Australasian Health Facility Guidelines

Part B - Health Facility Briefing and Planning
0137 - Mental Health Intensive Care 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 and models of care of the defined catchment population.

It is a new HPU written during 2012 - 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 Mental Health Intensive Care 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 and Section 90 - Standard Components, Room Data and Room Layout Sheets; 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 and 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 136 Non Acute Inpatient Mental Health Unit; and
- HPU 250 Ambulatory Mental Health Unit.

TERMINOLOGY

Mental Health Intensive Care Unit (MHICU) is the term in most common usage in the jurisdictions, however Psychiatric Intensive Care Unit (PICU) is also used. As the AusHFG already use the acronym “PICU” to refer to Paediatric Intensive Care Unit, it will not be used in this HPU.

Consumer: in the mental health context, the patient is referred to as the ‘consumer’ and will be the term utilised for 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.

Nomenclature of beds: different terminology is used by the different jurisdictions. 'Acute' beds may also be known as 'general' or 'open' beds. 'High dependency' may also be known as 'observation' or 'secure' beds. For consistency and clarity, this HPU uses the terms 'acute' and 'high dependency' when referring to these beds and zones.

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.

01.03 Policy Framework

GENERAL

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

- appropriate service models that ensure a comprehensive service network throughout state and regional health jurisdictions;
- safe and effective care that minimises both staff and consumer risks;
- 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) consumers / 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.

Project teams are encouraged to refer to Department of Health and Ageing, 2007, National Strategic Framework for Aboriginal and Torres Strait Islander Health.

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

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 the engagement process (as part of the development and planning of a MHICU) includes consumer and carer groups in the briefing process and development of local operational guidelines to support the consumers' admission.

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

01.04 Description

DESCRIPTION OF HEALTH PLANNING UNIT (HPU)

Psychiatric intensive care inpatient services provide short#term back up and support to other mental health services in the management, treatment challenges of individuals with complex, high acuity, and severe behaviour disturbances.

MHICUs require consumer admission / assessment functions.

A multidisciplinary team delivers intensive clinical management, strong psychiatric medications and close observation in a secure (closed inpatient unit) environment, until the consumer is well enough to be transferred to a less restrictive setting.

Criteria for admission to a MHICU are generally as follows:

- detained under a Mental Health Act;
- experiencing acute episode of psychiatric illness / disorder;
- exhibiting psychiatric symptoms complicated by severe behavioural disturbance;
- medically stable;
- unable to be supported in an open inpatient unit setting; and
- exhausted resources of high dependency units (HDU).

Admissions are expected to have a short length of stay for the duration of the ‘crisis’ period only. While this differs depending on the service model, two days to three weeks is the target range variously reported in the literature, although some stays will be longer. It should be identified that there may be consumers who require their treatment to be supported in a MHICU until discharge. This may be of many months duration. Refer to Feinstein A, Holloway F., 2002, Evaluating the use of psychiatric intensive care unit: is ethnicity a risk factor for admission?

CONSUMER CHARACTERISTICS

Consumers are classified as involuntary under the relevant Mental Health Act.

The age of admission to the MHICU is defined as 18 to 65 years, however flexibility is recommended according to consumer need and local policies.

Typical behaviours exhibited by consumers include: aggression, violence towards self and/or others, destruction of their environment, an inclination to abscond and loss of capacity for self#control.

Consumers are also vulnerable during profoundly psychotic episodes and seen as 'at risk’ requiring ongoing close observation and supervision at all times. These are not forensic consumers.

UNIT DESIGN

A MHICU requires a high level of security and safety provision with clear lines of sight.

This needs to be balanced with the requirement to provide an effective therapeutic environment which is pleasant, spacious, light filled, comfortable, non-threatening and domestic in style.

For a MHICU the following are important for the Unit’s design:

- a safe and secure environment;
- ability to separate consumers by gender or other criteria within the Unit;
- universal access and facilities for the disabled;
- privacy and safety including sexual safety;
- cultural needs of consumers;
- comfort and visual satisfaction (domestic style furnishings, decor, artworks);
- quiet spaces and active indoor and outdoor spaces for therapy and relaxation;

- maximum penetration of natural light and, where possible, views;
- avoidance of isolated spaces for both consumer and staff safety e.g. no unsupervised blind corners, recessed areas, alcoves;
- the need for space cannot be overemphasised as a means of reducing the potential for aggressive behaviour by means of wide corridors and recreation areas large enough to avoid crowding;
- fixtures and fittings that minimise the opportunity for consumer self-harm or injury to others, with special attention to bathrooms, bedrooms, courtyards, seclusion rooms and formal hearing rooms;
- acoustic management, particularly of bedrooms;
- safe and supervised access for visiting family members / carers;
- sufficient flexibility to adapt over time in response to changes in practice, treatment and the consumer demographic; and
- compliance with fire safety, building regulations and standards. Consideration should also be given to the following:
- availability of qualified staff and the mix of staff;
- changes in technology;
- maximising efficiencies in recurrent/operating costs; and
- interplay between inpatient and ambulatory care services.

BUILDING STRATEGIES

Architects, designers, engineers and builders should recognise and understand that the fabric of a MHICU is required to be considerably more robust than other units to withstand the destructive behaviours exhibited by some acutely unwell consumers.

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 consumers to self#harm.

SPATIAL REQUIREMENTS

Lounge, dining and activity areas require 10 m2 per person, as per high dependency units.

Outdoor areas require 10 m2 per person, as per high dependency units.

02 PLANNING

02.01 Operational Models

HOURS OF OPERATION

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

MODELS OF CARE – SERVICE DELIVERY

The MHICU is a tertiary service (role delineation of level 5 or 6) with Regional / District responsibility, providing short stay care to acutely mentally ill adults with extremely challenging behaviour.

Intensive professional care with high staff to consumer ratios is provided by psychiatrists, Visiting Medical Officers, registrars, nurses and allied health staff (pharmacy, psychology, social work, occupational therapy etc.).

Admission and discharge will not be direct from the community in most instances. Referrals will mostly be made from acute units and HDUs, according to clinical need. Some MHICUs may admit consumers directly from emergency care (or PECC unit if applicable) and perform the assessment and admission process within the MHICU. Other MHICUs may choose to only admit via the acute unit.

The rapid and timely response to a medical emergency supports the collocation of a MHICU closely located to a general hospital.

If admission to the MHICU occurs during the course of an acute admission, the interruption to a consumer's therapeutic program should be minimised by continuing with the program as is achievable.

