model of care, location and facility requirements.

In the development of an HPU for non acute mental health, it has been agreed that the scope will be restricted to inpatient units with 24 hour clinical presence and medical cover. The HPU covers three non acute inpatient mental health unit types:

- rehabilitation;
- extended care; and
- forensic.

Residential supported accommodation and community based non acute mental health facilities are deliberately excluded from the HPU. These units will be distinguished from non acute mental health inpatient units by:

- the nature of clinical care provided (e.g. inreach models or on-site clinical care restricted to business hours);
- the lead role of allied health professionals in providing support to consumers who have effective coping and living skills;
- reporting requirements; and
- the level of independence afforded to consumers within this supported environment.

01.03 Policy Framework

GENERAL

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

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

DIVERSITY AND SPECIAL GROUPS

Policy frameworks recognise the diversity of our community and 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, and Maori and Pacific Islanders in New Zealand;
- people with physical and cognitive disabilities including obese (bariatric) patients;
- people from cultural and linguistically diverse backgrounds;
- people who identify as Lesbian, Gay, Bi-Sexual, Transgender and Intersex;
- people from rural and remote areas; children and adolescents; and
- older persons and the frail aged.

SPECIFIC POLICIES

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 the Improvement of Mental Health Care is a key document influencing service provision.

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

New Zealand's commitment to mental health is reflected in Te Tāhuhu: Improving Mental Health 2005 - 2015: The Second New Zealand Health and Addiction Plan.

Disability Discrimination Acts from both Australia and New Zealand are overarching policies relevant to this HPU.

The following publications relate to the specific policies referred to above:

- Australian Government, 2005, Disability Discrimination Act 1992;
- Australian Government, 2009, Fourth National Mental Health Plan # An agenda for collaborative government action in mental health 2009–2014;
- Australian Government, 2009, National mental health policy 2008;
- New Zealand Government, 2000, New Zealand Public Health and Disability Act 2000;
- New Zealand Government, 2005, Te Tāhuhu: Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan; and
- United Nations High Commissioner for Human Rights, 1991, United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care.

CONSUMER RIGHTS

Consumer rights include:

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

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

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

01.04 Description

DESCRIPTION OF HEALTH PLANNING UNIT (HPU)
Non acute inpatient mental health services provides rehabilitation and recovery#focused interventions for consumers with complex, recurring or ongoing mental illness or disorders, through the provision of well planned, goal oriented and time limited rehabilitation interventions.

This HPU describes three non acute inpatient mental health unit types:

Rehabilitation
A mental health rehabilitation unit supports consumers through their recovery from mental illness and promotes social inclusion through the utilisation of evidence-based
practice and practice-based evidence. Hope is central to the recovery process. Rehabilitation consumers may be voluntary or involuntary. Typically length of stay for a rehabilitation consumer should be six to nine months.

Extended care
An extended care unit cares for consumers whose chronic mental illness necessitates inpatient admission over an extended period. These consumers generally fall into two subgroups:

- those with complex illnesses that only partially respond to interventions and have significant behavioural issues; and
- those who have complex disorders that are only partially responsive to medications, have poor skills, and tend to be much more vulnerable to risk.

The goal in extended care is to reduce risk and vulnerability, improve functioning and promote a level of social inclusion for these consumers. Consumers may be voluntary or involuntary, but are more likely to be the latter. Extended care consumers can have lengths of stay longer than 12 months, dependent on risk assessment and leave provisions.

Forensic
A forensic unit is a secure unit that accommodates involuntary consumers who overlap the criminal justice and mental health systems and who come under the jurisdiction's Mental Health Act. Length of stay is dependent on the provisions of the Mental Health Act, but is likely to be in excess of 12 months. A forensic unit may also have some consumers whose admission is short term, as directed by the court for assessment purposes.

These units generally have common facility requirements, but are distinguished by a number of differences which are documented in the HPU.

Ideally, extended care consumers with high support needs but relatively low risk profiles should be treated in supported accommodation (residential or community non-inpatient unit). However, there is a group of individuals with difficult to treat illnesses who may have challenging behaviours or be extremely vulnerable, whose needs may not be met in a supported accommodation setting and for whom higher levels of structure, such as those provided by non acute inpatient services, may be beneficial.

The non acute inpatient mental health unit may also be best placed to provide crisis support and psychosocial interventions to consumers living in supported accommodation, with the aim of preventing illness relapse and acute admissions.

PATIENT CHARACTERISTICS
The age of admission for the HPU is defined as 18 to 65 years, however, persons over the age of 65 who meet the admission criteria should not be excluded from the Unit. Through improved recovery and associated gains in quality of life, people with mental illness are living longer. Whilst it is hoped that this will occur in the community, for some, support beyond 65 years may be required in a more structured environment such as that provided by a non acute inpatient mental health unit.

The general characteristics of consumers being supported in non acute inpatient care are diverse. At one end of the spectrum is a cohort with an array of coping and daily living skills but for whom community living has posed significant challenges to their mental and physical wellbeing, as well as potentially putting others at risk.

At the other end, consumers experience sever ongoing recurrent symptoms with difficult behaviours, are prone to relapse, have difficulty complying with treatment, are treatment resistant, and have marked disability in terms of every day functioning.

The majority of consumers in extended care and forensic facilities are male. It is not uncommon for consumers to have unstable accommodation histories that render placement in the community problematic.

UNIT DESIGN

In developing the schedule of accommodation and design for a non acute inpatient mental health unit, planners must acknowledge that the facility will be 'home' to most consumers for a considerable period, ranging from months to years, and that some consumers should not be permitted to leave the Unit. Hence a variety of spaces, both indoor and outdoor, are required to support recovery, therapeutic intervention, purposeful recreation, privacy and harmonious living.

It is essential that involuntary consumers can be supported in an environment that maximises the opportunities for rehabilitation and recovery, including community integration, but at the same time minimises the risk to themselves and/or others.

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

Care is to be delivered in the least restrictive environment that optimises recovery. All security measures should be incorporated in the design to be as unobtrusive as possible, however it is accepted that additional security is required for some patient groups.

For consumers with significant risk issues and co#morbidities, a higher level of service support and security may be required. For this consumer group, the physical security requirements may not be dissimilar to an acute inpatient mental health unit. Low risk forensic consumers may be supported in a facility that strongly supports rehabilitation, recovery and eventual community reintegration.

In all instances, the physical security should be discrete and where appropriate, fully support rehabilitation and recovery endeavours.

BUILDING STRATEGIES

Architects, designers, engineers and builders should recognise and understand that the fabric of a mental health unit is required to be more robust than other units to withstand the challenging behaviours exhibited by some consumers / patients.

Particular attention should be paid to walls, doors, ceilings and glazing, giving consideration to acoustic management, the potential for property damage by consumers and potential for patients to self-harm.

02 PLANNING

02.01 Operational Models

HOURS OF OPERATION
The Unit's operating hours are 24 hours per day, seven days per week. Visiting times will be determined locally.

MODELS OF CARE – SERVICE DELIVERY
The service model will vary according to the group the specialist care is focused on: rehabilitation, extended care and forensic.

All three unit types are likely to be tertiary units providing a regional or statewide service, depending on the service model for the jurisdiction. The Unit should have adequate medical cover, clinical support and NGO involvement. Imaging services must be accessible in reasonable proximity.

Admissions to extended care, forensic and rehabilitation units are planned and occur during business hours. All admissions should be direct to the Unit rather than via emergency.

All non acute inpatient mental health units have the following elements in the service model:

- to be centred around the individual needs of each consumer;
- have clinical staff on site 24 hours, with 24 hour medical cover;
- provide specialised mental health assessment, treatment and rehabilitation;
- requires a multidisciplinary team to deliver the optimum range of interventions;
- is provided over a sustained, yet time limited period;
- is provided in conjunction with other hospital services, such as acute units and diagnostic services, and may be collocated with such services;
- requires partnership with non-government organisations which play a formal role in providing programs and support to consumers;
- provides somewhere to live, hotel services and other disability support services. Units may be based around a ward model or clusters of self-contained units, dependent on the consumer group and therapeutic goals; and
- values privacy and dignity.

