Part B – Health Facility Briefing & Design

200 Mental Health Unit – Older Persons

iHFG

International Health Facility Guidelines

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200 Mental Health Unit - Older Persons

1 Introduction

Description

The function of the Older Persons Mental Health Unit is to provide appropriate facilities for the reception, multidisciplinary assessment, admission, diagnosis and treatment of patients presenting with known or suspected psychiatric conditions and behavioural disorders along with assessment of physical health and psycho-social issues. Patients may be admitted on a voluntary or involuntary basis. Treatment is focused on clinical symptom reduction with a reasonable expectation of substantial improvement in the short term.

The Unit must provide a safe, restorative environment. Optimal physical environments are associated with shorter lengths of stay, lower levels of aggression and critical incidents, better client outcomes and better staff conditions and satisfaction. Recurrent costs will be substantially reduced and client services and outcomes improved in such settings.

Some patients may be agitated, aggressive and potentially a risk to themselves or others, including staff. The Unit must therefore provide a high level of security and the capacity for observation and even temporary containment. However, this should be achieved with a therapeutic focus so that while necessary measures for safety and security are in place, they are non-intrusive and do not convey a custodial ambience.

It must be stressed that Older Persons Mental Health Units are not “dementia” units but they should be able to accommodate people with dementia, confusion and disturbed behaviour appropriately.

Target Group

The target group for these services will comprise of older people who:

- develop or are at high risk of developing a mental health disorder at the age of 65 years and over, such as depression, psychosis, anxiety or a severe adjustment disorder
- have had a lifelong or recurring mental illness, and now experience age-related problems causing significant functional disability (i.e. become ‘functionally old’)
- have had a prior mental health problem but have not seen a specialist mental health service for at least five years and now have a recurrence of their illness or disorder that can be optimally managed by Older Persons Mental Health Unit
- present with severe behavioural or psychiatric symptoms associated with dementia or other long-standing organic brain disorder and would be optimally managed with input from Older Persons Mental Health Units. This may include people who are deemed at risk of harm to themselves or to others. Symptoms may include:
  - major depression
  - severe physical and/or verbal aggression
  - severe agitation
  - screaming
  - psychosis.

The families and carers of these older people are also part of the broader target group for Older Persons Mental Health Units.

Client Profile

- Robust elderly (although an Adult Acute Unit may be more suitable in some cases);
- Frail elderly;
- Violent/ disturbed elderly.

Patients may have;

- tendency to wander, become lost or abscond

- reduced personal and social skills and require assistance with personal hygiene, dressing, toileting and eating
- disturbed or aggressive behaviours (verbal / physical)
- confusion, bewilderment, agitation, memory loss
- repetitive, persistent or noisy behaviour
- resistance to care
- withdrawn behaviour
- intentional self-harming behaviour
- physical co-morbidity

Clinical conditions of patients;
- Schizophrenia and psychotic disorders;
- Dementia (incl. Alzheimer' disease) with severe behavioural and psychological symptoms
- Depression, anxiety and mania
- Potential suicide
- Underlying co-morbidities

Regardless of diagnosis, patients may be described as "hyperactive" or "hypoactive" and it is this description that may determine appropriate bed placement within the Unit.

2 Planning

Planning Models

Location

It is highly desirable to locate the Older Persons Mental Health Units on ground floor, in order to provide necessary secure outdoor areas.

Configuration

The Older Persons Mental Health Units it may be developed as:
- A stand-alone Inpatient Unit - or group of units – usually as part of a Mental Health Complex.
- A dedicated Inpatient Unit within a general hospital.
- A number of dedicated Patient Bedrooms as an annexe to an Acute Inpatient Unit within a general hospital.

Bed Numbers and Complement

The number of beds will be determined by the Service Plan but the larger a facility the more confusing it is likely to be for some patients.

Bedrooms may be grouped into clusters that can be defined for distinct patient groups such as male and female patients who may feel threatened if in close proximity to the opposite sex or "hyperactive" and hypoactive" patients. Small groups of bedrooms with an adjacent recreational space will allow better management of changing patient needs and flexibility of use.

