AMA Submission to the Legislative Council Government Administration Committee 'A'

Subcommittee Inquiry into Health Services in Tasmania

Psychiatric Services/Mental Health

August 2017

APPENDIX B

Part 1

Related Documents in Chronological Order

Australian Medical Association, Tasmanian Branch, Discussion Paper

# The Royal Hobart Hospital Redevelopment, and a proposal to develop of a 'Centre of Excellence' for psychiatric inpatients in Southern Tasmania

October, 2014

## Executive Summary

The Redevelopment of the Royal Hobart Hospital (RHH), the change of Government in Tasmania in early 2014, and the Review of the Redevelopment of the RHH, instigated by the new Government, and currently being undertaken by the Rescue Taskforce, have together created a 'once-in-a-lifetime' situation, whereby the needs of all public psychiatric inpatients in Southern Tasmania may be carefully scrutinised, and a new, visionary plan for their care be considered. This discussion paper will be taken to an AMA consultation on 20 October 2014, so that a position statement may be prepared for Government in respect to the Redevelopment, and the need for a 'Centre of Excellence'.

It is thought that the development of such a Centre of Excellence is now required because the current standard of care in inpatient units could be improved, because there are difficulties with morale, recruitment and retention in multiple sectors, and because the plans for future accommodation for psychiatric inpatients are neither therapeutic nor safe. These plans involve small footprints, and do not conform to current Australasian guidelines. This paper additionally suggests that the current geographical separation of psychiatric inpatient units also contributes to the provision of a lower standard of care.

The driving principles behind this discussion paper are the mainstreaming of the care of psychiatric inpatients, the co-location of patients to create a critical mass of highly skilled staff to improve patient care, and the design of units that are both therapeutic and safe. Improving patient care to very high standards is particularly necessary as the RHH is the state's major teaching and tertiary referral hospital.

This discussion paper suggests that serious consideration be given to co-locating at one site the acute psychiatric inpatient unit and the psychiatric intensive care unit, both of which are now located at the RHH, the step-up, step-down unit located at Mistral Place, and the medium-term units located in New Norfolk.

If the Redevelopment will ultimately involve a greenfield site, or a fundamental re-design of the units to be located at the new RHH in its current site, it is recommended these units be co-located at that either of those sites.

If the Redevelopment will ultimately involve ongoing work at the current site, using the current K block footprint for inpatient beds, it is suggested that two recommendations be considered. First, that the K block plans be re-drafted, as the current plans represent units that are not fit for purpose. If it is also decided that there is no suitable space to co-locate the psychiatric beds now at New Norfolk to the RHH, it is recommended that consideration be given to re-locating those beds to a new, purpose-built, medium-term unit, within 5-10 minutes vehicular travel of the RHH.

The Australian Medical Association (AMA) has an important role to play in the Redevelopment of the RHH, following one of the peak body's major principles, that of, 'Promoting and protecting the health care needs of patients and communities'.

History

In the 1970's, the Royal Derwent Hospital (RDH), in New Norfolk, held approximately 900 psychiatric inpatients. In response to the world-wide trend to de-institutionalise psychiatric inpatients, this hospital was gradually closed, so that by the end of the last century, only 27 patients remained in New Norfolk, in a newly built institution called the Millbrook Rise Centre (MRC). This institution is privately owned, and the buildings are leased to the State Government. This centre currently comprises three units, one medium-term secure unit, one medium-term open unit, and one additional unit for the multiply disabled. The inpatients treated at this site all have serious mental illnesses, and almost all are under the Mental Health Act and/or the Guardianship Board. Despite the efforts of many, it has been very difficult to export a high quality of care to this group of inpatients. Senior staff specialists have always supported this patient group, but there is never a training registrar attached to the site, there is little input from allied health staff, and the general standard of care provided is not thought to be contemporaneous. The distance of the site from Hobart has always thought to be particularly problematical, and contributes to the lower standard of care delivered. In addition, the private ownership of the buildings has also been problematical, involving not only recurrent expense but also an inflexible situation with respect to the utilisation of the physical environment. The lease on the MRC is due for renewal in the near future.