The Unit should offer a core set of integrated clinical rehabilitation programs linked to community based services and programs. The overall goal is to maximise recovery and support the acquisition of skills consistent with living well, in the community of choice. Best practice supports the delivery of as many interventions as possible in the community, however, for those for whom this is problematic (forensic, high risk, dangerous, extremely vulnerable) there should be a range of interventions delivered in the unit. These may include:

- engagement programs;
- diversional programs;
- symptom management;
- motivational interviewing;
- coping skills enhancement;
- substance misuse programs;
- social skills training;
- activities of daily living (ADL) programs;
- cognitive behaviour therapy (CBT);
- mental health education;
- vocational programs;
- medication self-management;
- exercise programs; and
- social inclusion.

Unit based interventions should be considered in four contexts.

- individual;
- group;
- family; and
- milieu / 'community' or unit.

MODEL OF CARE – FACILITY CONFIGURATIONS
The preferred unit configuration is a standalone facility, located alongside an acute hospital, on a mental health campus, or in a community location. (In Victoria, it is policy that all inpatient units be located on an acute site.) The choice of location reflects the intended role and function of the proposed unit. Proximity to acute mental health services and access to community mental health services are required. The advantage of collocation with acute services is superior access to medical and diagnostic services, particularly in emergency situations. The disadvantage of this approach is that the service may be seen as part of the acute health system, rather than being provided in a location that is better integrated with the community.

Collocation of a non acute inpatient unit with an acute inpatient mental health unit means that consumers and staff can be moved quickly and with relative ease between the units according to need. Security and emergency response situations are also easier to manage. This collocation however does mean that the pressure on acute beds can result in inappropriate admissions of acute patients to the non acute unit.

It is preferable for rehabilitation and secure extended care consumers to be supported in separate units for a variety of reasons, however, the facilities themselves might only have minor points of distinction.

UNIT SIZE
Recurrent cost modelling suggests that non acute inpatient units of less than 16 beds are not seen as cost effective. Units with more than 20 beds may lose their rehabilitation focus as the management of relationships with external service providers becomes more complex. Therefore a range of 16 to 20 beds would appear to be appropriate for this Unit. Non acute units in NSW, South Australia and Victoria are typically 20 beds. The Queensland Health mental health guidelines propose non acute mental health units of 20 to 24 beds.

The Unit's design should support the dynamic grouping of beds into smaller clusters, according to operational need to ensure that consumers can be separated according to risk status, behaviours, diagnosis etc. Groupings of four and eight beds are often quoted in literature and provide practical cluster sizes.

Some extended care and forensic facilities may consider designing small clusters of selfcontained units which support consumers' privacy and dignity whilst also promoting ADL. Adoption of this option should be directed by the service model.

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 patients may be referred. They impact on the capital and recurrent costs of a facility and will vary from unit to unit depending on a wide range of factors such as the clinical characteristics of the patients and the defined role of the unit. The cost implications of proposed policies should be fully evaluated to ensure the most costeffective 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. For further information refer to AHIA, 2010, AusHFG Part B: Section 80 General Requirements.

LOW STIMULUS STRATEGIES
Reduction and eventual elimination of the use of seclusion is a recognised goal across contemporary mental health services both nationally and internationally (NMHSRP 2009). Appropriate facility design, including adequate provision of de#escalation spaces to reduce and prevent agitation will contribute to this goal, along with a range of other prevention strategies. Jurisdictions can use the following spaces to implement de# escalation strategies:

- the consumer's bedroom;
- a low stimulus / quiet lounge, furnished with heavy, fixed furniture, for voluntary time out;

- private courtyards; and
- a sensory integration room in which consumers can engage in activities that relax them e.g. music, aromatherapy etc.

The schedule of accommodation includes a generous number of lounges and courtyards where de-escalation can occur. It is unlikely that a dedicated low stimulus area incorporating quiet room, seclusion room and courtyard are required however this has been shown as optional.

SMOKING
Local non-smoking policies will apply, however all jurisdictions will have supportive programs 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 patients. A larger than standard examination couch may be provided in the treatment room.

CATERING
As part of the consumer's rehabilitation and activities of daily living, it is beneficial for capable patients to participate in meal preparation to the extent which they are able. This might range from self-service at breakfast, to preparing a simple lunch or dinner, assisting with a barbeque meal and participating in cooking lessons. Where possible, opportunities for family / visitors to prepare food and dine with consumers should also be provided.

To this end, catering should be organised to support a combination of centrally prepared and consumer prepared meals, according to the varying rehabilitation goals of the Unit's occupants.

It is recommended that the Unit have at least two kitchens which are equipped to cope with meals prepared outside the Unit (either plated or delivered in bulk) as well as being used by consumers capable of participating in daily meal preparation and cooking demonstrations. Dangerous items would be stored in locked cupboards, safe items displayed on open shelves. The kitchens would be lockable when not in use.

It is suggested that each kitchen have its own dining area that can cater for up to 10 consumers as smaller dining areas will contribute to a more domestic atmosphere. A supervised, lockable, refreshment facility will be available for consumers. It is essential that consumers have access to fresh drinking water at all times.

EMERGENCIES
Medical emergencies will be handled in accordance with the health facility's operational guidelines. 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 medication / clean utility.

Psychiatric emergencies such as suicide, violent behaviour etc., will be handled in accordance with unit protocols, procedures, guidelines and relevant jurisdictional policies.

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 agencies would be an essential part of the design process.

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

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

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

- psychiatrists;
- nurses;
- psychologists;
- allied health staff - occupational therapists, art therapists, exercise physiologists, and social workers;
- administrative staff;
- housekeeping, maintenance and catering staff;
- security and other emergency response personnel; and
- consumer advocates.

Visiting services may include:

- physiotherapist;
- music therapist;
- pharmacist;
- dietician;
- community health staff;
- legal officers;
- advocates;
- official visitors and representatives from other agencies and/or non-government organisations;
- vocational trainers / educators; and
- students.

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

02.03 Planning Models

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

LOCATION
A ground floor location is preferred for this HPU so that patient areas (i.e. bedrooms, therapeutic areas, indoor recreation spaces and generous outdoor recreation spaces) are horizontally connected. If footprint is limited, a multi-storey facility that has appropriate zoning of patient areas (on#grade) and staff areas (not accessible to patients) would be acceptable.

The extent of on-grade outdoor areas should not be compromised by the selected location as outdoor areas are extremely important components of the Unit.

TRAFFIC FLOWS
For hospital and community settings, circulation will be planned to facilitate appropriate egress routes for consumers accessing services outside of the Unit. Allowances must also be made for consumers arriving at the Unit by consumer transport/escort vehicle.

If the Unit is part of a hospital or mental health campus, intra#hospital movements may be between:

- the Unit and the acute mental health inpatient unit;
- the Unit and medical imaging; and
- the Unit and operating theatres.

CONFIGURATION / LAYOUT
The plan for the Unit should reflect specific operational polices and the Unit’s model of care.

The non acute inpatient mental health unit will be a standalone Unit with its own entry and reception. It may be a single building or a group of buildings that together constitute the Unit.

Access and egress from the Unit will be via a central, secure, staff controlled entry point.

The ability to create clusters of beds for the separation of consumers (e.g. based on behaviours, risk profile, gender, age, diagnosis, acuity, living skills etc.) is recommended. Again, these clusters may be achieved

within one single Unit, or be a group of buildings. Such a configuration should not reduce flexibility of use from day to day or over time, nor should it compromise the ability of staff to supervise consumers. Each cluster of bedrooms could have its own lounge, dining area, kitchen, laundry, courtyard, or these could be shared between bedroom clusters.

If a designated low stimulus area (e.g. quiet lounge, quiet courtyards, seclusion room) is required in addition to other areas that can be used for de-escalation, it should be located away from bedroom and activity areas, so as to maintain the privacy and dignity of consumers and minimise the impact on others in the Unit. Its location or amenity should not be such that it creates a stigma for consumers who use the space. Rather it should be a pleasant space that consumers voluntarily use when the need arises.