Unit Design

The following principles should be applied:
- Reduce the size of the patient groups
- Make the environment as familiar as possible
- Make the environment as domestic as possible
- Make the environment safe and secure
- Make the environment simple, with good visual access
- Reduce unnecessary stimulation
- Highlight helpful stimuli
- Provide for planned wandering
- Provide opportunities for both privacy and community, i.e. a variety of social spaces
- Provide for visitors, i.e. links to the community

Layout

Consideration should also be given to the following issues when planning the layout of a mental health unit:

- Prevalence of violence and theft
- Availability of qualified staff
- Need for space, light and a functional layout
- Changes in the composition of the patient population
- Rapid changes in technology
- Maximising efficiencies in recurrent /operating costs

The final layout of a mental health unit will reflect the interplay between the following factors;

- The interplay between inpatient and ambulatory care services in the Health Service model of service delivery
- Special needs of potential patients
- The effect of mixing mental health and non-mental health clients
- Proximity to Emergency Unit
- Lines of sight – along corridors and across recreational and common areas into courtyard
- Dead-end corridors where patients may be unable to be seen must be avoided and consideration must be given to safe and supervised access for housekeeping, catering, maintenance, security, contractors and other staff who may feel uncomfortable in the mental health environment.

Functional Areas

The Older Persons Mental Health Units will comprise a number of zones as follows:

- Main Entry / Reception / Clerical area
- Admissions Area
- Inpatient bedrooms
- Recreation and family / carer areas including outdoor areas
- Clinical support areas – utilities, treatment rooms, storage etc.
- Staff offices, administrative and management area
- Staff amenities

Main Entry/ Reception/ Clerical Area

These areas are designated for the reception of all persons entering the Unit with the exception of involuntary admissions who will access the unit via a separate Secure Entry (if provided), and deliveries and staff from within the Hospital itself.

A safe environment must be provided for staff in this workspace while providing a welcoming ambience for patients and others. Direct access for reception staff to a safe retreat in an adjacent secure area should be provided in the case of any threat to staff safety from persons arriving at the main entry.

Admissions Area

This zone may include Consult / Exam Rooms

Bedrooms

Generally single bedrooms are recommended but it may be appropriate to include one or two 2 bed rooms in order to assess a patient's ability to socialise once discharged particularly if returning to shared accommodation in a Nursing Home or similar.

Ideally adjustable hi-lo beds be selected for the unit; "hi" adjustable bed position to assist nursing staff in patient care and bed making; "lo" adjustable bed position when patients are resting/sleeping to minimise falls.

A personal display board and lockable storage for personal clothes/ belongings should be provided in bedroom.

One or two bedrooms acoustically treated and contained for very agitated “screaming” patients.

Bathrooms

Most bedrooms should have a dedicated ensuite shower/ toilet. However, consideration may be given to having a one or two fully accessible showers and toilets apart from the bedrooms for use by patients occupying recreational areas.

Size and design of these rooms are crucial as it is a high risk area for both agitated patients and staff and as far as possible, design should be such as to make the showering experience safe and pleasant.

Fixtures and fittings should be securely attached and designed so as to provide no possibility for self-harm or use as a weapon. Refer to Fixtures and Fittings Section for details.

Staff Station & Staff Handover

Ideally staff station & staff handover areas should be a single space oversighting all inpatient zones. Conflict of observation versus confidentiality should be reviewed.

Clean Utility/ Treatment Room

If appropriately sized and equipped, a single room can serve the following functions;

- Examination and procedures that may be best undertaken away from the bedside
- Visual acuity testing; storage & use of ophthalmoscope & auroscope
- X-ray viewing (screens or PACS monitor)
- Medication storage and distribution
- Storage of medical / surgical consumables and sterile supplies
- Storage of resuscitation trolley and defibrillator

Provision of Hand basin is essential.

Direct access from the Staff Station for access control and second locked access from the Unit corridor is recommended.