Up until the late 1990's, acute psychiatric inpatient care at the RHH was provided in two open units, "5A" and "6A". Patients that could not be managed in that environment were transferred to "ward 7" at the RDH. This unit had a very large and very secure outdoor area. In 1998, the current acute ward, the Department of Psychiatry (DoP), was opened, and the Psychiatric Intensive Care Unit (PICU) was opened shortly thereafter, in 2001. Up until recently, the DoP had 34 beds. The unit was purpose-built, within the limits of a multi-storey teaching hospital bounded by city streets on all sides. Prior to the downsizing of the unit brought about by the Redevelopment process, the unit had a reasonably large footprint. The unit also had a somewhat 'domestic' feel, with multiple dining, lounge and recreation areas. It also had an internal green space. The unit has been repeatedly criticised however because it does not have a contemporary therapeutic feel, and because it makes very minimal use of natural light. It is also not on the ground floor, so it has no natural contiguity with open or green spaces.

The PICU was built on the ground floor, but because of the particular site chosen, the unit has no external views. The majority of the medical staff working in psychiatry during the design phase of the unit held serious reservations about this, and wrote a letter to the then administration asking for it to be re-designed. Other problems include the complete absence of ensuite bathrooms, and the ability to utilise each bedroom as a seclusion room. In its favour, the unit has 10 physical beds, although only eight are currently commissioned. The unit also has a large footprint, and one corridor that runs around the entire unit, making it both easy to navigate and an exercise area. The unit also has a wet-room, a separate television/interview room, a dining room, a separate lounge/television room, a visitors room and an external courtyard. The unit has generally had high very occupancy rates. The DoP also has a one-bed high dependency unit (HDU), which complements the PICU. It is

used in various situations, for younger patients, when particular patients in PICU need to be separated etc.

It should be noted that there have never been completely adequate facilities for adolescent patients in the acute wards. Children and younger adolescents requiring a psychiatric admission have usually been managed under a joint paediatric-psychiatric bed-card on the paediatric ward. Older adolescents with serious mental illnesses have usually been managed in either PICU, DoP or the DoP's HDU. The first two options necessitate the younger patient mixing with older and often seriously unwell patients, and the latter option is almost always one patient at a time. None of the options are ideal, and there has long been a call for a specific adolescent area.

Although the public mental health sector has in the distant past had a room that was suitable for mothers and babies, it no longer admits this patient type to the DoP. Instead it has a contractual arrangement with a private psychiatric hospital in Hobart for access to a bed in a mother-baby unit, and this arrangement has been in place for about 10 years. Although this arrangement works well for a proportion of patients referred, there have always been logistical problems, particularly relating to bed availability. In addition, the private unit is not able to accept mothers who are acutely unwell, necessitating the admission of the mother to the DoP or the PICU, and the separation of mother from baby, who must either go to the local paediatric ward, which is not always deemed suitable, and then to other relatives.

Patients requiring electro-convulsive therapy (ECT) in the public system have traditionally been transferred up to thrice weekly to the RHH Day Surgery ECT suite for treatment. In the past, the RHH has also treated patients from the private psychiatric hospitals. This no longer occurs .

Staffing levels and expertise were very good in both the DoP and the PICU for many years. In 2006, for example, documents reflect that there were five full-time staff specialists employed over the two units and to consultation-liaison services, and another four specialists provided another one full-time equivalent. The service also had an on-site inpatient clinical director, and a clinical professor (who were for some time the same person). Nursing staff were almost always psychiatrically trained, were often very experienced, and were usually permanent employees. This led to a very high skill mix. The wards ran their own ECT and clozapine clinics without outside staffing.

The consultation-liaison psychiatry team at the RHH for a lengthy period included two full-time psychiatrists, a rotating registrar, a dedicated nurse, and a part-time psychologist. The staffing of adult services has diminished over more recent years, and the team now comprises a staff specialist and a registrar only. Some other services in this area are provided by child psychiatry and older persons' mental health teams.

The Mistral Place (Mistral Place) unit is less than 100 metres from the RHH. It has 10 beds. For many years, it was primarily used as a step-down unit for the DoP, and many patients with accommodation problems had extended stays in the unit. It was traditionally staffed by medical staff working at the DoP and PICU.