Unobtrusive observation of consumer areas by staff is essential but needs to be balanced with consumer privacy. Good sight lines from staff areas such as staff station, to consumer areas is an important design criterion.

All corridors with the exception of those in staff#only areas should be a minimum of 1800mm clear. Dead# end corridors and recesses where consumers may be out of view should be avoided.

For security and fire safety reasons, all exits should have at least six metres of clear external space so that people are not encouraged to congregate outside perimeter doors. All corridors and exits are required to comply with the current Building Codes Australia (BCA) requirements (Australian Building Codes Board 2009).

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

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

SHARED FACILITIES
If the Unit is collocated with other mental health facilities, every attempt should be made in the planning to avoid duplication of support areas such as staff amenities, formal hearing room, public spaces, and staff office areas.

Sharing of clinical space and consumer / patient recreational areas with other mental health units is not appropriate.

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

- number of staff occupying or needing access to the room / space;
- operational procedures;
- number and type of consumers; and
- staff and consumer safety requirements.

02.04 Functional Areas

FUNCTIONAL ZONES
The Unit consists of the following functional zones:

- main entry, reception;
- interview / consulting rooms;
- treatment rooms;
- bedrooms, ensuites and bathrooms;
- activity and recreation areas – indoor;
- activity and recreation areas – outdoor;
- visitor / family amenities;
- meeting rooms;

- clinical support areas; and
- staff amenities.

MAIN ENTRY / RECEPTION
All non acute inpatient mental health units should have a welcoming greeting / waiting area for consumers, carers and others. Public amenities (toilets, baby change) are provided in reception. A play area for children is optional.

All reception desk should enhance security while maintaining a visually welcoming environment. Security screens can be used, however they should be designed so as not to impede communication or visibility.

The nature of the security requirements in the main entry / reception will differ according to the security status of the Unit's consumers. All Units will have a controlled entry with remotely operated door so that no visitor can directly access the Unit without reporting to Reception staff first. Intercom and CCTV may be appropriate to achieve this.

In addition to these measures, a forensic unit may have dedicated security personnel in the reception managing, entry and egress from the Unit and monitoring perimeter security, in addition to other responsibilities. If this arrangement is desired, security personnel will require a reception counter which allows CCTV to be monitored without being seen by members of the public.

A room for interviewing or meeting booked consumers / patients should be provided with direct access from the waiting area where consumers can be received in a private and welcoming environment. This room can also be used for interviewing carers and visitors. To provide privacy for visitors and staff, this area may also be used for undertaking security checks before allowing entry to the inpatient unit.

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

INTERVIEW / CONSULTING ROOMS
Interview / consulting rooms may include rooms for interview, consultation, admission / assessment and treatment. The scheduled interview rooms (14 m2) are large enough to cater for up to six people. Multipurpose meeting rooms are available for larger family conferences and group therapy. Interviews and therapy sessions involving consumers should be restricted to designated consultation and multipurpose rooms.

TREATMENT ROOMS
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. It will require an examination couch, examination light and a second exit.

BEDROOMS
All bedrooms should be provided as single rooms. One or more larger single bedrooms should be provided to accommodate bariatric patients. One bedroom should be accessible for an independent wheelchair user. Design should minimise potential ligature points.

Bedrooms should be furnished to reflect the extended lengths of stay and rehabilitation goals in this Unit. The following design features should be considered:

- built-in wardrobe - larger than standard inpatient room wardrobe to store clothing and personal effects for an extended period;
- built-in desk - sufficiently large to fit lap top computer;
- storage for books, personal television, stereo etc.;
- small electronic safe for storage of personal items and medication in Webster packs;
- lightweight, flexible chairs;
- Velcro notice board;
- door vision panels with impact#resistant glass;
- domestic style beds - mattresses should not be innerspring and should have a high fire resistance rating; and
- integrated venetians or blinds to external windows.

Services should include:

- body protected power;
- two power outlets;
- data points;
- staff alarm system; and
- low wattage night light for illumination (if required) mounted to direct light towards the floor, and switches to be located inside and outside the room.

Service panels should be restricted to corridors.

Consumers should be able to lock their bedroom doors ("classroom lock" setting allows staff to put the door on lock mode from the outside, but consumers / patients can exit freely from the inside). Door widths should be 1100mm clear and open outwards to prevent patients attempting to blockade themselves in their bedroom (this has implications for corridor width). Outward opening doors should be recessed to prevent obstruction of corridors.

BATHROOMS AND ENSUITES

Provision of private ensuites to each bedroom is preferred in non acute rehabilitation units, giving consumers a greater sense of privacy and reducing concern of intrusion by others. Private ensuites may have a door that can be locked in the open or closed position, depending on individual requirements.

Storage should be provided for toiletries etc. Some separate toilet / shower facilities shared between patients with access from the corridor may be considered in extended care and forensic units if the intended cohort requires a higher level of supervision. This should be done with caution however, so as not to unnecessarily compromise privacy and dignity. A mix of private ensuites and shared toilet / shower facilities is likely to deliver maximum flexibility.

An optional common bathroom, including bath, may be included in the HPU so that consumers may choose to take a bath for therapeutic purposes.

Fittings (such as towel rail, clothes hooks etc.) require a breaking strain of 15 kilograms to minimise opportunities for self-harm. Avoid other ligature points such as shower curtains through appropriate design e.g. recessed area for garbage bin, recessed toilet roll holders, toilet seats that resist breakage and removal, in-fill moulded hand rails (not in accessible toilets), recessed soap and shampoo shelf. An impact resistant and non-distorting mirror should be wall mounted.

ACTIVITY AND RECREATION AREAS - INDOOR

A sufficient number of indoor activity spaces should be sized and furnished to accommodate a range of concurrent activities, both active and passive (e.g. meals, cooking, television, art, games, music, computers, reading, indoor facilities for exercise) as part of a consumer therapy program, telephone contact. Areas may include:

- dining rooms;
- group recreation areas (lounges, multipurpose activity spaces);
- TV / music / computer area (media room); quiet lounges;
- ADL kitchens;
- self-care laundries; and
- indoor exercise facility.

The main lounge area should open onto an outdoor area and be large enough to cater for all consumers, particularly when outdoor areas are unusable in cold, wet weather. It may be appropriate for the media room to be a sub-lounge, adjacent to the main lounge, so that internet based activities can be supervised by staff.

It is suggested that each cluster of bedrooms have its own lounge, courtyard and laundry. A kitchen and dining area may be shared between clusters. By affording the clusters a degree of self#containment, it is hoped that a domestic atmosphere will result.

The indoor exercise area should be located and designed to achieve excellent staff observation from recreational and therapy areas.

Transparent barriers and passing traffic will enhance supervision. The room should overlook, and preferably open onto, accessible outdoor space.

ACTIVITY AND RECREATION AREAS – OUTDOOR
Outdoor areas for programmed activities, exercise and relaxation are treated as therapeutic areas. Therefore as much design effort and attention to detail should be given to achieving tranquil and functional outdoor spaces as to internal spaces.

The space should be zoned to achieve:

- passive areas such as private courtyards, seating in landscaped gardens;
- active areas that encourage exercise such as half basketball court, walking paths;
- a fixed barbeque area; and
- at least one outdoor area should be capable of hosting a large outdoor event such as a visitor barbeque.

Access will be from the lounge / dining / activity spaces and doors should be visible from the staff station. The design should avoid blind spots to enhance supervision. There should be ready access to a toilet from outdoor areas.

Some of the outdoor areas such as verandas should incorporate extensive weather protection and sun protection to ensure that outdoor spaces are useable all year round, and prevent adverse effects for those patients with medication#related photosensitivity. Shade cloth is not effective for weather protection, but is suitable as a sun protection strategy if well designed. Attention should be given to detailing roof overhangs, guttering and drain pipes to minimise means of escape and eliminate opportunities for self-harm.

Landscaping should allow people to participate in gardening, should they wish. Landscape features and plantings should be set back from the perimeter wall to avoid breaches of perimeter security, if applicable. Full and soft lighting should be provided to outdoor areas at night. Whilst views are desirable, design must also ensure that outdoor areas cannot be overlooked by the general public and other patients.