MODEL OF CARE – FACILITY CONFIGURATIONS

It is not recommended that a MHICU be a standalone facility.

Unit configurations applicable to MHICUs are as a separate Unit located within a mental health or acute care complex. The MHICU may be entirely self-contained, or MHICU beds may be collocated with high dependency and/or acute adult mental health inpatient beds with shared support facilities.

UNIT/ CLUSTER SIZE

There is variation in the literature about the optimal Unit size. Eight to 12 beds is the consensus range, depending on the service catchment demand.

Ideally the MHICU will be designed to have clusters of beds that enable separation or segregation of consumers for acuity, gender, diagnosis, risk taking behaviours, time out or seclusion etc. Beds may be broken down into clusters of two, three, four or six beds, to accommodate the need for separation or segregation with associated soft spaces (internally and externally) to support the clustered areas. The most acute consumers are nursed in the smaller clusters.

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 other health services from where consumers may be referred. They impact on the capital and recurrent costs of a facility and will vary from unit to unit depending on a wide range of factors such as the clinical characteristics of the consumers and the defined role of the Unit. The cost implications of proposed policies should be fully evaluated to ensure the most cost-effective and efficient design solutions are developed in providing therapeutic and high quality physical environments.

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

The following policies are particularly relevant to a MHICU.

ELECTROCONVULSIVE THERAPY (ECT)

ECT and recovery should only take place in a day procedures unit, the operating unit of a Hospital campus or, dedicated and fully equipped ECT suite within a mental health complex, if activity data and support staffing is endorsed and supportive of this model. Safe, secure and appropriate private travel routes to and from the ECT suites should be considered as part of the design process.

For further information refer to Mental Health and Drug and Alcohol Office, NSW Health, 2011, Electroconvulsive Therapy: ECT Minimum Standard of Practice in NSW.

LOW STIMULUS AREA

Seclusion is “the confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented” (NMHRSP 2009). It is an intervention of last resort that protects the consumer, other consumers, staff and visitors from significant harm through containment, isolation and stimulus reduction in order to allow the consumer to settle (NSW Health, 2012). Generally seclusion will only be implemented for involuntary consumers after other de-escalation strategies have failed. Refer to jurisdiction policies on seclusion and restraint, which may differ from jurisdiction to jurisdiction.

Reduction and eventual elimination of the use of seclusion is a recognised goal across contemporary mental health services both nationally and internationally (NMHSRP 2009). Appropriate facility design will contribute to this goal, along with a range of other prevention strategies.

MHICUs seek to avoid the use of seclusion and its associated stigma, thereby creating a more positive therapeutic milieu in the Unit. Nevertheless, an area away from the main MHICU is required where a single consumer can be nursed if required.

Seclusion rooms have very specific design requirements that are addressed in Section 134.21.23 of HPU 134 Adult Acute Mental Health Inpatient Unit.

Time-out is a different management strategy for voluntary quiet time. A quiet room is used which will be more comfortably furnished.

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

References pertinent to these strategies are:

- HPU 134 Adult Acute Mental Health Inpatient Unit; and
- Mental Health and Drug and Alcohol Office, NSW Health, 2012, Aggression, Seclusion and Restraint in Mental Health Facilities in NSW.

SMOKING

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

BARIATRIC CONSUMERS

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

CATERING

It is recommended that meals be prepared for consumers in the hospital’s main kitchen or as per the hospital’s existing arrangements.

It is beneficial for capable consumers to be involved in serving themselves e.g. breakfasts or snacks, as a part of activities of daily living. If this practice is implemented, the Unit kitchen will need a large serving bench attached to the kitchen which is accessible by consumers. Consumers should not have access to the Unit kitchen.

A cold beverage facility should be accessible to consumers and their visitors at all times. Hot drinks should only be accessible under carer / staff supervision.

EMERGENCIES

Medical emergencies will be handled in accordance with the health facility's standard policies and 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 treatment room / clean utility.

Psychiatric emergencies such as suicide, violent behaviour etc., should be supported in accordance with Unit policies, procedures and guidelines.

STAFFING

A high staff-to-consumer ratio is a feature of a MHICU. Actual numbers of staff will depend on the size of the Unit and the clinical service plan, functional brief and supported models of care.

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

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

STAFF ESTABLISHMENT

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

- psychiatrists;
- registrars;
- nurses;
- psychologists;
- allied health staff (occupational therapists, art therapists);
- administrative staff;
- housekeeping, maintenance and catering staff;
- security and other emergency response personnel; and
- consumer advocates. Visiting services may include:
- legal officers;
- advocates;
- official visitors;
- dieticians;
- pharmacists;
- representatives from other agencies;
- community health staff; and
- students.

A staff establishment by full time equivalent (FTE), category and shift (when completed and endorsed) will assist with the spatial requirements for both the inpatient unit and staff office accommodation and the associated amenities to support the Unit.

FIREARM SECURITY – POLICE

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

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

02.03 Planning Models

GENERAL PRINCIPLES

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

LOCATION

It is essential that this HPU have a ground floor location in order to ensure safe and secure outdoor areas. It is also necessary to avoid risks for the acutely mentally ill associated with a location above ground level.

Location of the Unit needs to ensure that the general public and patients in other parts of the facility cannot see into the building or outdoor areas.

TRAFFIC FLOWS

Movements external to the Unit may be between:

- the Unit and the Adult Acute Mental Health Inpatient Unit (acute or HDU zones);
- the Unit and the Psychiatric Emergency Care Centre (or Emergency Department);
- the Unit and medical imaging; and
- the Unit and operating theatres.

This consumer group can be unpredictable. Consider the requirements associated with moving consumers between units to minimise transportation distances and to avoid movement through high traffic public areas.

CONFIGURATION / LAYOUT

The plan for the Unit should reflect specific operational polices and the specific model of care.

The main entry and reception can be shared with other mental health services if they are collocated, however, public access into the MHICU itself will be via a central, secure, staff controlled entry point.

The ability to create clusters of beds for the separation of consumers (based on gender, age, diagnosis, acuity and behaviours) is recommended. 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.

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

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 between staff station and 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 BCA requirements (Australian Building Codes Board 2009).

In developing the layout, consider emergency access / egress of consumers, police and consumer flow to operating theatres / day procedures for ECT, imaging etc.

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 MHICU 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, low stimulus area, formal hearing room, public spaces and/or staff office areas.