The Tolosa Respite and Rehabilitation Centre (Tolosa St) has six beds for respite and six for rehabilitation. Like the afore-mentioned units, it is staffed by clinicians from mental health services. Although it has utilised different admission criteria at different times, the centre is now flexible with

respect to these, and it has also become very responsive to need. As such it is often very helpful in preventing acute exacerbations of illness, and in preventing admissions to the acute inpatient units. Employing clinical staff, it is able to manage patients of relatively high acuity.

The Secure Mental Health Unit (SMHU), or the Wilfred Lopes Unit, is the secure forensic unit for Tasmania. It was opened in 2006. It is on the site of the state's major prison, Her Majesty's Risdon Prison, in Risdon Vale. Although it is accessed separately from the prison, it does have security staff present 24 hours a day, and a high perimeter fence with razor wire. The unit has 32 rooms, but it has traditionally only been staffed for 20 patients. The majority of these patients are under the jurisdiction of the judicial system, with the exception of a small number of civil patients who are transferred under special legislation when they can no longer be managed in the civil system. This unit incorporates many contemporary facility design principles, with an exceptionally large footprint, multiple lounge, dining, recreation and outdoor areas, multiple and particularly spacious areas for de-escalation, and seclusion if necessary, and very high levels of staffing. The provision of large de-escalation units is particularly contemporaneous. These units are for the use of agitated and aggressive patients. They include lounge, courtyard, bedroom and bathroom facilities, and are generally only used for one patient at a time. Patients can be accommodated in these units away from other patients, either with staff or in seclusion. The design of the units however frequently obviates the need for seclusion.

There are now three community mental health teams covering the southern region. As a result of an external review that showed that the previous six community teams, three geographically based, one rehabilitation team, one mobile intensive support team, and one extended hours team, acted like 'silos', with little flow between the teams, a substantial restructure occurred in 2006. The specialist teams were disbanded in favour of three geographically-based 'one-stop shops'. In the context of the addition of a State-wide Helpline, also in 2006, this has led to the development of highly stream-lined process for accessing help within the community, with almost no gaps to fall through, and minimal territorial disputes. There have been other advantages for patients with respect to better continuity of care, as patients are not frequently transferred from one team to another. The Helpline in its reasonably short existence has been housed in a number of different and relatively isolated facilities, and has always suffered from a lack of direct contact with senior mental health staff because of its geographical location.

The range of supported accommodation in Southern Tasmania has grown over the last decade especially, and the individual facilities are too numerous to mention. However it is important to note that by far the majority are run by Community Sector Organisations. It is equally important to note that there has not until very recently been a high-level supported accommodation facility. This has meant that some patients, who many years ago might have been accommodated at the RDH, have not been able to manage in the community and have had to be treated in acute or medium-term beds.

The clozapine clinic has been in operation at the RHH, next to the PICU, with easy external access, for 20 years. It caters for over 180 patients with severe mental illness in a patient-friendly and spacious setting. By concentrating expertise within the clinic, and in the provision of a welcoming environment which assists with medication adherence, the clozapine clinic contributes significantly to the mental health of patients in Southern Tasmania.

Relevant public bed numbers

DoP – previously 34 beds, after recent construction works at RHH, now 30 beds (Hobart City)

PICU – 8 beds (10 physical beds, staffed for 8) (Hobart City)

Mistral Place – 10 beds (Hobart City)

MRC – 27 beds (New Norfolk)

Tolosa St Respite and Rehabilitation Centre – 12 beds (Glenorchy)

SMHU – 20 beds (32 physical beds, staffed for 20) (Risdon Vale)

Detoxification – 10 beds (see below for explanation) (St John's Park New Town )

More recent changes

As a result of budget cuts over recent years there have been numerous positions lost. These have come from management, policy and frontline staff. This document will not detail the clinical losses, other than to say that for there has been a small but significant reduction to those providing direct clinical services, in addition to losses of managerial staff, particularly those at the middle management level (for example, team leaders).