Storage should be provided for bulky equipment used in outdoor activity areas e.g. sporting equipment, tables, chairs, gardening equipment etc. Access will be required for garden/lawn maintenance without staff having to go through the unit, and for emergency services access.

VISITOR / FAMILY AMENITIES
Carers and visitors require access to a comfortable lounge and courtyard in the Unit for private visits with the consumer. Location and design of the space should give consideration to the needs of children visiting the unit.

Access to a beverage bay is required. Visitor toilet and baby change facilities are scheduled in the reception area. Formal meeting rooms for family conferences are also scheduled.

MEETING ROOMS
Provide at least two multi#purpose meeting rooms to cater for a range of activities such as formal hearings, teleconferencing, occupational therapy, group therapy, family conferences, staff meetings and professional development. At least one meeting room should be equipped for video conferencing services.

A small waiting area for family / carers should be positioned close to the formal hearing room. Depending on the Unit's layout, the reception waiting area may be sufficient, or a separate sub-wait might be required if this is not proximal to the formal hearing room.

Meeting rooms used for consumer interactions such as formal hearings or group therapy require two doors.

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.

LOW STIMULUS AREA
It is unlikely that a dedicated low stimulus area incorporating quiet room, seclusion room and courtyard will be needed in this type of Unit however the inclusion of this space has been shown as optional.

If included, a low stimulus area may be located in an area of the Unit which is likely to have less activity / traffic. It should consist of a quiet lounge and outdoor space / courtyards. The area may also include a seclusion room and sensory integration room, depending on local jurisdiction policy.

These spaces should be comfortably furnished to create a calming environment.

CLINICAL SUPPORT AREAS
Support areas will include:

- staff station and clinical resource room;
- staff offices;
- medication room / clean utility;
- linen store;
- dirty utility / disposal room; and
- storage - clinical, non-clinical, patient.

STAFF STATION / CLINICAL RESOURCE ROOM
It is suggested that these two functions could be combined with an open counter area partially screened with glass panels or balustrade wire (staff station) for consumer / visitor interaction, and an adjoining clinical resource room (quieter enclosed office) in which confidential discussions can occur. Functions for these two spaces might be arranged as follows:

Staff station

- workstation for ward clerk;
- space for computers, telephones, printer, facsimile. A separate area is provided for photocopier and stationery storage;
- docking stations for portable phones, pagers and personal duress alarms; and
- procedure manuals and references.

Clinical resource room

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

Ideally, the Unit's design would allow a single staff station to monitor all areas and provide an escape route / safe haven for staff, however this is dependent on how bed clusters are arranged. A decision to provide sub-staff stations should only be reached after serious consideration of planning options and staffing levels, being mindful of compromises to safety and operational efficiency.

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

Note that fluorescent lighting is too strong for night duty requirements. Dimmer facility and/or down lighting above work spaces for night duty staff should be installed.

STAFF OFFICES
An office for the Unit manager should be located in the Unit so that the manager is 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 may be secured after hours and at weekends, whilst still giving authorised staff access to amenities, photocopier etc.

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

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.

STORAGE
Separate storage areas are required for equipment used in indoor and outdoor activities e.g. sports equipment, surplus tables and chairs for special family / visitor events, library trolley, board games etc. Locate the storage close to where the respective equipment is most likely to be used. Consumer access to these areas will be according to local procedures.

General storage will be provided for Unit functions, including mattresses, pillows, mobility aids and occupational therapy materials. This will be accessible to staff only. Additional occupational therapy materials may be stored in the applicable multifunction activity room. A separate room for photocopier and stationery is included.

Storage for occupational therapy activities will be provided in the applicable multifunctional activity room as well as in the general store for Unit.

A storage area capable of storing large items is required for consumers' property that cannot be kept in the bedroom e.g. suitcases, surplus clothing, electrical goods etc. Bulk storage shelving is recommended. This area will not be accessible to consumers without supervision.

Lockers may be provided in a common area for storage of personal items that may be accessed regularly without supervision but are not permitted in bedrooms (this would most likely apply to forensic units). A small electronic safe may be installed in each bedroom for storage of valuable personal items and medication in Webster packs.

STAFF AMENITIES
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. The size of these spaces will depend on the staff establishment.

Provide other staff amenities (e.g. toilets, showers, car parking, lockers etc.) in accordance with standard requirements.

02.05 Functional Relationships

EXTERNAL
The non acute inpatient mental health unit has a range of relationships, including with the following facilities, services and organisations:

- adult acute mental health unit;
- community mental health teams;
- medical imaging unit;
- pathology;
- other specialist services;
- departments of training and education, community services, Corrective Services;
- NGOs providing residential supported accommodation;
- NGOs and other providers of day programs;
- drug and alcohol services; and
- police and ambulance services.

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

The central reception zone should feed into the interview and therapeutic intervention zone (including assessment / admission, consultation, examination etc.). In a secure extended care or forensic unit, the reception zone will be adjacent to a secure entry zone.

Group the bedrooms so that vulnerable patients can be separated according to behaviours, risk status etc. as required. Locate recreation areas (indoor and outdoor) in proximity to each group of bedrooms with access from lounge / dining / activity areas.

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

03 DESIGN

03.01 Accessibility

EXTERNAL
The Unit requires an entry / exit for voluntary patients and their families / carers. Security provisions for those entering the Unit will be dependent on the security rating of the service.

Provide a separate, secure, entry point for involuntary patients.

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

The Unit should have access to public transport to support the independence of consumers / patients who have applicable leave provisions.

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

03.02 Parking

The following facilities are to be provided:

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

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

03.03 Disaster Planning

Each unit will have operational plans and policies detailing the response to a range of internal and external emergency situations.

Consider issues such as the placement of emergency alarms, the need for emergency or uninterrupted power supply (UPS) to essential clinical equipment, electronic sensor taps, services such as emergency lighting, telephones, duress alarm systems and computers and the emergency evacuation of patients, many of whom will require assistance.

For further information refer to:

- Part C: Design for Access, Mobility, OHS and Security, Space Standards and Dimensions; and
- Part B: Section 80 General Requirements.

03.04 Infection Control

GENERAL
The following aspects contribute to effective infection prevention and control, and are relevant within the context of this HPU:

- hand hygiene facilities e.g. hand-basins, disinfectant products;

- provision for the isolation of infectious patients;
- linen handling;
- separation of clean and dirty work flows;
- storage;
- waste management; and
- surface finishes.

Project teams should refer to individual jurisdiction policies and guidelines, and to Part D: Infection Prevention and Control.

HANDBASINS
Handbasins are required in treatment and medication rooms.

03.05 Environmental Considerations

ENVIRONMENTALLY SUSTAINABLE DESIGN
Sustainability applies to many areas such as:

- air handling and ventilation;
- thermal integrity (insulation, etc.);
- water management;
- choice of sustainable products e.g. low 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 HPU.

ACOUSTICS (CONSUMER OCCUPIED AREAS ONLY)
Noise is a constant source of complaint from consumers / patients and may compromise consumer confidentiality as well as comfort and recovery. In particular, noise at night will have a negative impact on the ability to sleep.

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

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

Solutions to be considered include:

- location of the Unit;
- use of sound absorbing materials and finishes;
- sound isolating construction;
- separation of quiet areas from noisy areas; and
- changed operational management.

Special acoustic isolation is required for seclusion rooms, consultation / therapy rooms. General acoustic isolation is required for bedrooms, ensuites and recreation areas. In acoustically treated rooms, return air grilles should be acoustically treated to avoid transfer of conversations to adjacent areas. Door grilles to these areas should be avoided. Further information is available in Part C: Design for Access, Mobility, OHS and Security, Space Standards and Dimensions.

NATURAL LIGHT
Natural light contributes to a sense of wellbeing for all building occupants including consumers, staff and other users. Research studies suggest a link between greater levels of natural light and improved clinical outcomes, particularly for persons with mental illness (Joseph 2006). However, too much sunlight can adversely affect consumers with medication related photosensitivity. Therefore, ensure outdoor areas have shaded areas.