Sharing of clinical space and consumer recreational areas with other mental health units, however, is not recommended for the MHICU.

Where facilities are shared the following considerations need to be taken into account in determining the 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 / MHICU entry point;
- secure entry zone;
- seclusion;
- consultation / treatment rooms;
- medication room / clean utility;
- consumer bedrooms;
- consumer bathrooms;
- low stimulus area;
- dining room;
- activity and recreation areas – indoor;
- activity recreation areas – outdoor;
- visitor / family amenities;
- meeting rooms;
- staff station / clinical resource area;
- storage; and
- staff offices and amenities.

MAIN ENTRY / RECEPTION / MHICU ENTRY POINT

A dedicated secure, staff controlled entry point to the MHICU is required to allow supervised access into the Unit. Depending on the overall configuration of the campus, the MHICU's controlled entry point may be collocated with the Main Entry / Reception for the mental health complex - which is the central point of entry for all visitors and consumers to the mental health complex.

For a stand-alone MHICU the entry point is separate from the Main Entry / Reception, it may need a dedicated waiting area for visitors to the MHICU. This sub-waiting area should have access to public amenities including an accessible toilet. The MHICU entry point should be designed so that no visitor can directly access the MHICU without either reporting to staff or having some means of communicating with

staff inside the Unit. Options include intercom and CCTV both outside the main door and at the entry door to the inpatient area.

If a reception desk model is adopted at the MHICU entry point, it should be designed to enhance security while maintaining a visually welcoming environment. Security screens can be used, however they should be designed so as not to impede communication or visibility. Alternatively, the depth of the reception counter can be increased. The staff controlled entry point should have direct access to a safe retreat in an adjacent secure area. Personal and fixed duress alarms should be provided.

Involuntary consumers being admitted to the MHICU are likely to enter via a secure entry (either via police or ambulance). An appropriate access route will be planned for consumers being transferred internally from an acute unit or emergency department (if transfer by vehicle is not indicated or required). This spatial area requires review as part of the design relationships within the building.

SECURE ENTRY ZONE

Given that this type of Unit will be a tertiary service, the mode of consumer transfer will regularly be inter hospital, requiring a secure vehicle and consumer reception / assessment area.

The secure vehicle area will preferably have direct access to the MHICU. However, its optimum location will depend on overall planning solutions and resolution of functional relationships for the mental health or general acute care facility as a whole, as the secure vehicle area will likely be utilised by other consumers (e.g. HDU and acute consumers) as well as MHICU consumers. If the secure entry is shared, it is not appropriate to expect the MHICU consumers, who are particularly unwell, to be escorted via a long route through other parts of the facility.

A secure consumer admission / assessment area will be required in the MHICU. This area might also be suitable for visits with consumers.

Refer to Non-Standard Components for details.

CONSULTATION / TREATMENT ROOMS

Consultation / treatment rooms may include rooms for interview, consultation, assessment and treatment. Rooms will variously cater for individual and group therapy. The number and specific purpose will be determined by the Unit’s size, service profile and number of clinicians visiting on any one day.

Interviews involving consumers should be restricted to dedicated consultation / therapy rooms. Consultation / treatment rooms should be located within the envelope of the inpatient zones within reasonable observation of staff stations.

Consultation and interview rooms need to be large enough to comfortably accommodate up to six people, including the consumer, clinicians and carers. Consultations / group therapy involving more than six participants (such as family conferences) will generally occur in a medium / large meeting room.

All rooms should have two exit doors and at least one fixed duress alarm for safety. Furniture arrangement should encourage informal discussion whilst not obstructing staff exit routes should the need arise.

The examination / assessment and/or treatment room (these may be the same or separate rooms) will be used for preliminary consumer assessment, examination and minor procedures such as dressings and injections. It requires locked cupboards (keyed alike) for the storage of clinical equipment, syringes / needles and other possibly hazardous materials. ‘Sharps’ containers need to be securely enclosed for ease of disposal and for prevention of their use as weapons or for self#harm. An examination couch, examination light, hand basin and second exit door are required. Doors should be lockable with swipe card (with key override) or similar restricted access, given the range of possibly hazardous equipment stored in this space.

Sound-proofing and robust walls and doors are essential.

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.

All cupboards should be lockable. Glass-fronted cupboards for medication storage may assist in inventory control. Comply with the requirements of the respective state or territory poisons legislation in the provision of storage.

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

A hand basin is required.

Swipe card access to entry doors with key override should be provided.

CONSUMER BEDROOMS

All bedrooms will be single. To facilitate separation of consumers, bedrooms may be clustered in groups of three, four or six rooms. Each cluster is to have access to a private sitting area. The design should allow the clusters to be managed independently or as a whole, as required.

Bedroom doors should ideally open outwards to prevent consumers attempting to blockade themselves in their bedroom. This has implications for corridor widths. Outward opening doors should be recessed to prevent obstruction of corridors.

Services will include:

- body protected power;
- two power outlets;
- optional internet outlet;
- staff alarm system – mobile or fixed with five metre locators;
- low wattage night light switched from outside the room; and
- nurse call/staff assist.

Medical gases will not be provided.

Consumers will have access to lockable storage for their personal possessions outside their bedroom.

Project staff are encouraged to review Department of Health, NSW, 2013, Technical Series TS11 - Engineering Services and Sustainable Development Guidelines.

ENSUITES AND BATHROOMS

Provision of private ensuites to each bedroom versus shared toilet / shower accessed from the corridor may be decided on a project-by-project basis. The following issues are for consideration:

- private ensuites with direct access from a bedroom create a greater sense of privacy and reduce concern of intrusion by other consumers. Some consumers may perceive their privacy or safety to be compromised in a shared bathroom with corridor access;
- private ensuites may be designed without a door, or the door can be lockable in the open or closed position depending on individual requirements;
- shared bathroom facilities with corridor access should be arranged as separate toilets and showers. They may be designated as male and female;
- shared facilities with corridor access allow better staff supervision which is particularly valuable for more acute consumers in the Unit;
- corridor access bathrooms increase the number of doors into the corridors which may in turn detract from efforts to create a domestic and easily navigable environment; and
- corridor accessed bathrooms act as a backup in instances where a private ensuite is out of service.

Staff express a preference for managing the most acute consumers in clusters where bathroom facilities have corridor access.

Projects may adopt a mix of private and shared ensuites / bathrooms to achieve the respective advantages. As close supervision is aided by corridor access ensuites; this arrangement should be put in place for the most unwell consumers.