There have also been several service restructures. Mental Health Services (essentially all services not at the RHH), and Acute Services (essentially all services at the RHH) used to have two entirely separate administrative structures, and separate budgets; the two services were combined. In addition, when the three regional health organisations were set up, the southern organisation took responsibility for a number of areas that had not previously been aligned: Mental Health Services, Drug and Alcohol, Forensic Mental Health Services, and Correctional Primary Health, several of these services being state-wide. In 2015, another restructure will occur when the three regional health organisations combine to form one larger health service. These restructures will hopefully assist with efficiency, clinical standards, and service provision. However, the effect on staff of repeated restructures has been to adversely affect morale. For staff specialists working in adult psychiatric services, for example, this has had a particular effect. Once employed to work in an area with predictable boundaries, work-site is now less certain. As a result, there are ongoing problems with leave and back-fill, and subsequent and substantial difficulties with morale, recruitment and retention. More recent budget cuts have led to additional concerns and difficulties with staffing, with less frequent use of visiting medical officers and locum psychiatrists.

In the DoP and PICU, there have been a number of other adverse changes over recent years, and there is a belief amongst senior staff that the quality of care provided in those units has been significantly impacted. These changes have included the loss of the on-site clinical director, the loss of the academic professor with a resultant reduction in the amount of clinical research completed in the acute units, a reduction in the number of staff specialist sessions into the units (the recent draft model of care for the DoP states that, including consultation-liaison services, there are only four staff specialist positions. There are probably another 0.5 FTE with part-time input), increasing casualization of the nursing workforce, leading to fewer psychiatrically trained or permanent nursing staff, and vacancy control leading to more workforce shortages more generally, especially in the

nursing area. There has also been the removal of four beds in the DoP, with additional beds to be removed if the PAPU/RFC decanting proposal is to go ahead. (The recent draft DoP model of care document states that occupancy rates in the DoP have shown a 'slight downward trend' over the past three years, and in PICU have been 'fairly constant at between 80 to 95% occupancy, until a significant decline was recorded in January 2014 and again in June 2014'. This discussion paper suggests that this is insufficient information on which to base a decision to close a significant number of beds. Removing acute beds also does not appear to assist in 'future-proofing' the RHH, and is at odds with other craft groups). Finally, the construction works involving the DoP have meant the loss of the internal courtyard/green space, and the creation of an architecturally difficult environment, with multiple blind alleys, reduced sight-lines etc.

The model of care at Mistral Place was changed earlier in 2014. The unit is now a more active, step-down from the DoP, and step-up from the community, facility, with shorter stays. This is a substantial improvement. The medical staffing is however now provided by the community teams. Although the model probably provides greater continuity of care for some of the patients, it is inefficient for the medical staff, with the 10 patients being managed by up to 10 different medical staff.

Despite the relatively recent introduction of the CSO sector into the community, providing generic support to the mentally ill, the demands on public community mental health services continue to increase year by year. It is not completely clear why this is the case, but the changes are probably due to a combination of factors including: increased community and General Practice awareness of the Helpline, de-stigmatisation of mental illness, increased expectations within the public sector of community follow-up after acute admission, no financial cost associated with public mental health care, difficulties accessing private psychiatrists and psychologists, and essentially no provision of long-term psychological care for patients with conditions like Borderline Personality Disorder in the private sector. As a result of these factors, leading to significantly higher numbers of new referrals, the teams are coming under increasing pressure, and are experiencing difficulties with both acute work and more long-term preventative work, the latter being especially curtailed.

To assist in the de-institutionalisation of some patients from the MRC into supported accommodation, mental health services has very recently begun to set-up some higher level supported accommodation facilities in New Norfolk, known as 'Andrews St'. These units have clinical staff embedded within them and are a contemporary model of care, often known as "community care units". It is understood that these recent changes have proved to be very successful.

In February 2014, the Tasmanian Mental Health Act 2013 was introduced. Described as 'model mental health legislation' for the Australasian region, the new act aims to improve the oversight of those patients with severe mental illness who do not have the capacity to consent to admission or to treatment. The Act has brought with it the not unexpected list of teething problems that any substantial legislative change involves, however there have been a number of significant downstream effects. Primarily these relate to varying interpretations within the new act, especially with respect to capacity issues, and to the amount of time both junior and senior doctors spend in preparing patients and paperwork for Tribunal hearings, and in attending the hearings themselves. It has been estimated that junior medical staff working on the acute wards, who had previously spent approximately 5% or less of their day in Tribunal-related work, now spend up to 30% of their day

involved in this work. There has been no compensatory increase in the workforce to cover this shortfall.