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

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

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

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

Strategies to enhance privacy include:

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

Bedrooms and other areas occupied by consumers / patients should be designed and configured to give staff the greatest ability to observe consumers without compromising the domestic setting and unnecessarily impinging on privacy.

INTERIOR DECOR
Interior decor includes furnishings, style, colour, textures, ambience, perception and taste that can help ameliorate an institutional atmosphere. However, cleaning, infection control, fire safety and patient care requirements 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. These colours may prevent the accurate assessment of skin tones e.g. yellow / jaundice, blue / cyanosis, red / flushing. Extremes of colour and pattern such as geometric designs which may disturb perception should also be avoided, however, strong colours may assist orienting consumers / patients to their bedrooms and activity areas. Colour should be used to highlight doors / areas that consumers will access (bedrooms, bathrooms, activity areas, therapy areas) and neutral colours used to 'hide' doors that they should not access (utility rooms, staff areas).

In this Unit furniture, soft furnishings, artwork and plants should be robust but domestic in style, to create a homelike and calming environment. Careful consideration should be given to areas in which furniture should be fixed versus moveable. Furniture should be arranged to promote positive group dynamics. Moveable furniture should be sufficiently heavy to avoid use as a weapon. Furniture items should be easily replaceable in case of breakage.

It is important for consumers to have some control of their surroundings e.g. access to light switches and television remotes. Flat screen televisions should be mounted to polycarbonate screens.

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. Where necessary and appropriate, languages other than English and / or consistent use of pictograms / symbols 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.

For further information refer to:

- AHIA, 2010, AusHFG Part C: Section 750, Signage; and
- Department of Health, NSW, 2009, Technical Series 2 # Wayfinding for Health Facilities.

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

03.06 Space Standards and Components

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

Relevant information can be sourced from Part C: Section 790, Safety and Security Precautions.

ERGONOMICS
Design and build the Unit to ensure that patients, staff, visitors and maintenance personnel are not exposed to avoidable risks.

Furniture, fitting and equipment selections need to be appropriate for use by older people, without disadvantaging other adults who work in and visit the Unit. For example, some lounge chairs may have a higher seat so that it is easier for older people to sit and stand.

For further information refer to Part C: Section 730, Design for Access, Mobility, OHS and Security.

ACCESS AND MOBILITY
Where applicable bathrooms, public toilets and ensuites intended and designed for independent wheelchair users, including staff, are to comply with Australian Standards. For relevant standards and guidance refer to:

- Part C: Section 730, Design for Access, Mobility, OHS and Security; and
- Standards Australia, 2010, AS 1428 (Set) 2010 Design for access and mobility Set (SAI Global).

BUILDING ELEMENTS
Building elements include walls, floors, ceilings, doors, windows and corridors. Careful consideration must be given to the fabric of the building (particularly wall construction) to ensure it is robust enough to withstand abuse.

Consideration should be given to the appropriate use of materials such as impact#resistant glass and, low maintenance / resilient surfaces. Design also needs to minimise opportunities for self#harm, e.g. no ligature points and wherever possible/available, nonremovable fixtures and fittings (refer Fixtures and Fittings clauses in this HPU).

For information related to building element requirements refer to Part C: Section 710, Design for Access, Mobility, OHS and Security.

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

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

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

All doors and door frames within the unit must be solid core and meet all relevant BCA and fire regulation standards.

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

For further information refer to Part C: Section 710, Space Standards and Dimensions.

WINDOWS AND GLAZING
In consumer areas, all window frames should be heavy duty (commercial frame) construction and securely fixed to the wall fabric. Glass should be impact#resistant and shatter#proof Grade A safety glass: compliance with Australian and New Zealand Standards (as detailed below) is recommended. Polycarbonate is not recommended as it suffers from surface scratching which obscures vision. Larger pane sizes are not as inherently strong as smaller pane sizes.

The design of opening windows will vary according to the security status of the intended consumers. Forensic and extended care units may have static bedroom windows or small openings. A rehabilitation unit's bedroom window may have a more generous opening. Regardless, all windows should be designed to prevent / discourage escape. 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. Window locks may be controlled by staff or consumers according to the consumers risk status.

The installation to bedrooms of a double#glazed viewing panel with integral venetian blinds is a decision that can be made on a project#by#project basis. An advantage is that they allow observation without disturbing the patient. External windows in consumer bedrooms should allow a patient to see outside.

Glazing materials are as recommended in Standards Australia, 1996, AS/NZS 2208:1996 Safety glazing materials in buildings (SAI Global).

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.

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

The Unit must not only be safe, it must feel safe. Security may be physical and psychological. Barriers may be real or symbolic, but all must be unobtrusive. Within this context, the least restrictive environment that provides a safe environment is the goal.

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

Physical security must be built in as part of overall design and not superimposed on a completed building and surrounding outdoor areas. A safety audit via a risk analysis of potential hazards should be undertaken during the design process.

Mobile and fixed duress alarms require a five metre radius locator which is able to be viewed on a computer monitor my staff and security.

The following aspects need to be considered:

- safety of consumers, staff and visitors;
- consumer legal rights;
- the status of the hospital or part thereof under the relevant Mental Health Act; and
- legislation in force at the time of development.

Facility planners and designers should enhance safety by means of the design, the methods of construction and the materials chosen, including the selection of fittings, fixtures and equipment.

RISK MANAGEMENT AND HARM MINIMISATION

The physical environment has a significant impact on the health and safety of end users. By adopting a risk management and harm minimization approach, many safety and security related hazards can be eliminated or minimised at the planning and design stages. This may reduce the likelihood of adverse incidents occurring.

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

Occupational health and safety (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 all end users, including staff, maintenance personnel, consumers and visitors.

For further information refer to National Mental Health Working Group, 2005, National safety priorities in mental health: a national plan for reducing harm.

ACCESS CONTROL

As consumers may be a mix of voluntary and involuntary, rehabilitation, extended care. Forensic units should be designed with controlled entry and exit points so that patient access / egress can be supervised and no consumer should be able to leave the unit unobserved. Security features may include transfer lobby / airlocks, electronic locking, intercoms, video surveillance, and possibly technologies such as x#ray for property searches (forensic facility).

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

All meeting rooms used by consumers, including interview and formal hearing rooms require:

- two means of egress; and
- duress alarms - fixed, personal or a combination of these.

When the Unit is located within a multi#storey building, it is critical that unauthorised and unsupervised access to external spaces above ground level, such as balconies or roof areas, can be prevented unless they specifically designed for patient use.

CLOSED CIRCUIT TELEVISION (CCTV) SURVEILLANCE

The use of consumer surveillance via CCTV is often a very contentious issue. CCTV may be useful for monitoring areas such as stairways and blind spots, hallways, entrances and outdoor areas. It must not be used as an alternative to direct clinical patient observation by staff as this may have a deleterious impact on therapeutic rapport and contravene a consumer’s right to privacy. It should also be avoided in situations where, although the cameras view and capture activity, there may be no person at the other end to view the monitor.

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

- 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 CCTV;
- the fact that monitors may not always be able to be constantly observed;
- the associated maintenance costs involved; and
- the ability to negate the need for video security with improved functional design.

DURESS ALARM SYSTEM
A system of personal duress alarms with location finders should operate throughout the unit and in all outdoor areas so that there is limited need for fixed duress alarm points. The optimum approach is a combination of personal alarms with location finders with a five metre radius linked to a real time monitor facility and some fixed alarms particularly in areas where staff work in a relatively fixed position such as Reception to ensure there is a back#up system if one system fails.

Visiting officers and staff such as magistrates and VMOs should be provided with and trained in the use of personal duress alarms and the response mechanism in place. There should be sufficient numbers of personal alarms to ensure all staff and relevant visiting staff can carry one while in the unit.

The charger for personal alarms must be located in a staff-only area accessible 24 hours/day. Shift by shift testing of personal duress alarms should be part of all unit operational guidelines.

The location of fixed duress call points is critical to ensure that:

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

Refer to individual jurisdiction safety and security policies.

PERIMETER FENCING AND SECURITY
A rehabilitation Unit catering for voluntary consumers requires a boundary that deters inappropriate entry to or exit from the property. It does not require a secure perimeter designed to prevent absconding.