Courtyards/ Gardens

When designing courtyards and gardens the following requirements need to be considered;

- Oversighted by the Staff Station
- Controlled access for patients, preferably from recreation area/s
- Separate discreet access for gardeners and maintenance staff
- Weather-protection to allow use during inclement weather (agitation may increase if no external access)
- Shade cloth and sun protection.
- No footholds on fences. (Fencing height to be addressed)

Occupational Therapy Room

The Occupational Therapy Room should be multi-purpose, in design and fit-out, to allow varied activities aimed at promoting independence in daily living. Functions and activities involve:

- A.D.L. assessment and retraining
- ergonomic assessment
- sensory, perceptual, cognitive and motor assessment and therapy
- group treatments
- leisure activities
- social interaction

Ideally the occupational Therapy Room may be adjacent to the multifunction activity Room and may share a common movable wall. This would enable the potential for a large space if required.

Fittings and furniture for this area should include;

- emergency call
- stainless steel sink

- clock
- domestic style furnishings that may include chairs, tables and plinth
- wall and door protection for chairs and wheelchairs
- Hand basin

Functional Relationships

General

Acute mental illness in older people may be accompanied by co-morbid physical health or medical issues and is sometimes complicated by delirium. Therefore, acute episodes of illness frequently persist much longer than the four or five days common in adult mental health or general acute inpatient units, and patients require follow-up care. Older Persons Mental Health Units thus need to be supported by acute geriatric medical services and appropriate non-acute services, including non-acute mental health inpatient facilities, specialist residential aged care facilities with adequate mental health expertise or input and adequate acute and non-acute services for older people with medical issues, delirium and dementia.

External

Principal relationships with other Units include:

- Community Centres
- Residential Aged Care Facilities
- General Practitioners

Internal

Optimum internal relationships include:

- Emergency Unit / PECC
- Adult Acute Mental Health Unit
- Acute Geriatric Inpatient Unit
- Medical Imaging
- Outpatient clinics
- Pathology
- Linen, Catering, Stores etc.

3 Design

Environmental Considerations

Access

External

Discreet access for goods and services (linen, food, supplies etc.) that does not traverse patient-occupied areas.

Internal

Access to and between zones needs to be restricted to authorised persons only (including access by patients to external areas).

Parking

The following will be required;

- Disabled access drop-off for patients and their visitors
- Ambulance (If appropriate)
- Police (if appropriate)
- General visitor parking including disabled access parking bays

For staff parking, refer to Part C of these Guidelines for further information.

Acoustics

The unit should be designed to minimise the ambient noise level within the unit and transmission of sound between patient areas, staff areas and public areas.

Consideration should be given to location of noisy areas or activity away from quiet areas including patient bedrooms and selection of sound absorbing materials and finishes.

Acoustic treatment will be required to the following:

- Day areas such as patient living, dining and activities areas
- Consulting Rooms
- Admission Area

In acoustically treated rooms, return air grilles should be treated to avoid transfer of conversations to adjacent areas. Door grilles to these areas should be avoided.
One or two bedrooms may be acoustically treated and contained for very agitated and noisy patients.

Refer also to Part C of these Guidelines.

Natural Light

The provision of natural light is important particularly in the management of dementia. Natural Light has calming effect, affects sleeping patterns of patients.

Observation and Privacy

The design of the Inpatient Unit needs to consider the requirement for staff visibility of patients while maintaining patient privacy. Unit design and location of staff stations will offer varying degrees of visibility and privacy. The patient acuity including high dependency, elderly or intermediate care will be a major influence.

Factors for consideration include:

- use of windows in internal walls and / or doors
- location of beds that may affect direct staff visibility
- provision of bed screens to ensure privacy of patients undergoing treatment;
- location of sanitary facilities to provide privacy for patients while not preventing observation by staff.

Interior Design/ Décor

Decor is not just referring to colour. It refers to furnishings, style, textures, ambience, perception and taste and can be very personal and subjective.

Decor can be used to prevent an institutional atmosphere. Cleaning, infection control, fire safety, patient care and the patient's perception of a professional, caring environment should always be considered when dealing with decor.

Interpretations and "research" on the use and value of colour in the clinical area differ; some issues are obvious, others less so and often not backed up by empirical evidence. Consider the following:

- Some colours, particularly the bold primaries and green should be avoided as many people find them disturbing.
- Extremes of colour and pattern such as geometric designs which may disturb perception should be avoided. However, strong colours on floors may assist in orienting patients to their bedroom cluster etc.
- Colours and interior design should also be chosen to reflect the tastes and age of patients who will use the facility.
- Re-decoration is not a budgetary priority so care in selection of materials and colour is important in the first instance.
- Wall colour should be different to floor colour to define floor plan.
- Consider use of colour and stepping of ceiling heights to provide node points along corridors and to define seating alcoves.