The overall effect of a number of changes and variables over recent years, including the geographical separation of the inpatient units, budget and staff cuts, losses in the acute inpatient units and organisational restructures, has been to lower the standard of patient care delivered, to lower morale, and to create subsequent difficulties with respect to recruitment and retention.

Options for future care of psychiatric patients in Southern Tasmania

Decant to Psychiatric Assessment and Planning Unit and Roy Fagan Centre, with eventual move to K block - "single stage construction methodology"

Up until recently, it had been understood by clinical staff working within mental health services that both the DoP and the PICU were required to close, and that patients were to be decanted to two sites, the new Psychiatric and Planning Unit (PAPU) to be built at the RHH, and to the Roy Fagan Centre (RFC) at Lenah Valley. The PAPU was to be a six bed short-stay unit, admitting all acute patients requiring inpatient care from the Emergency Department at the RHH. The RFC, currently a unit for the treatment of older persons with mental illness, was to have 30 acute beds, and admit all patients requiring care for longer periods; both units would be required to manage agitated patients. Staff understood that this decanting plan was going ahead, and that there were no other options. It was only at an AMA consultation with KPMG on 8/9/2014 that another decanting plan to the Caruthers Building at St John's Park was noted. After the K block towers had been built, in either scenario, all patients would return to the RHH. A formal AMA consultation was held in respect to the PAPU/RFC decanting plan on 29/4/2014. The unanimous consensus of those present at the consultation was that the PAPU was 'grossly inadequate' in size, and would therefore be neither therapeutic nor safe. In addition, the decanting of 30 acute patients to a stand-alone facility at the RFC was also thought to be unsafe, as there would be no safe response to either code black, aggressive episode, or code blue, medical emergency. Overall it was felt that neither unit was 'fit for purpose'. Further difficulties were identified in the loss of a critical mass of both beds and staff, and disruption to the care of older patients who would need to be moved from the RFC. There was unanimous agreement that the proposed plan would not be supported by AMA members.

It has also been noted that this plan also involves a decanting of the clozapine clinic from its current position to a much smaller internal site in the building that houses Mistral Place. Staff who have worked in the clozapine clinic for many years understand that the facility requires a suitable, therapeutic space from which to provide care, and that the proposed site is also unsuitable.

Decant to PAPU and Caruthers, with subsequent move to K Block

No details of the proposal to decant patients to PAPU and Caruthers have been presented to the AMA. The concerns listed for the PAPU/Caruthers decant model would presumably be similar to those listed for the PAPU/RFC decant model.

'Overbuild' and move to K Block – 'two stage construction methodology'

It was only when the AMA became involved with the discussions surrounding the decanting plans that these further options became more fully understood. The decanting plans were apparently originally favoured because their use obviated the need to consider the construction risk of an 'overbuild'. This term refers to the option of both the DoP and PICU remaining in situ, whilst the K block is built above both units. The construction risk refers to the possibility of physical damage occurring to either human or structure during the building process. This risk can be mitigated but may not be well understood by clinical staff. The overbuild process would additionally mean that the DoP and the PICU, and those being treated in and working in the units, would be surrounded by a building site for several years, which would be both dusty and noisy. In addition, the overbuild process would further diminish the units' access to natural light.

The original plan in the two stage building process was for the PICU unit to move directly to its final destination, level three, but for the other acute beds first to go to level seven, before eventually moving to levels two and three. The more recent plans had the units moving more directly to the lower levels, but as a staged process. There is apparently another option, of both units moving immediately to their final destinations, if the current PICU and DoP units can 'shrink' even further into their current footprints, losing more beds, but this is an option with little current detail available.

K block plans

It should be noted that the Redevelopment, designed to future-proof the hospital, sees all craft groups except psychiatry either increasing in bed numbers or remaining the same; psychiatry is the only craft group to have bed numbers cut. No long-term figures have been made available that clearly justify this decision (see above). Bed numbers in the PICU and DoP units have been traditionally high in the 42 bed configuration, and this discussion paper suggests that cutting acute beds to 30 may lead to significant long-term problems with bed block.