Bathroom /ensuite doors should be lockable inside by the consumer but able to be opened by staff in an emergency. Private ensuite doors should open outwards against a wall and should be able to be locked in the open position or closed position, depending on the particular needs of the consumer.

Fittings (such as towel rail, clothes hooks etc.) will have a breaking strain of 15 kilograms to minimise opportunities for self-harm. Other ligature points such as shower curtains need to be avoided 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.

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

If vinyl is used for wall and floor surfaces, any joins are to be welded.

Refer also (in this HPU) to Section 3.09 regarding Plumbing Fixtures.

LOW STIMULUS AREA

An area is required where a single consumer can be nursed if required. This may be in a small bed cluster that can be isolated to nurse one consumer. Alternatively, it can be in a low stimulus area that has a quiet room, seclusion room and access to a bathroom, outdoor protected area/courtyard and sitting area other than the bedroom/seclusion room facilities.

The low stimulus area may be within the Unit proper (in a quiet location) or shared with HDU/acute mental health beds if they are collocated.

Refer to relevant section in HPU 134 Adult Acute Mental Health Inpatient Unit.

DINING ROOM

There should be a formal dining area where consumers can sit in groups or alone. Alternative dining spaces should be provided, should it be necessary to separate consumers, within the MHICU.

Square tables with rounded corners are preferable to round tables and should be sufficiently large to safely hold four trays and constructed from a heavy building material. Décor should reflect a domestic environment.

There should be direct access to an outdoor area that also has overhead sun and wet weather protection for use in all weathers.

Access to a toilet from both the dining and outdoor areas should be considered.

A small beverage bay may be located in the dining room or separate alcove for general use by consumers outside of mealtimes, plus it facilitates easy hydration for consumers.

A small servery will be required for storage of meal carts, basic provisions and rubbish, however it is anticipated that meals would be delivered from the hospital kitchen, or via a servery in collocated mental health inpatient units. It is not anticipated that the servery would be used by consumers for activities of daily living / food preparation.

ACTIVITY AND RECREATION AREAS - INDOOR

Insufficient ‘space’ in a mental health facility tends to increase the level of aggression in the Unit. Although length of stay is intended to be brief, a variety of well-proportioned indoor activity areas should be provided so that consumers can participate in a range of activities concurrently, such as meals, television, art, games, music, computers, library, indoor facilities for exercise, telephone contact. This will contribute to a positive therapeutic environment and influence the quality and efficacy of the clinical intervention.

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

- quiet lounges for relaxation, time out or to socialise;
- television / music room with TV, multimedia players etc. in fixed cabinetry;
- multi-function recreation area used by all consumers in the Unit (a secondary use of the dining room);

- indoor exercise facility; and
- self-care laundry – optional.

Recreation rooms should be clearly observable by staff.

More than one lounge should be provided to support the management of different consumer groups. A large lounge for people engaged in a range of recreational activities should have direct access to a secure outdoor area. Gender specific areas are identified as a particular need in the literature. Each cluster of beds should have access its own sitting areas. The arrangement of furniture in activity areas should seek to enhance social interaction.

The Unit will have access to a sufficiently large multipurpose room that can accommodate formal hearings and undertake telehealth activities either within the MHICU or shared with collocated units. The access route to this room needs to be secure and offer privacy for consumers.

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

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

Cupboards should be lockable and extremely durable.

ACTIVITY AND RECREATION AREAS - OUTDOOR

Outdoor areas for programed activities or relaxation are treated as therapeutic areas. There should be passive outdoor spaces (seating in landscaped garden area) and active outdoor spaces that encourage exercise (half basketball court, walking paths etc.). Some of the outdoor area should have soft surfaces e.g. grass, soft fall as well as weather protection and sun protection. Views from the Unit into gardens are desirable, as is an outlook beyond the Unit. Full and soft lighting should be provided to outdoor areas at night.

It may be appropriate to have one large and one small outdoor area to facilitate separation of consumers. Alternatively, access to the outdoor area can be supported by staff to enable the separation of consumers.

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

- visibility from day areas, avoiding blind spots, for supervision purposes;
- screened from public view to protect privacy;
- ordered rather than wild gardens are recommended, and plants with soft rather than prickly foliage;
- shaded and weather sheltered areas available;
- open / active areas (e.g. basketball ring);
- passive areas such as seating in landscaped gardens;
- fixed outdoor furniture;
- a barbeque area;
- a designated smoking area if applicable;
- landscape features and plantings set back from the perimeter wall to avoid breaches of perimeter security; and
- lighting for night use and improved vision to outdoor areas after dark.

VISITOR / FAMILY AMENITIES

Opportunities need to be provided for carers to be involved in care. A room should be provided for consumers to meet with visitors, including children in private, however it must be observable by staff. It will be located so that visiting children do not need to enter the Unit proper, or an alternative room for this purpose will be available. This, or a separate meeting area, should also be available for interviews between carers and staff.

A waiting space in close proximity to the formal hearing room should be provided for visitors in attendance at hearings etc. Visitors should have access to a beverage bay. Visitor toilets and baby change facilities should be provided, at the main entry / reception or the MHICU entry point.

MEETING ROOMS / TELEHEALTH

Multipurpose meeting room/s will be required for:

- case conferences where there may be more than a dozen people in attendance, especially if the case is complicated and community staff and other outside agencies are involved;
- group therapy sessions;
- staff meetings;
- in#service / educational sessions for staff, family and other carers; and
- formal hearings for review of involuntary consumers.

The exact use and number of such room/s will vary according to how many of these spaces can be shared between the various mental health services located on the site.

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

Video conferencing facilities should be available within or in close proximity to the MHICU so that the Unit can fulfil its obligations as a tertiary level service in assessing consumers remotely or providing support / education to other services. Potential for a future link to the Law Courts is also recommended.

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

CLINICAL AND NON-CLINICAL SUPPORT AREAS

Support areas will include: staff station and clinical resource room; medication room / clean utility; linen store; dirty utility; and storage - clinical, non#clinical, consumer.

STAFF STATION / CLINICAL RESOURCE ROOM

It is suggested that these two functions could be combined in an ‘open counter’ area (staff station) should be considered for staff and consumer visitor interactions. This area could be made safe with soft barriers such as stainless steel wire balustrade or offset narrow glass panels. Adjoining the staff station would be an enclosed clinical resource room in which confidential discussions can occur. Functions for these two spaces might be arranged as detailed below.