Space Standards and Components

Human Engineering

Human Engineering covers those aspects of design that permit effective, appropriate, safe and dignified use by all people, including those with disabilities. It includes occupational ergonomics, which aims to fit the work practices, furniture, fittings and equipment and the work environment to the physical and cognitive capabilities of all persons using the building.

As the requirements of Occupational Health and Safety (OHS) and antidiscrimination legislation will apply, this section needs to be read in conjunction with the section on Safety and Security in these Guidelines in addition to OHS related guidelines.

Ergonomics

Units shall be designed and built in such a way that patients, 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 patients.

Refer to Part C of these Guidelines for more details.

Building Elements

Building elements include walls, floors, ceilings, doors, windows and corridors and are addressed in detail in Part C of these Guidelines - Space Standards and Dimensions.

Doors

All bedroom, bathroom and toilet doors should open outward in an emergency without the use of special tools.

The seclusion room if provided needs to have at least one wide door that should open outwards. Door, hinges and locks to be sturdy and resist breakage. Door viewing panels to be resist breakage.

Refer to Part C, of the Guidelines with specific reference to Secure Rooms.

Windows and Glazing

In areas where damage to glass may be anticipated, avoid larger pane sizes as smaller panes are inherently stronger for a given thickness than larger panes.

Impact-resistant Grade A safety glass to comply with local Standards – Safety Glazing Materials in Buildings is the recommended choice. Polycarbonate is not recommended as it suffers from surface scratching and deteriorates thus reducing vision.

Where windows are operable, effective security features such as narrow windows that will not allow patient escape, shall be provided. Locks, under the control of staff, shall be fitted.

Also refer to Part C of the Guidelines.

Infection Control

The infectious status of many patients admitted to the Unit may be unknown. All body fluids should be treated as potentially infectious and adequate precautions taken accordingly. Patient hygiene may also at times give cause for concern and will need to be addressed.

Hand Basins

Hand-washing facilities shall not impact on minimum clear corridor widths. At least one is to be conveniently accessible to the Staff Station. Hand basins are to comply with Standard Components - Bay - Hand-washing and Part D - Infection Control.

Safety and Security

General

Safety and security involves people and policies as well as physical aspects but the latter must be built in as part of overall design and not superimposed on a completed building and surrounding outdoor areas. A safety audit via a risk analysis of potential hazards should be undertaken during the design process.

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

The following aspects need to be considered:
- Safety of patients, staff and visitors
- Patients' legal rights
- The status of the hospital or part thereof under the Mental Health Act
- Legislation in force at the time of development

Physical Security Aspects

Include the following;
- Access control
- Containment (if and when necessary)
- Good sight lines and avoidance of isolated spaces for both patient and staff safety (e.g. no unsupervised blind corridors)
- Fittings that minimise the opportunity for patient self-harm or injury to staff
- Smooth finishes and rounded edges
- Use of impact-resistant glass
- Arrangement and design of rooms and furniture that prevents barricading
- A communication system which enables staff to signal for assistance from other staff as required via personal and fixed duress alarms.
- Impact resistant wall materials
- Sound attenuation

Access Control

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

Security features are required at all entrances and exits. These may include electronic locking, intercoms, and video surveillance.

Controlled and / or concealed access will be required as an option in a number of functional areas. Such controls should be as unobtrusive as possible.
All Meeting, Counselling, Group Therapy, Family Therapy and Review Board
Meeting rooms require two means of egress and a duress alarm.

When the Unit is located within a multi-storey building, access to external spaces above ground level such as balconies or roof is to be prevented.

The perimeter security of the outdoor area surrounding the building is important in reducing staff anxiety in relation to patients' movement and safety and patient privacy.

Video Security

The use of video surveillance may be useful for monitoring areas such as stairways and blind spots, seclusion rooms, hallways and entrances. It is not an appropriate alternative to observation

of patients by clinical staff and staffing levels should be sufficient to ensure that reliance is not placed on such electronic surveillance.