It is additionally noted that the designs of the acute mental health units in K block are of units that are also not fit for purpose. The units do not appear to have been designed using contemporary principles, and all units are manifestly too small for the number of beds shown.

The unit labelled 'Psychiatric ICU' has a particularly small footprint, and has been the subject of criticism from a wide range of stakeholders. Such a unit requires essentially contiguous dining, lounge, recreation and outdoor/terrace areas to safely manage agitated patients. Not only are some of the recommended areas completely absent, but the dining, lounge, and recreation areas are non-contiguous, which diminishes the sense of space, and will contribute to the entire unit having a particularly claustrophobic feel. In addition, it should be noted that seclusion is a 'last resort' form of treatment, and is generally seen as a form of punishment by patients. As such, any patient must be moved into seclusion only when absolutely necessary; no patient should ever be locked in their usual bedroom. As such, any rooms labelled 'seclusion' should not be counted as bedrooms; this would mean that the units actually only catered for 28 patients. It is also important to note that it would be highly disruptive to ward function to have any seclusion room adjacent to a dining, lounge, or recreation areas, as they appear in the K block plans. It is believed by many senior staff that the overall design of this unit would significantly increase not only the rates of seclusion, but also the

use of sedating and potentially harmful psychotropic medications, and the number of assaults, patient to patient, and patient to staff.

With respect to the other acute areas in the K block plans, they too have generally insufficient space, and, due to design, perception of space. In addition, there are no outdoor or terrace areas, and no genuine green spaces. Modern units also generally favour the use of single rooms with en-suites, two-bed rooms being generally discouraged. One of the acute units shows five two-bed room configurations.

There also do not appear to be any bathrooms located in close proximity to lounge, dining and recreation areas. There are no rooms obviously identified for wheelchair, bariatric or mother-baby requirements. There is insufficient space at staff bases, and in some situations sightlines for nursing staff appear to be inadequate. All of the above features are recommended in the design of contemporary acute mental health units (see more below). All three units generally appear to be significantly overcrowded, with insufficient facilities.

Redevelopment and 'second stage' plans

The second stage plans for acute mental health inpatients, on the corner of Campbell and Collins St, involve many unknowns. There appears to be general agreement that as the stage is unfunded, that it is very unlikely that the stage will be built in the foreseeable future. This reality indicates very importantly that the plans for psychiatric inpatients laid down over the next 12 months are likely to affect the care of patients for many years to come.

The requirements of acute mental health units

Acute mental health units must be designed using contemporary design principles, and follow appropriate guidelines.

Overarching principles include the requirements that units are gender, culture and family sensitive. First and foremost, units must be therapeutic. To quote the Australasian Health Facility Guidelines, 2012, for Adult Acute Mental Health Inpatient Units:

'Consumers may be agitated, aggressive and potentially a risk to themselves or others. Therefore the environment should be conducive to the management of complex behaviours offering the capacity for observation of consumers by staff, discreet security, and where necessary temporary containment. However this should be achieved with a therapeutic focus so that while necessary measures for safety and security are in place, they are non-intrusive and do not convey a custodial ambience.

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

The document goes on to highlight how the, 'need for space cannot be overemphasised as a means of reducing the potential for aggressive behaviour, by way of wide corridors and recreation areas large enough to avoid crowding'. To improve both access to sufficient physical space and for safety and therapeutic reasons, it is always recommended that acute mental health units are built on the

ground floor, contiguous with both open and green spaces. External views and high ceilings both serve to enhance the perception of space, which may also be therapeutic.

It is particularly important to note that inpatient psychiatric care should not primarily be seen as 'bed-based', in contrast to the care provided by other craft groups. Psychiatric inpatients are first and foremost ambulatory. The space that they are accommodated in needs to be primarily therapeutic. To be therapeutic, there needs to be sufficient room to eat, socialise, recreate, exercise, and to receive specific therapies.