Staff station:

- workstation for ward clerk;
- space for computers, telephones, printer, facsimile, copier;
- docking stations for portable phones, pagers and personal duress alarms; and
- procedure manuals and references. Clinical resource room:
- staff handovers and case discussions;
- medical records storage; and
- locker storage for staff personal belongings if separate locker room is not provided.

The size of the staff station should be based on the number of staff who will occupy the areas given the high staff to consumer ratios.

There should be unobstructed emergency escape routes.

Note that fluorescent lighting is too strong for night duty requirements, unless dimmer controlled. Down lighting above work spaces for night duty staff may be considered.

STORAGE

Storage is required for common occupational therapy equipment and appropriate recreation equipment located in close proximity to indoor recreation areas and consultation rooms.

Storage for consumers' personal belongings will be provided in a common area, accessible under staff supervision.

It may be appropriate to have a store room located in the outdoor recreation area for ease of accessing outdoor equipment.

Storage of clinical information and general administrative equipment will occur in the staff station / clinical resource room and office areas.

STAFF OFFICES AND AMENITIES

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, perhaps collocated with other mental health service office space. 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.

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

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

Staff amenities will include a staff room and outdoor area, located to provide privacy to staff whilst on breaks. These amenities will be accessible at all times for staff use. Provide other staff amenities e.g. toilets, showers, car parking, lockers etc. in accordance with standard requirements.

02.05 Functional Relationships

EXTERNAL

The MHICU will require the following support services at level 4 to justify a level 5/6 role delineation:

- pathology;
- pharmacy;
- medical imaging;
- anaesthetics;
- intensive care services;
- coronary care services; and
- operating suite.

INTERNAL

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

Appropriate relationships need to be achieved between any Acute or HDU mental health beds that are collocated with the MHICU so that opportunities to share support facilities are maximised e.g. reception, secure entry zone, meeting rooms, low stimulus area, staff amenities.

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

03 DESIGN

03.01 Accessibility

EXTERNAL

The Unit requires a controlled entry for visitors and ambulant consumers being transferred from other inpatient mental health units.

A secure entry point is needed for police assisted or ambulance transferred involuntary consumers.

A separate staff entry is preferred.

Ready access is required for support services such as food, linen, supplies, waste disposal etc. This access will be controlled by staff.

INTERNAL

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

A designated entry / exit is needed for consumers being transferred to the main hospital for ECT, imaging etc., whether ambulant, by wheelchair or by trolley.

03.02 Parking

Provide:

- all weather drop#off for consumers / visitors;
- short term parking for police or ambulance vehicles; and
- visitor parking in close proximity, including disabled car spaces.

For information regarding staff parking considerations, 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 consumers, many of whom will require assistance.

A number of items e.g. duress alarms, central computer require connection to an uninterrupted power supply and a generator to provide continuous power between the time of power failure and the time it takes the generator to kick in.

For further disaster planning 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;
- provision for the isolation of consumers with infectious conditions;
- linen handling;
- separation of clean and dirty work flows;
- storage;
- waste management; and
- surface finishes.

Recommended publications for further advice and information include individual jurisdiction policies and guidelines, and Part D: Infection Prevention and Control.

HAND BASINS

Hand basins are required in treatment and medication rooms.

Corridor basins may be replaced by antiseptic hand rub in dispenser units.

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 Unit.

ACOUSTICS

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

Confidentiality of consumer information should also be protected.

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

- sanitary facilities;
- equipment;
- other consumers;
- staff activities e.g. conversations, talking on phone, rounds, meetings, cleaning;

- areas of public movement, lift lobbies, etc.;
- traffic through the Unit including visitors, food, linen and other trolleys, or movement of consumers into or out of the Unit; and
- helipad / helicopter noise.

Solutions to be considered include:

- sound isolating construction. Consider special acoustic isolation throughout this Unit. Return air grilles should be acoustically treated to avoid transfer of conversations to adjacent areas. Door grilles to these areas should be avoided;
- location of the Unit;
- use of sound absorbing materials and finishes;
- separation of quiet areas from noisy areas; and
- changed operational management.

For further information refer to 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 Building Codes Australia (Australian Building Codes Board 1990).

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

Author cited refers to Joseph, A., 2006, Health Promotion by Design in Long-Term Care Settings.

PRIVACY

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

Strategies to enhance privacy include:

- single bedrooms;
- ensuites (if appropriate for consumer’s level of risk);
- acoustic treatment;
- single gender areas;
- low stimulus area located so as to give occupants privacy; and
- no vision into the Unit from the outside.

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

INTERIOR DECOR

Interior decor includes furnishings, style, colour, textures, ambience, perception and taste that can help ameliorate an institutional atmosphere. Cleaning, infection control, fire safety, consumer care and presenting a professional environment should always be considered.

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

In this Unit, furniture and interior decoration should be robust but domestic in style to create a homelike environment (Devlin and Arneill 2003). Furniture should be arranged to promote positive group dynamics. Furniture items should be easily replaceable in case of breakage.

For publications referred to above see:

- Devlin, A.S. and Arneill, A.B, 2003, Health Care Environments and Patient Outcomes - A Review of the Literature; and
- Fleming, R., Forbes, I. and Bennett, K., 2003, Adapting the Ward: for people with dementia.

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 requirement.

All signage and way finding 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 advice refer to Part C: Section 750, Signage.

Consideration needs to be given to the system used in the numbering of 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.

Refer also to Part C: Section 790, Safety and Security Precautions.

ERGONOMICS

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

Badly designed recurring elements such as height, depth and design of workstations and counters, shelving and the layout of critical rooms have a great impact on the occupational health and safety (OHS) of staff as well as the welfare of consumers.

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

ACCESS AND MOBILITY

Where relevant, comply with Australian Standards relating to designing for access and mobility. This would applies to bathrooms, public toilets and ensuites designed for independent wheelchair users including staff.

At least one bedroom and ensuite should be provided for independent wheelchair users. Reception desks should be designed so that at least one place is wheelchair accessible on both sides.

Further details can be sourced from the following publications:

- 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.

Carefully consider the fabric of the building, particularly wall construction, to ensure it is robust enough to withstand abuse. Appropriate materials should be incorporated such as impact#resistant glass and low maintenance / resilient surfaces.

Minimise opportunities for self#harm, e.g. no ligature points and wherever possible / available provide non# removable fixtures and fittings.