When considering the use of video security, the following factors should be considered;

- NSW Health and Area Health Service policies
- The rights of patients to privacy balanced against the need to observe activities for safety and security reasons
- The ability of the staff establishment to manage the level of observation required without video security
- The maintenance costs involved

Finishes

Finishes including fabrics, floor, wall and ceiling finishes, should be selected with consideration to infection control, ease of cleaning and fire safety, while avoiding an institutional atmosphere.

In areas where clinical observation is critical such as bedrooms and treatment areas, colour selected must not impede the accurate assessment of skin tones.

Fixtures & Fittings

Safety Principles

A safe and secure environment in Mental Health Units may be achieved when good design is evident with respect to sight lines, lack of unobservable spaces and opportunities for self-harm, together with appropriate staffing levels and operational policies.

Fittings and fixtures selected for Mental Health Units should also be assessed to ensure they do not create any additional safety hazards for staff.

These guidelines in respect to Fixtures and Fittings do not negate the need for close observation of patients deemed as at risk, or for clinical care appropriate to the acuity of the patients.

While these guidelines may refer to the provision of specific fittings or fixtures, they may not always be required. For example, coat hooks and towel rails are not necessary. Alternatives such as a bench or cupboard may be adequate to meet the patient's needs.

The potential for suicide of patients is a special concern in Mental Health Units and hanging is the main method. Hanging may involve suspending the body from a high ligature point although many deaths also occur through asphyxiation or strangulation, without suspension of the body, using a ligature point below head height.

Due to the impossibility of observing all patients at all times, in areas which patients occupy or to which they have access, utmost care must be taken in selection of fixtures and fittings and their potential to be used as ligature points. They must also be assessed for their potential to be used as a weapon or other means of self-harm.

Any fitting or fixture capable of supporting a patient’s weight should be avoided unless it is an item of furniture intended to bear the patient’s weight.

Fittings and fixtures should be safe, durable, tamperproof, and concealed where possible. They must be flush with the surfaces to which they are attached or designed in a way that prevents attachment of anything around them e.g. cords or belts. It is critical to ensure that if anything is or can be attached to the fitting or fixture; it will break away when weight of 15-20kg is applied.

Shower Curtains and Tracks

Where installed, shower tracks should be plastic and mounted flush to the ceiling to prevent the possibility of attaching anything such as cords, belts etc.

If installed, it is critical to ensure that the entire track plus hooks has a 15-20kg breaking strain to ensure that if curtains are gathered into a single cluster the aggregate does not exceed 15-20kgs

If curtain hooks are able to be "pushed" together then they should not be installed as this will increase the breaking strain far beyond the 20kg as outlined.

If the fall-to-floor ratio of the floor drains in showers is adequate to prevent flooding, the provision of shower curtains may be avoided but consideration needs to then be given to dry storage for towels etc. Flooring in and around the cubicle must be non-slip.

Window Treatments

Curtains, Holland blinds or any type of blinds or curtains with cords should not be used in patient bedrooms. However, alternative means of providing privacy must be considered. Enclosed Venetians with flush controls or electronic controls in nurses' station are a preferred option where privacy and sun shading are required.

If curtains are selected for use in patient recreational areas, the tracks must be flush to the ceiling and have a breaking strain of 15-20 kg (as for shower curtains). Consideration should also be given to fabric type, with respect to weight/thickness and how easily it tears.

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

Rails, Hooks and Handles

The use of horizontal grab rails in toilets and showers should be avoided; solid, vertical rails with moulded hand grip are preferred. Alternative provision of towel storage, such as a bench, can be considered to avoid use of towel rails or hooks. Where rails or hooks are provided, they must comply with a breaking strain of 15-20 kg.

Door and cupboard handles / knobs should be of a design that does not provide ligature points. Fittings moulded to incorporate hand pulls should be investigated to avoid use of handles altogether.