Extended care and forensic units catering to involuntary patients do require secure perimeter fences. A recommended height is 2.7 metres to four metres, however the design and height should not create a custodial environment or increase the possibility of falling injuries should an attempt be made to escape. 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.

Design of secure perimeter fences should avoid purchase points (hands and feet) to prevent scaling and incorporate barriers to the exchange of contraband such as illicit drugs, weapons etc. from public areas outside the Unit. Landscape features, plantings and outdoor lighting must be set back from the perimeter wall or fence to avoid purchase points and design should avoid blind spots to facilitate good observation of patients by staff and vice versa. Attention should be given to detailing roof overhangs, guttering and drain pipes, which may provide a means of escape.

Project staff are recommended to familiarise themselves with OHS legislation, and with safety and security policies pertaining to their local jurisdiction. The following publications also provide relevant information and guidance:

- Part C: Section 790, Safety and Security Precautions;
- Department of Health, NSW, 2013, Technical Series TS11 - Engineering Services & Sustainable Development Guidelines;
- Department of Health, NSW, 2009, Technical Series TS7 - Floor Coverings in Healthcare Buildings; and
- Standards Australia, 2009, AS/NZS ISO 31000:2009 Risk management # Principles and guidelines (SAI Global).

03.08 Finishes

GENERAL
Finishes in this context refer to walls, floors, windows and ceilings. Recommended reading can be found in Part C: Section 710, Space Standards and Dimensions.

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

FLOOR FINISHES
Floor finishes should be appropriate to the function of the space.

Consider acoustic performance, slip resistance, consequences of patient falls, infection control, movement of beds and trolleys, maintenance and cleaning protocols.

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

The following publications are recommended reading:

- Part C: Section 710, Space Standards and Dimensions; and
- Department of Health, NSW, 2009, Technical Series TS7 - Floor Coverings in Healthcare Buildings.

CEILING FINISHES
Ceiling finishes should be selected with regard to appearance, cleaning, infection control, acoustics and access to services. Ceilings in a mental health unit should be fixed, not moveable panels.

Requirements and guidance regarding ceiling finishes can be found in 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.

Fittings:
Items attached to walls, floors or ceilings that do not require service connections such as curtain and IV (intravenous) tracks, hooks, mirrors, blinds, joinery, pin boards etc.

These guidelines, in respect to fixtures and fittings, do not negate the need for close observation of patients deemed at risk, or for clinical care appropriate to the acuity of the patient. The following refers specifically to fittings and fixtures in mental health units and is to be applied to all types of units from community mental health centres to non acute and acute mental health inpatient settings.

More detailed information can be found in the Room Data Sheets (RDS) and Room Layout Sheets (RLS) and in:

- Part C: Section 710, Design for Access, Mobility, OHS and Security; and

- Part F: Section 680 Furniture Fittings and Equipment.

GENERAL PRINCIPLES
The potential suicide of consumers / patients is of particular concern in a mental health unit. Therefore, assess fixtures and fittings for potential use for self-harm, ligature point or as a weapon.

Any fitting or fixture capable of supporting individual consumers' / patients' weight should be avoided, unless it is an item of furniture intended to bear the consumer/ patient weight. Fittings in this Unit require a breaking strain of no more than 15 kilograms.

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

ARTWORK, SIGNAGE AND MIRRORS
Rigidly fix artwork, signage and mirrors to walls with concealed, flush, tamper#proof mountings. Where possible, include consumers / patients in the selection of art works. It may be appropriate for consumers / patients to contribute to the artwork on display.

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

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

PLUMBING FIXTURES
All exposed plumbing fixtures should be tamper#proof and resistant to breakage and removal, particularly plumbing fixtures accessible to consumers / patients.

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

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

Sink and basin wastes and toilet cisterns should be concealed or enclosed behind the wall.

It is suggested that electrical and water supply shut#off systems be installed in the Staff Station to reduce risk of access to live electrical currents or inappropriate use of showers and consequent flooding.

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

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

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

Door and cupboard handles/knobs should be designed to avoid ligature points. Consider using fittings moulded to incorporate hand pulls to avoid the use of handles.

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

Where installed, shower tracks should be plastic and mounted flush to the ceiling. It is critical to ensure that the entire track plus hooks has a 15 kilogram breaking strain, so that if the curtains are gathered into a single

cluster the aggregate does not exceed 15 kilograms. Do not install a track which allows the hooks to be pushed together, as this will increase the breaking strain far beyond the required 15 kilograms.

WINDOW TREATMENTS
Curtains, Holland blinds or other types of blinds / curtains with cords should not be used in consumer bedrooms. Integrated venetian blinds with flush controls or electronic controls in the staff station are suggested to provide privacy in a safe manner.

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

Consideration should be given to fabric type with respect to weight/thickness and ease of tearing.

OTHER
Light fittings, smoke and thermal detectors and CCTV cameras should be vandal#proof and incapable of supporting a consumer's weight.

03.10 Building Service Requirements

GENERAL
This section addresses a range of building service topics, but project teams are recommended to refer also to the following publications:

- Part E: Building Services and Environmental Design;
- Department of Health, Western Australia, 2006, Western Australia Health Facility Guidelines for Engineering Services; and
- Department of Health, NSW, 2013, Technical Series TS11 # Engineering Services & Sustainable Development Guidelines.

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 air conditioning should generally be provided.

Special consideration should be given to ventilation outlets and the equipment used, with particular regard to the following:

- 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.

For information regarding air handling systems refer to:

- Part D: Infection Prevention and Control;
- Department of Health, NSW, 2013, Technical Series TS11 # Engineering Services & Sustainable Development Guidelines; and
- Standards Australia, 2003, AS HB 260#2003: Hospital acquired infections # Engineering down the risk (SAI Global).

ELECTRICAL SERVICES
Connect services such as emergency lighting, telephones, duress alarm systems (including the central computer) and electronic locks to the emergency power supply.

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

Treatment rooms should be body protected.

FIRE SAFETY
Fire requirements are covered by relevant Building Codes and Standards.

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

Fire mimic panels should be installed in Staff Stations.

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

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

INFORMATION TECHNOLOGY AND COMMUNICATIONS
Address the following Information Technology / Communications issues and the associated infrastructure requirements to ensure long term flexibility:

- wireless technology;
- radiofrequency identification (RFID) for access control, locks etc.;
- duress alarm systems;
- voice / data (telephone and computers);
- videoconferencing capacity / telemedicine;
- electronic medical records;
- clinical point of care;
- patient administration systems (PAS);
- paging and personal telephones, replacing some aspects of call systems;
- consumer multimedia devices including bedroom monitors that function as televisions, computer screens for internet access, etc.;
- bar coding for supplies and x#rays / records;
- server and communications rooms;
- e#learning and simulation;
- e#medication management and e#storage systems e.g. automated; and
- dispensing systems.

STAFF AND EMERGENCY CALL SYSTEM
Installation of a consumer call system in bedrooms and en suites is not considered necessary as most consumers in the Unit are ambulant and capable of asking for assistance. If a system is installed however, it should be compatible with systems throughout the facility and capable of staff override.

Staff assistance and psychiatric emergencies would be managed by local health service guidelines and protocols. Medical emergencies will need access to the hospital's cardiac arrest system.

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

DURESS ALARMS
Duress alarms (personal or fixed) should be provided in accordance with jurisdiction health policies. Further information is available in Part C: Design for Access, Mobility, OHS and Security, Space Standards and Dimensions.

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

HYDRAULIC SERVICES
Warm water systems will be required.

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; and
- *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:

- property bay – visitors;
- interview room - large;
- admission / assessment room;
- secure entry zone (police / ambulance / patient transport enclosed transfer area, entry - airlock);
- store - medication room / clean utility;
- kitchen;
- dining room / beverage bay, mental health;
- exercise room; and
- courtyards - various.

PROPERTY BAY VISITORS
Description and Function
Forensic and some extended care units will have security policies that define items that may be taken into the Unit by visitors. All other visitor belongings will need to be stored in a locker for the duration of the visit.

Location and Relationships
The visitor property bay will be located in the reception area.