For more information and guidance refer to the Fixtures and Fittings section in this document, and 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 consumers.

Doors in this Unit require higher levels of performance specification. Provide solid core doors and door frames and meet all relevant Building Code Australia (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. Bedroom doors should have a viewing panel.

Bedroom doors will open outwards to prevent consumers 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.

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

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.

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

Polycarbonate is not recommended as it suffers from surface scratching which obscures vision.

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

Double-glazed viewing panels with integral venetian blinds should be provided in bedroom to allow observation without disturbing the consumer. Their positioning and construction should ensure that the glazing cannot be broken or removed.

For information regarding the recommended impact-resistant and shatter-proof Grade A safety glass (to comply with AS/NZS 2208 Safety Glazing Materials in Buildings) consult Standards Australia, 1996, AS/NZS 2208:1996 Safety glazing materials in buildings (SAI Global).

SHUTTERS

If shutters are used to secure serveries, beverage bays and linen bays, the following OHS requirements apply:

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

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

03.07 Safety and Security

SAFETY

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

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

Special consideration should be given to the safety needs of acutely mentally ill persons, including:

- reduction of self-harm and suicide;
- medication safety;
- reduction of aggressive behaviour;
- cultural safety of indigenous people;
- safety of staff and visitors in the Unit;
- ability to call for assistance; and
- containment of consumers within the Unit.

Strategies to address these safety concerns include:

- any fitting or fixture capable of supporting a consumer’s weight should be avoided, unless it is an item of furniture intended to bear the consumer’s weight. Fittings in this Unit require a breaking strain of no more than 15 kilograms;
- rounded edges on furniture;
- consultation, interview, formal hearing room and activity areas should each have two doors for egress; and
- ability to separate consumers in different zones of the Unit.

SECURITY

An MHICU requires the highest level of security and safety provision of any health facility. A safe and secure mental health unit is more likely to be achieved when good design is allied with appropriate staff levels and operational policies.

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

Security features may include:

- transfer lobby / airlocks;
- Unit exits or doors to external functional areas e.g. garbage disposal, loading dock etc., should be located in staff only areas;
- key security;
- electronic locking;
- intercoms;
- CCTV / video surveillance;
- personal and fixed duress alarms;
- movement sensors / floor sensors in bedrooms / ensuites;
- all rooms should be lockable, including corridor cupboard doors and fire hose reel cabinets; and
- perimeter fencing height of between 2.7 metres to 4.8 metres.

RISK / HAZARD MANAGEMENT

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

Broad consultation with all stakeholders and other identified processes may be utilised to identify risks according to the availability of expertise to ensure security, health and safety risks are proactively managed.

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

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

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

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

Relevant information can be sourced from National Mental Health Working Group, 2005, National safety priorities in mental health: a national plan for reducing harm.

ACCESS CONTROL

The Unit should be designed with controlled entry and exit points so that no consumer can leave the Unit unless in the company of staff. Public access to the Unit will be centrally controlled.

Key pad locking systems should not be used as consumers will quickly learn the combination.

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

CLOSED CIRCUIT TELEVISION (CCTV) SURVEILLANCE

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

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

- health service policies;

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

DURESS ALARM SYSTEM

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

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

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

- staff can reach them without having to cross the path of the consumer or distressed family member;
- they cannot be activated accidentally e.g. by a chair being pushed back; and
- large rooms may require multiple fixed alarm buttons.

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

PERIMETER SECURITY

The Unit requires a secure perimeter. A recommended height for perimeter fencing has not been established. A typical range is 2.7 metres to four metres. Fencing should be high enough to contain consumers without increasing the possibility of falling injuries should an escape attempt be made. In determining an appropriate height, consideration will be given to the proximity of the perimeter fence to buildings, the topography of the site and consumer profile. Security is enhanced by installing curved fencing rather than having angled joins. CCTV is useful for perimeter security.

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

In addition to individual jurisdiction policies and OHS legislation, the following publications offer information and guidance relevant to safety and security in a MHICU:

- Part C: Section 790, Safety and Security Precautions;
- Department of Health, NSW, 2013, Technical Series TS11 - Engineering Services and 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.

Refer to Part C: Section 710, Space Standards and Dimensions.

WALL FINISHES

Materials used in wall construction need to be able to resist damage from aggressive behaviour. In addition, wall protection should be provided to areas where bed or trolley movement occurs such as corridors, bed head walls, treatment areas, equipment and linen trolley bays.

FLOOR FINISHES

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

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

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.

Information can be sourced from:

- 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 need to be secure to prevent consumers absconding via the ceiling space.

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

03.09 Fixtures, Fittings & Equipment

DEFINITIONS

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

Fixtures: Items that require service connection (e.g. electrical, hydraulic, mechanical) that include, but are not limited to hand basins, light fittings, medical service panels etc. but exclude fixed items of serviced equipment.

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

For more detailed information refer to the Room Data Sheets (RDS) and Room Layout Sheets (RLS), and to:

- 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 or as a weapon. Any fitting or fixture capable of supporting a consumer's weight should be avoided, unless it is an item of furniture intended to bear the consumer's 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.

Fixtures and fittings should be easily replaceable so that any damaged or faulty items can be repaired quickly.

In order to avoid installation of inappropriate fittings and fixtures, consultants can be requested to prepare a list of complying fixtures and fittings for approval by the client.

ARTWORK, SIGNAGE AND MIRRORS

Rigidly fix artwork, signage and mirrors to walls with concealed, flush, tamper-proof mountings.

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

PLUMBING FIXTURES

All exposed plumbing fixtures should be tamper-proof and resistant to breakage and removal, particularly plumbing fixtures accessible to consumers.

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.

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

RAILS, HOOKS AND HANDLES

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

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

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

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

SHOWER CURTAINS AND TRACKS

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

Floor barriers (screen tracks or hobs) should be avoided as they are trip hazards.

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 kilograms 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, roller blinds or other types of blinds / curtains with cords should not be used in bedrooms. Enclosed Venetian blinds with flush controls or electronic controls in the staff station are suggested.

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

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

LIGHTING

Variable lighting in the evening, rather than on/off lighting, can reduce aggression. The quality of darkness should be maximised at night to enhance sleep. Night lights are required as a fall prevention strategy, so positioning should be carefully considered so as not to disturb sleep.

Light fittings should be vandal#proof and incapable of supporting a consumer’s weight.