Plumbing Fixtures

Consideration should be given to the following items;

- Shower heads should be flush with the wall
- Taps must not be able to be used as ligature points
- Exposed services such as sink wastes which may be easily damaged should be avoided
- Toilet cisterns should be enclosed behind the wall
- Toilet seats should resist breakage and removal

Heating/ Cooling

Consideration shall be given to the type of heating and cooling units, ventilation outlets, and equipment installed in patient-occupied areas of Mental Health Units. Special purpose equipment designed for psychiatric use shall be used to minimise opportunities for self-harm. The following shall apply;

- All air grilles and diffusers shall be of a type that prohibits the insertion of foreign objects
- All exposed fasteners shall be tamper-resistant
- All convector or HVAC enclosures exposed in the room shall be constructed with rounded corners and shall have closures fastened with tamper-resistant screws
- HVAC equipment shall be of a type that minimises the need for maintenance within the room.

Air conditioning vents should be fixed to the ceiling to prevent access to the roof cavity.

Artwork, Signage and Mirrors

Artwork and signage should be rigidly fixed to walls with concealed, flush, tamper-proof mountings. Artwork based on non-tearable fabric may be considered.

Mirrors shall be of safety glass or other appropriate impact-resistant and shatterproof construction but free from distortion. They shall be fully glued to a backing to prevent availability of loose fragments of broken glass.

Furniture

Loose furniture should be sturdy and heavy enough to prevent use as a weapon.

Design of furniture – especially of beds - should minimise any risk of use as a low ligature point.

Ceiling Fittings

Light fittings, smoke and thermal detectors, CCTV cameras where used and air-conditioning vents to secure areas, particularly the seclusion rooms (if provided) should be vandal-proof and incapable of supporting a patient's weight.

Air conditioning vents should be fixed to the ceiling to prevent access to the roof cavity

Building Services Requirements

Information Technology/ Communications

Unit design should address the following Information Technology/ Communications issues;

- Paperless records
- Hand-held computers
- PACS
- Paging and personal telephones replacing some aspects of call systems
- Data entry including scripts and investigation requests
- Email
- Bar coding for supplies and X-rays / Records.

Nurse Call

Hospitals must provide an electronic call system that allows patients and staff to alert nurses and other health care staff in a discreet manner at all times.

The need for and type of patient call system should be reviewed. In bedrooms, it will need to be a call button that may not always be in easy reach, systems can be abused and most patients are ambulant and capable of asking for assistance.

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

Lighting

Older people need three times as much light as a 20-30 year old. Abrupt changes in light can stop them cold as it takes up to seven minutes for the eye to adjust to the changed level of light. If they try to walk in that time, they can't tell where the floor is and they can easily fall and lose their balance. Glare of any type is also blinding. An especially excellent and inexpensive aid: nightlights placed about 12" above the finished floor just outside the bathroom door and illuminated switches for the bathroom lights. Falls in a dim bathroom at night are especially dangerous.

Care should be taken with sensor lights in – for example – bathrooms – as they have been known to confuse and frighten patients with dementia.

4 Components of the Unit

The Older Persons Mental Health Units will consist of Standard Components to comply with details described in these Guidelines. Refer also to Standard Components Room Data Sheets and Room Layout Sheets.

5 Schedule of Accommodation - Mental Health Unit - Older Persons

Older Persons Mental Health Units with 16 Bed (2 x 8 bed modules). This SOA is applicable to Levels 4 to 6.

Main/Entry Reception Areas

ROOM / SPACE	Standard Component					Qty x m²	Remarks
						16 Bed 2 x 8 Beds	
AIRLOCK - ENTRY	AIRLE-10-I					1 x 10	
RECEPTION	RECL-9-I					1 x 9	
OFFICE - 2 PERSON SHARED	OFF-2P-I					1 x 12	For Administration staff
STORE - PHOTOCOPY/ STATIONERY	STPS-8-I					1 x 8	
STORE - FILES	STFS-10-I					1 x 10	
WAITING - PUBLIC	WAIT-10-I					1 x 10	
TOILET - PUBLIC	WCPU-3-I					2 x 3	
TOILET - ACCESSIBLE	WCAC-I					1 x 6	
CONSULTATION/INTERVIEW ROOM	CONS-MH-I					3 x 14	
MEETING ROOM (& REVIEW BOARD)	MEET-L-30-I					1 x 30	Also used for Group / Family Therapy