Considerations
An appropriate key management system will need to be operational.

INTERVIEW LARGE
Description and Function
These rooms are used to interview and assess consumers and conduct family conferences. Standard interview rooms have been enlarged by 2 metres2 for the purposes of this HPU to reflect the potential for a group of people to be involved in the consultation, rather than a single clinician and consumer.

Location and Relationships
The interview room may be located in the reception area for meetings with visitors or with other consultation / therapy rooms in the inpatient area.

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

SECURE ENTRY ZONE
Description and Function
In circumstances where consumers are brought to the unit by police, ambulance or other consumer transfer vehicle, secure entry facilities should comprise:

- fully enclosed parking zone for vehicles that can be secured by a lockable roller door;
- consideration of electronic doors;
- separate area for police to disarm and for gun storage; and
- a small work space for use by escorting officers to complete required paperwork.

Location and Relationships
The secure entry zone should be located to allow consumers entering via the secure entry zone to access the Unit proper directly, without going through the public reception area.
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 an interview room in the inpatient zone.

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.
This area will not be used for pedestrian access.

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

Location and Relationships
Consumers are not permitted to enter this room # however it is located in the consumer zone so that it is accessible for dispensing. 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 preferred).

ADL KITCHEN
Description and Function
The ADL kitchen has been enlarged from 12 metres2 to 16 metres2 in order to accommodate management of centrally cooked meals, as well as consumer use throughout the day. The kitchen will have a servery area.

Location and Relationships
The ADL kitchen will be adjacent to the dining area.

Considerations
Planners may wish to increase the number of ADL kitchens so that fewer consumers have to share the kitchen. If this is the case, the size can be reduced to a standard component.

EXERCISE ROOM

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.

COURTYARDS VARIOUS

Description and Function

These are secure outdoor areas for programmed activities or relaxation. Functional requirements include passive areas such as seating in landscaped gardens and active areas that encourage exercise. Some outdoor areas should have weather protection and sun shade so that they are useable all year around. Outdoor spaces can be small spaces for a quiet courtyard or private visit, or be large enough to host a large visitor function or sporting activity.

Location and Relationships

Small outdoor areas should be accessible from the consumer lounges for each cluster of bedrooms. Larger outdoor areas should be accessible from the main indoor lounge and be visible from the Staff Station. Garden views from other parts of the Unit should also be maximised.

Considerations

Perimeter fences should be screened. If creating a screen by planting of trees or shrubbery these should not compromise security.

AX APPENDICES

AX.01 Schedule of Accommodation

The Schedule of Accommodation lists generic spaces for this HPU. Quantities and sizes of spaces will need to be determined in response to the service needs of each unit on a case by case basis.

This Schedule of Accommodation assumes a 20 bed unit. Bedrooms are assumed to be grouped into four clusters, each of which has its own lounge, courtyard and laundry.

A kitchen and dining area is shared between two clusters, although planners may prefer each cluster to have its own kitchen and dining area.

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

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

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

MAIN ENTRY / RECEPTION

AusHFG Room Code	Room / Space	SC / SC-D	Qty	m2	Remarks
AIRLE-6	Airlock - Entry, 6m2	Yes	1	6	Optional; can be combined in waiting area
RECL-10	Reception / Clerical, 10m2	Yes	1	10	Health service staff. May be combined with security reception.
RECL-10	Reception / Clerical, 10m2	Yes	1	10	Security checks of visitors to secure/ forensic unit. Incorporates CCTV monitors.
SECR-10	Security Room, 10m2	Yes	1	10	For secure/ forensic unit. Next to secure entry zone. Includes gun safe and bench for paperwork.
WAIT-10	Waiting, 10m2	Yes	1	10	
PLAP-10	Play Area - Paediatric, 10m2	Yes	1	10	Optional
WCAC	Toilet - Accessible, 6m2	Yes	1	6	Includes baby change facilities.
WCPU-3	Toilet, Public, 3m2	Yes	1	3	
	Property Bay - Visitors		1	3	For secure/ forensic unit
INTF	Interview Room	Yes	1	14	For meetings with visitors; admission / assessment of booked consumers. Access from inpatient and near reception preferred positioning.

SECURE ENTRY ZONE

AusHFG Room Code	Room / Space	SC / SC-D	Qty	m2	Remarks
	Enclosed Transfer Area		1	20	Optional for Extended Care and Rehabilitation Unit. Not required if all consumers are voluntary.
AIRLE-10	Airlock - Entry, 10m2		1	10	

CONSUMER / PATIENT AREA (20 BED UNIT)

AusHFG Room Code	Room / Space	SC / SC-D	Qty	m2	Remarks
1BR-MH	1 Bed Room - Mental Health, 14m2	Yes	18	14	
ENS-MH	Ensuite - Mental Health, 5m2	Yes	18	5	All private ensuites recommended in Rehabilitation Unit.
	1 Bed Room - Mental Health - Special		2	18	Bariatric, access, special needs patients.
	Ensuite - Mental Health - Special		2	6	As above
ADLB	ADL Bathroom	Yes	1	12	Optional
BHWAS-B	Bay - Handwashing, Type B	Yes	3	1	1 per cluster
SSTN-14	Staff Station, 14m2	Yes	1	14	Dependant on staffing numbers
OFF-CLW	Office - Clinical Workroom	Yes	1	15	Including benching and computers
INTF	Interview Room	Yes	2	14	All with second door
TRMT	Treatment Room	Yes	1	14	Includes spatial allowance for resuscitation trolley (1m2) and examination couch.
CLUR-12	Clean Utility/ Medication Room, 12m2	Yes	1	10	
ADLK-ENC	ADL Kitchen	Yes	1	20	Includes servery
DINBEV-25	Dining Room/ Beverage Bay, Mental Health	Yes	2	25	Able to accommodate occupational therapy activities
LNPT-30	Lounge - Patient / Family		1	40	Main lounge. Up to 20 people.
LNPT-10	Lounge - Patient / Family		1	15	TV, music, media, computer access
LNPT-10	Lounge - Patient / Family		4	15	1 per cluster of bed rooms.
LNPT-10	Lounge - Patient / Family		1	15	Adjacent to courtyard. For visitor use as well.
MEET-L-20	Meeting Room, 20m2	Yes	1	20	Occupational therapy, group therapy, family conferences. Includes wet area.
MEET-L-30	Meeting Room, 30m2	Yes	1	30	Formal hearings, teleconferencing, staff meetings, professional development, group therapy.
LAUN-MH	Laundry - Mental Health	Yes	2	8	1 per 2 clusters of bed rooms
	Exercise Room		1	20	Gym equipment
WCAC	Toilet - Accessible, 6m2	Yes	1	6	For consumer use, close to activity and outdoor areas
STPP	Store - Patient Property	Yes	1	10	Due to length of stay of consumers
STEQ-20	Store - Equipment, 20m2	Yes	1	20	Indoor activity equipment, outdoor activity equipment
	Courtyard - Outdoor Dining, Activities		1	200	BBQ area (near ADL kitchen), tables and chairs, sink, exercise area and walking paths.
	Courtyard - Passive		4	30	1 per cluster off lounge if using clustered bedrooms

LOW STIMULUS AREA - OPTIONAL

AusHFG Room Code	Room / Space	SC / SC-D	Qty	m2	Remarks
SECL	Seclusion room	Yes	1	15	Optional
	Quiet Room		1	14	Built to seclusion room specifications, but furnished more comfortably
LNPT-10	Lounge - Patient / Family		1	10	For space outside of quiet/ bed room
WCPT	Toilet - Patient, 3m2	Yes	1	4	
SHPT	Shower - Patient, 4m2	Yes	1	4	
	Courtyard - Quiet/ Time Out		1	20	

A dedicated low stimulus area is optional. Inclusion depends on jurisdiction policies regarding seclusion in non acute units, local operational policies and the potential to use other scheduled rooms for de#escalation.