03.10 Building Service Requirements

GENERAL

In addition to topics addressed in the clauses below, refer to:

- 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 and 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; generally air conditioning should be provided.

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

- provide air grilles and diffusers that prevent the insertion of foreign objects;
- provide tamper-resistant fasteners where these are exposed;
- construct all convector or HVAC enclosures expressed in the room with rounded corners and with closures fastened with tamper-resistant screws;
- use HVAC equipment that minimises the need for maintenance within the room; and
- vents should be fixed to the ceiling to prevent access to the roof cavity.
- Refer to:
- Part D: Infection Prevention and Control;
- Department of Health, NSW, 2013, Technical Series TS11 - Engineering Services and Sustainable Development Guidelines; and
- Standards Australia, 2003, AS HB 260-2003: Hospital acquired infections # Engineering down the risk (SAI Global).

ELECTRICAL SERVICES

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

Protect power outlets in bedrooms from 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;
- patient administration systems (PAS);
- paging and personal telephones replacing some aspects of call systems;
- consumer multimedia devices televisions, computer screens for internet access, etc.;
- bar coding for supplies and x-rays / records;
- consumer information screen integrated with menu ordering, nurse call and other modalities;
- server and communications rooms; and
- e-medication management and e-storage systems e.g. automated dispensing systems.

STAFF AND EMERGENCY CALL SYSTEM

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

The call system should:

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

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

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

HYDRAULIC SERVICES

Provide warm water systems.

Emergency shut off valves should be installed to prevent inappropriate use of ensuites / bathrooms.

MEDICAL GASES

Medical gases will not be required in bedrooms, however, provide bottled gases for emergencies may be required. Secure storage for gas bottles will be needed to prevent use as a weapon.

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:

- interview room - family / large;
- recreation / day area;
- dining room;
- pantry / kitchen;
- lounge – consumer,
- quiet room;
- media room;
- indoor exercise facility;
- lounge / dining / activity (HDU); and
- courtyards (various).

ADMISSION / ASSESSMENT ROOM AND CONSULTATION ROOM – LARGE

Description and Function

These rooms are used to interview and assess consumers as part of the admission process or ongoing treatment. The size of these rooms has been enlarged from 12 to 14 m2 for the purposes of this HPU, to enable a group of people to be involved in the consultation, rather than a single clinician and consumer.

Location and Relationships

The admission / assessment room may be located in the secure entry zone of the Unit, or in close proximity. The Consultation Room will be located in the inpatient zone where other examination / interview rooms are located.

Considerations

The admission / assessment room will be furnished with comfortable chairs and a small desk. The consultation 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.

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 is preferred.

DINING ROOM / BEVERAGE BAY

Description and Function

This is an area for consumers / patients and visitors to eat meals and snacks. A lockable beverage bay will be included. It is five m2 bigger than the standard component dining room / beverage bay to ensure that it is big enough for all consumers / patients to dine together on occasions where this is possible.

Location and Relationships

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

Considerations

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

INDOOR EXERCISE FACILITY

Description and Function

This space is included as an option for a MHICU. Regular physical exercise is acknowledged as an important strategy in managing mental illness, however it is also acknowledged that clinicians may take the view that ICU consumers are too unwell to use gym style exercise equipment.

Location and Relationships

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

Considerations

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

SECURE ENTRY ZONE

Description and Function

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

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

Location and Relationships

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

There should be easy access to the MHICU's Admission / Assessment Room and to the Seclusion Room.

Considerations

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

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

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 12 bed Unit that is planned in three clusters: one cluster of six beds, one cluster of four beds and one cluster of two beds each.

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, 10m2	Yes	1	10	For security
RECL-10	Reception / Clerical, 10m2	Yes	1	10	A dedicated MHICU reception, depending on relationship to main reception for mental health services on site. Can be smaller depending on clerical functions occuring in this area.
WAIT-SUB	Waiting - Sub, 5m2	Yes	1	5	A sub-wait specifically for the MHICU visitors
WCAC	Toilet - Accessible, 6m2	Yes	1	6	Depending on proximity of other visitor amenities.

CONSUMER AREA

AusHFG Room Code	Room / Space	SC / SC-D	Qty	m2	Remarks
1BR-MH	1 Bed Room - Mental Health, 14m2	Yes	7	14	
ENS-MH	Ensuite - Mental Health, 5m2	Yes	3	5	
WCPT	Toilet - Patient, 4m2	Yes	2	4	Gender designated corridor access toilets. Each pod has 2 toilets.
SHPT	Shower - Patient, 4m2	Yes	2	4	Gender designated corridor access showers Each pod has 2 showers.
	1 Bed Room - Mental Health - Special		1	18	Bariatric
	Ensuite - Mental Health - Special		1	6	
BHWAS-B	Bay - Handwashing, Type B	Yes	3	1	Optional, Recessed bays in corridors - 1 per cluster of beds. May be replaced with alcohol based hand rubs
SSTN-14	Staff Station, 14m2	Yes	1	14	Size dependent on staffing numbers
OFF-CLW	Office - Clinical Workroom	Yes	1	15	Including benching and computers
INTF	Interview Room	Yes	2	14	2 doors
TRMT	Treatment Room	Yes	1	14	Includes spatial allowance for resuscitation trolley (1m2) and exam couch
CLUR-14	Clean Utility/ Medication Room, 14m2	Yes	1	14	Optional: may be combined with treatment room
PTRY	Pantry	YES	1	8	Not intended for consumer use. Collocated with dining room
DINBEV-25	Dining Room/ Beverage Bay, Mental Health	Yes	1	25	Able to accommodate occupational therapy activities, May be separated spaces to enable separation of comsumers.
LNPT-20	Lounge - Patient / Family		1	25	Main lounge/ activity area
LNPT-10	Lounge - Patient / Family		1	15	General access
LNPT-10	Lounge - Patient / Family		2	15	Designated for special groups or allocated to smaller bed clusters for consumers requiring separation. Also may be used for dining. A quiet area
LNPT-10	Lounge - Patient / Family		1	15	Private family visits, family conferences
LAUN-MH	Laundry - Mental Health	Yes	1	8	Optional
	Exercise Room		1	20	For consumer use - close to dining area and outdoor activity areas
WCAC	Toilet - Accessible, 6m2	Yes	1	6	Supports ADL activities
STPP	Store - Patient Property	Yes	1	10	
STEQ-14	Store - Equipment, 14m2	Yes	1	14	Indoor and outdoor activity equipment, occuational therapy equipment
	Courtyard -General		1	80	Based on 10m2 per person and 100% occupancy. Reduce to accommodate additional clusetr bedrooms
	Courtyard -General		2	25	For smaller bed clusters

- Note 1: Lounge/dining/activity areas – 10 metres2 per person (as per MHIPU_ HDU).
- Note 2: Outdoor areas – 10 metres2 per person (as per MHIPU _ HDU).
- Note 3: Consult rooms/Interview (inpatient only use) one per five beds.
- Note 4: Examination/assessment rooms – Minimum one per unit.