Inpatient Bed Area (8 Bed)

ROOM / SPACE	Standard Component					Qty x m²	
						16 Bed 2 x 8 Beds	
1 BED ROOM - MENTAL HEALTH	1 BR-MH-I					6 x 18	
2 BED ROOM - MENTAL HEALTH	2 BR-MH-I					1 x 28	Optional. May be 2 additional single rooms.
ENSUITE - MENTAL HEALTH	ENS-MH-I					7 x 5	
BAY - HANDWASHING	BHWS-B-I					2 x 1	Recessed bays in corridors. 1 per 4 beds
BAY - LINEN	BLIN-I					1 x 2	Lockable

Inpatient Bed Area – Module B (8 Beds)

ROOM / SPACE	Standard Component					Qty x m²	
						16 Bed 2 x 8 Beds	
1 BED ROOM - MENTAL HEALTH	1 BR-MH-I					6 x 18	
2 BED ROOM - MENTAL HEALTH	2 BR-MH-I					1 x 28	Optional. May be 2 additional single rooms.
ENSUITE - MENTAL HEALTH	ENS-MH-I					7 x 5	
BAY - HANDWASHING	BHWS-B-I					2 x 1	Recessed bays in corridors. 1 per 4 beds
BAY - LINEN	BLIN-I					1 x 2	Lockable

Shared Areas between Modules

ROOM / SPACE	Standard Component					Qty x m²	
						16 Bed 2 x 8 Beds	
DINING ROOM	DINMH-30-I similar					1 x 50	
PANTRY / SERVERY	PTRY-I					1 x 8	With servery counter
LOUNGE / ACTIVITY AREA	LDA-MH-20-I similar					1 x 50	
MULTIFUNCTION ACTIVITY AREA	MAC-20-I similar					1 x 32	Shared by 2 units. Access to
OCCUPATIONAL THERAPY ROOM	-					1 x 20	Separated for Male & Female
COURTYARD	CTSE-I similar					1 x 100	
LAUNDRY - MENTAL HEALTH	LAUN-MH-I					1 x 6	
SECLUSION ROOM	SECL-I					1 x 12	Optional if location of Obs (secure) unit too remote
STORE - PATIENT PROPERTY	STPP-I					1 x 8	
BATHROOM	BATH-I					1 x 16	Optional
TOILET - STAFF	WCST-I					1 x 3	Optional if location of main amenities too remote

Clinical Support Areas

ROOM / SPACE	Standard Component					Qty x m²	
						16 Bed 2 x 8 Beds	
STAFF STATION	SSTN-14-I					1 x 14	To oversee all sub-units. May sub-divide if necessary
OFFICE - CLINICAL HANDOVER	OFF-CLN-I					1 x 15	
MEDICATION / TREATMENT ROOM	MED-MH-I					1 x 12	
BAY - RESUSCITATION TROLLEY	BRES-I					1 x 1.5	Locate in Staff Station or Medication/ Treatment
DIRTY UTILITY	DTUR-10-I					1 x 10	
CLEANER'S ROOM	CLRM-5-I					1 x 5	
DISPOSAL ROOM	DISP-8-I					1 x 8	Includes recycling bins.
STORE - EQUIPMENT	STEQ-16-I					1 x 16	
STORE - GENERAL	STGN-9-I					1 x 9	