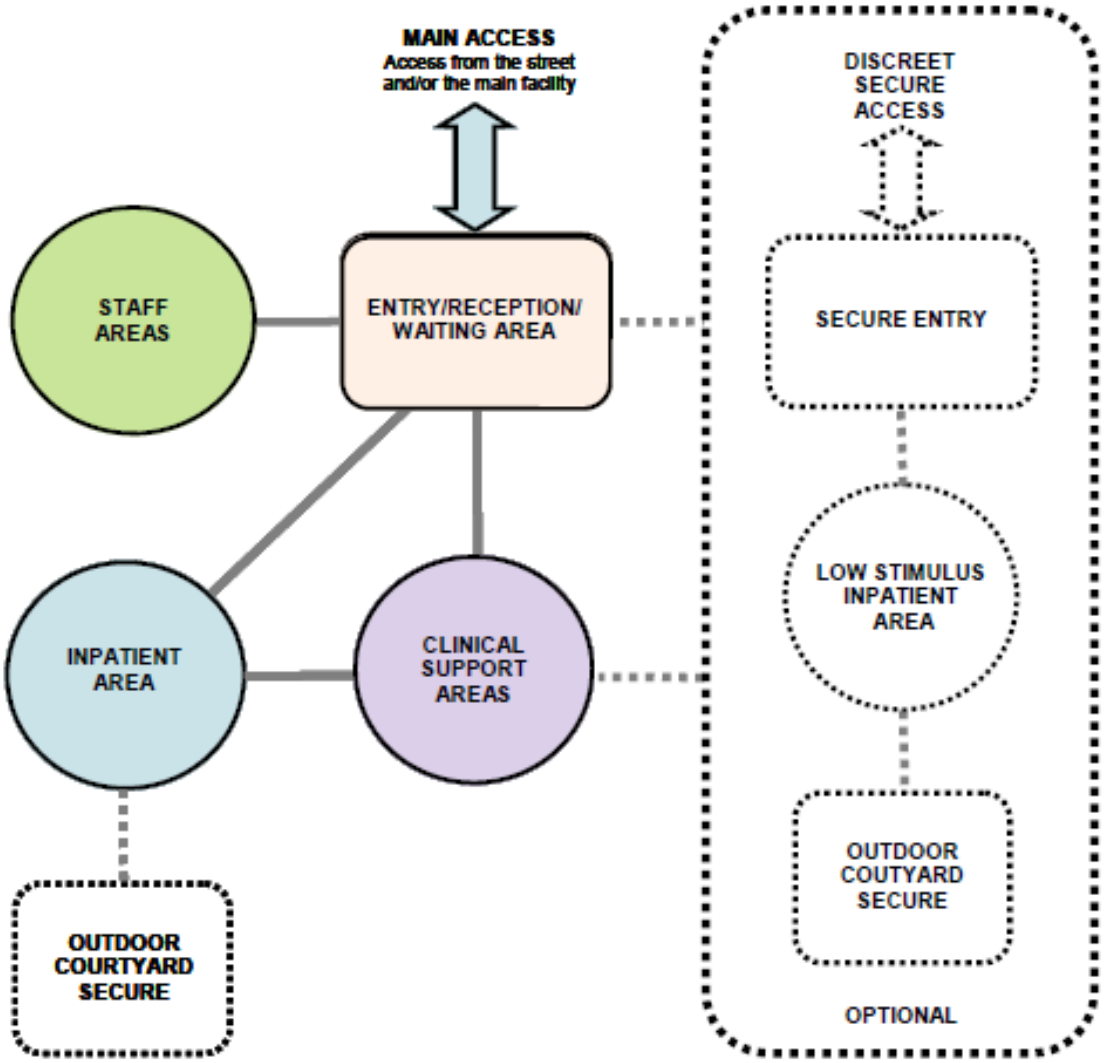
CLINICAL SUPPORT

AusHFG Room Code	Room / Space	SC / SC-D	Qty	m2	Remarks
OFFICE-S12	Office - Single Person, 12m2	Yes	1	12	Clinical Director
OFF-S9	Office - Single Person, 9m2	Yes	1	9	Nursing manager
OFF-S9	Office - Single Person, 9m2	Yes	1	9	Staff Specialist
OFF-2P	Office - 2 Person, Shared	Yes	1	12	CNC, Psychologist
OFF-3P	Office - 3 Person, Shared	Yes	1	15	Consultants, registrars
	Office - Workstations, 4.4m2		4	4.4	Allied health staff, administration staff, hot desks. Refer to staff establishment numbers
STPS-8	Store - Photocopier/ Stationery, 8m2	Yes	1	8	May be incorporated into reception
STFS-10	Store - Files	Yes	1	8	
CLIN	Bay - Linen	Yes	1	2	
CLRM-5	Cleaner's Room, 5m2	Yes	1	5	
DTUR-10	Dirty Utility, 10m2	Yes	1	10	
DISP-8	Disposal Room, 8m2	Yes	1	8	
STGN-8	Store - General, 8m2	Yes	1	8	
SRM-18	Staff Room, 18m2	Yes	1	18	
PROP-2	Property Bay - Staff	Yes	1	2	
WCST	Toilet - Staff, 3m2	Yes	2	3	
SHST	Shower - Staff, 3m2	Yes	1	3	
	Courtyard - Staff		1	20	

Office areas are given as a guide only; actual numbers are dependent on the staff establishment and to individual jurisdictions specific staff office accommodation policies. Project teams in NSW should refer to Asset and Contract Services, NSW Health, 2005, NSW Office Accommodation Policy # Public Health Organisations and Ambulance Service.

AX.02 Functional Relationships / Diagrams

The following diagram sets out the functional relationships between zones in a non acute mental health inpatient unit.



AX.03 Checklists

Refer to the Planning Checklists at the ends of Parts A, B, C and D of the AusHFG.

AX.04 References

The following references are cited in this document:

- AHIA, 2010, AusHFG Part C: Design for Access, Mobility, OHS and Security, Space Standards and Dimensions, Australasian Health Facility Guidelines, Australasian Health Infrastructure Alliance (AHIA), Sydney, NSW.

- AHIA, 2010, AusHFG Part E: Building Services and Environmental Design, Australasian Health Facility Guidelines, Australasian Health Infrastructure Alliance (AHIA), Sydney, NSW.
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- AHIA, 2010, AusHFG Part B: HPU 133 Psychiatric Emergency Care Centres (PECC), Australasian Health Facility Guidelines, Australasian Health Infrastructure Alliance (AHIA), Sydney, NSW.
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- AHIA, 2010, AusHFG Part B: HPU 250 Ambulatory (Community/Outpatient) Mental Health Unit, Australasian Health Facility Guidelines, Australasian Health Infrastructure Alliance (AHIA), Sydney, NSW.
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AX.05 Further Reading

SERVICE PLANNING

- NSW Health 2008, Chronic and Continuing Care: Rehabilitation and Recovery, NSW Non#Acute Inpatient Mental Health Service Strategy 2007#2012 (unpublished), NSW Health;
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- Department of Human Services 2005, Expanding support and treatment options within mental health services, Prevention and recovery services, Service Guidelines, Victorian Government; and
- Department of Human Services 2007, An analysis of the Victorian rehabilitation and recovery care service system for people with severe mental illness and associated disability. Project report, Victorian Government, Melbourne.

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- Coombes, W & Coombes, P 2004, A Literature Review: The Effect of the Built and Natural Environment of Mental Health Units on Mental Health Outcomes and the Quality of Life of the Patients, the Staff and the Visitors, prepared for The Centre for Mental Health, NSW Health.

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- ACT Health 2007 (updated 2009), National Mental Health Seclusion and Restraint Project (NMHSRP) National Documentation Outputs, Australian, ACT Health, viewed 3. June 2010, http://www.nmhsrp.gov.au/c/mh and
- UK Department of Health, 1993, Design Guide Medium Secure Psychiatric Units, NHS Estates.

RELEVANT STANDARDS AND LEGISLATION

- ACT Mental Health (Treatment and Care) Act 1994;
- Northern Territory Mental Health and Related Services Act 1998;
- NSW Mental Health Act 2007;
- Queensland Mental Health Act 2000;
- South Australian Mental Health Act 2009;
- Tasmanian Mental Health Act 1996;
- Victorian Mental Health Act 1986; and
- West Australian Mental Health Act 1996.