LOW STIMULUS AREA

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	Yes	1	10	For space outside of quiet/ bed room
WCPT	Toilet - Patient, 4m2	Yes	1	4	
SHPT	Shower - Patient, 4m2	Yes	1	4	
	Courtyard - Secure		1	15	Wet weater and sun protection

This can be planned to swing between Acute/HDU Unit and MHICU, so long as separation of Units is maintained. As an alternative to a 'low stimulus area', one of the small bed clusters can be used to nurse a single acute consumer assuming occupancy allows.

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-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
MEET-L-12	Meeting Room, 12m2	Yes	1	15	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. Provide waiting area if not in close proximity to other waiting space.
STPS-8	Store - Photocopier/ Stationery, 8m2	Yes	1	8	
CLIN	Bay - Linen	Yes	1	2	Enclosed and lockable
CLRM-5	Cleaner's Room, 5m2	Yes	1	5	
DTUR-S	Dirty Utility - Sub, 8m2	Yes	1	8	Optional, may be shared with another unit
DISP-8	Disposal Room, 8m2	Yes	1	8	second entry door to external corridor recommended to reduce access to MHICU
STGN-8	Store - General, 8m2	Yes	1	8	
SRM-18	Staff Room, 18m2	Yes	1	18	May be shared if located in close proximity to another unit.
PROP-2	Property Bay - Staff	Yes	1	2	
WCST	Toilet - Staff, 3m2	Yes	2	3	
SHST	Shower - Staff, 3m2	Yes	1	3	May be shared if located in close proximity to another unit.
	Courtyard - Staff		1	15	
	Discounted Circulation %			32%	

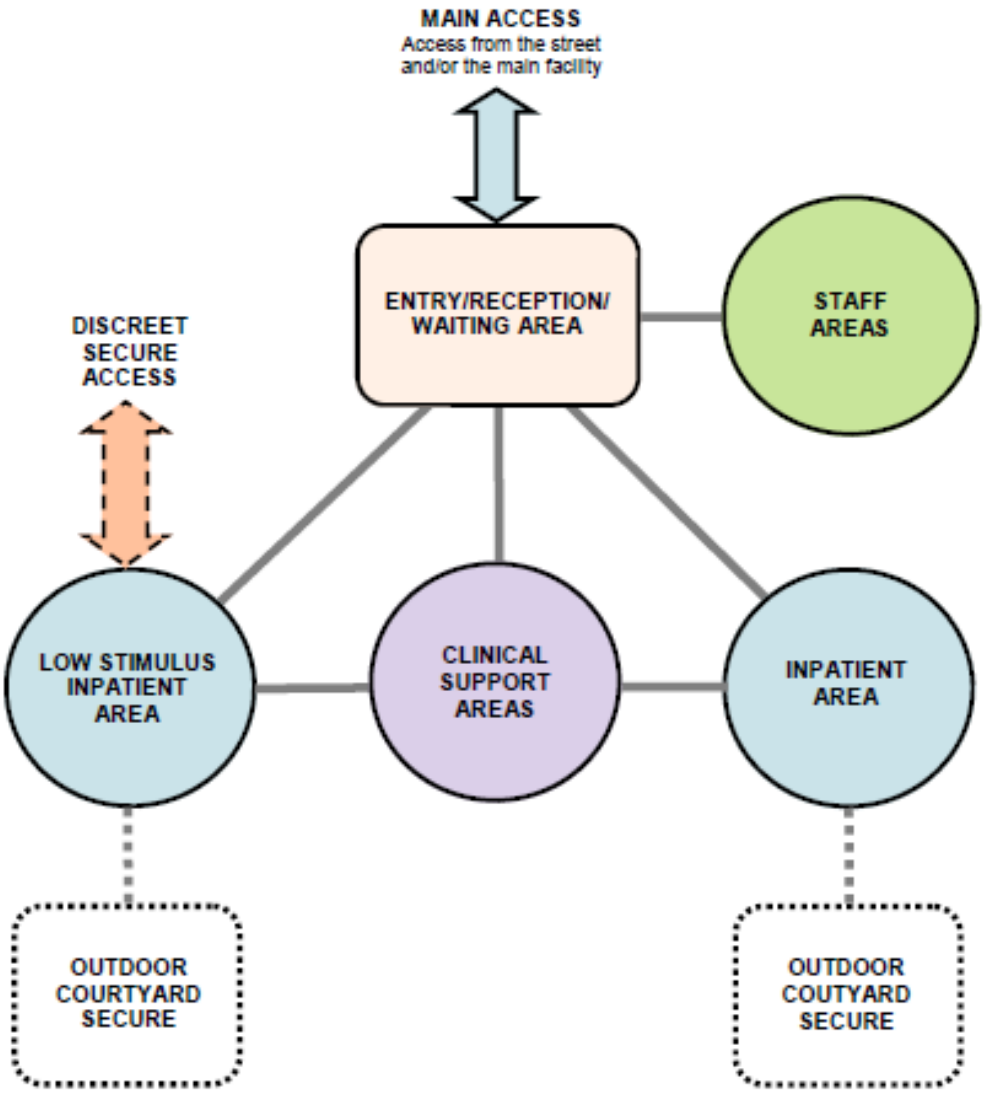
Office areas are given as a guide only; actual numbers are dependent on the staff establishment and to individual jurisdictions' specific staff office accommodation policies.

SECURE ENTRY ZONE

AusHFG Room Code	Room / Space	SC / SC-D	Qty	m2	Remarks
	Police / Ambulance Enclosed Transfer Area		1	20	
AIRLE-10	Airlock - Entry, 10m2	Yes	1	10	Support an ambulance trolley and multiple staff assisting
	Gun Safe Alcove		1	2	Includes bench for paperwork

AX.02 Functional Relationships / Diagrams

The following diagram sets out the functional relationships between zones in an MHIC Unit.



AX.03 Checklists

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

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