Staff Areas

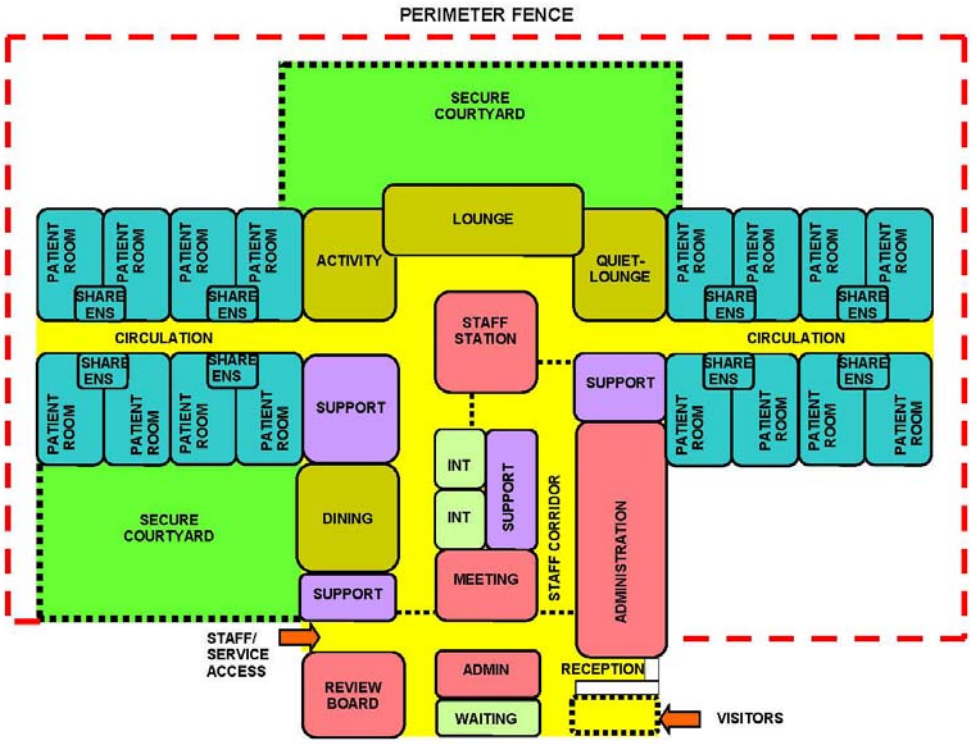
ROOM / SPACE	Standard Component					Qty x m²	
						16 Bed 2 x 8 Beds	
OFFICE - SINGLE 12 m2 (DIRECTOR)	OFF-S12-I					1 x 12	
OFFICE - SINGLE 9 m² (NURSE MANAGER)	OFF-S9-I					1 x 9	
OFFICE - SINGLE 12 m² (PSYCHIATRIST)	OFF-S12-I					1 x 12	No. determined by Staff Establishment
OFFICE - SHARED - MEDICAL STAFF	OFF-WS-I					5.5	No. determined by Staff

							Establishment
OFFICE - SHARED - NURSING STAFF	OFF-WS-I					5.5	No. determined by Staff Establishment
OFFICE - SHARED - ALLIED HEALTH	OFF-WS-I					5.5	No. determined by Staff Establishment
STORE - PHOTOCOPY / STATIONERY	STPS-8-I					1 x 8	
MEETING ROOM	MEET-L-30-I					1 x 30	
STAFF ROOM	SRM-20-I					1 x 20	
PROPERTY BAY - STAFF	PROP-2-I					1 x 2	
TOILET - STAFF	WCST-I					2 x 3	
CIRCULATION ALLOWANCE						32 %	

Please note the following:

- Areas noted in Schedules of Accommodation take precedence over all other areas noted in the FPU.
- Rooms indicated in the schedule reflect the typical arrangement according to the Role Delineation.
- Exact requirements for room quantities and sizes will reflect Key Planning Units identified in the service plan and the policies of the Unit.
- Room sizes indicated should be viewed as a minimum requirement; variations are acceptable to reflect the needs of individual Unit.
- Office areas are to be provided according to the Unit role delineation and number of endorsed fulltime positions in the unit.
- Staff and support rooms may be shared between Functional Planning Units dependant on location and accessibility to each unit and may provide scope to reduce duplication of facilities.

6 Functional Relationship Diagram - Mental Health Unit - Older Persons



7 References and Further Reading

- Australasian Health Facility Guidelines, Part B Health Facility Briefing and Planning, Adult Acute Mental Health Unit, Rev 5, 2012; refer to website www.healthfacilitydesign.com.au
- DH (Department of Health) NHS Estates (UK) Health Building Note 35 Accommodation for people with Mental Illness, part 1 – The Acute Unit., 2006; refer to website www.estatesknowledge.dh.gov.uk
- The Facility Guidelines Institute (US), 2010 Edition. Guidelines for Design and Construction of Health Care Facilities) refer to website www.fgiguidelines.org

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