Bedrooms should be grouped into clusters to accommodate approximately eight patients each, of distinct consumer groups, for example based on age, gender or diagnosis. One bedroom should be specifically designed for those requiring wheel-chairs, and another for bariatric patients, or for a mother and baby. One room should be set aside for the potential use of visiting family. This room should have a bed and an ensuite.

Each area should maximise the use of natural light, and have a strong domestic feel. All units, and ideally all clusters of beds, should have their own additional space for lounge, dining, and recreation areas. The previously mentioned guidelines state repeatedly that access to covered outdoor areas is critical. To quote the Australasian Guidelines again:

'Courtyards or terraces, ideally with views, are integral components of a mental health unit and are essential to the consumer's treatment and well-being. As much design effort and attention to detail should be given to these areas as to internal spaces...Courtyards should be designed to reduce the consumer's sense of being contained, and provide some form of sensory stimulus.'

Seclusion rooms, as previously mentioned, should not be counted as bedrooms. In an era in which attempts are being made both nationally and internationally to reduce seclusion, this issue merits special attention. Any seclusion needs must be carefully considered, and any seclusion room very carefully designed such that transfers are safely managed, such that observation is safely and unobtrusively completed, and such that the care of others is not routinely disturbed. Consideration should be given to incorporating a 'de-escalation suite', a large area with lounge, courtyard, bedroom and bathroom facilities, so that agitated patients can be sequestered but not necessarily in isolation. In addition, many modern units now have a sensory modulation (or 'chill-out') rooms. The inclusion of such a unit reduces the requirement for seclusion.

A vision for a Centre of Excellence

The major recommendation of this discussion paper is that relevant senior administrators and clinicians in the Rescue Taskforce and the Tasmanian Health Organisation –South consider that the region would significantly benefit from the development of an inpatient bed-based Centre of Excellence for psychiatry, and such a centre should be built at the RHH, at either a greenfield site or on the current site. Psychiatry at the RHH needs to be more than just an acute inpatient unit, because the hospital is a teaching and tertiary referral hospital. The critically important principles of mainstreaming the care of all psychiatric inpatients, and developing a critical mass of staff to improve standards of care must be considered.

As the state's major teaching hospital, inpatient units must have strong ties with the University of Tasmania. Work should be done with the University to increase the number of conjoint academic

positions, including the creation of a new academic professorial chair. Consideration should also be given to bed-based research. A Centre of Excellence with strengthened University ties would lead to better training of staff and more research being undertaken.

As the state's major tertiary referral centre, any inpatient units must be able to accept intrastate transfers for diagnostic and treatment purposes. The latter is especially important in the context of intensive care. If all three major hospitals in Tasmania only have small high dependency units, any patient requiring a higher level of care due to aggression will need to be transferred to the SMHU.

A Centre of Excellence would have a critical mass of beds and could accommodate intensive care, acute, step-up, step down and medium-term beds. The mainstreaming of all inpatient care to an acute hospital is less stigmatising, and will lead to improved care and better patient outcomes.

A Centre of Excellence would have a critical mass of staff, which would lead to improvements in morale, and improvements in recruitment and retention of staff.

A Centre of Excellence would need to be built along contemporary facility design principles, following all relevant national and international guidelines, and with robust involvement of and consultation with all key stake-holders. Any architects engaged must have had sufficient prior experience in contemporary facility design.

A Centre of Excellence should cater for different patient groups including adolescents, older persons, those with disabilities, mothers and babies, and visiting family members; all such groups need access to appropriately designed facilities.

A Centre of Excellence should have an on-site clinical director, dedicated to inpatient care, to provide leadership, support and input into relevant policy.

A Centre of Excellence could also support a number of other services, who would benefit substantially from co-location. These services might include:

An in-house ECT suite. Such a unit could not only provide ECT to inpatients, it could also provide services to outpatients and to private hospital patients. Ready access to such a unit on a ground floor would be convenient for multiple user groups. 'Ownership' of the suite would also assist with skill acquisition and community use. It would also assist in efforts to raise revenue.

An appropriately spacious and therapeutic clozapine clinic. Such a clinic could also be utilised for the monitoring that is now required following the depot administration of olanzapine. Offices could also be provided for staff to complete occupational therapy and neuropsychological assessments, important in determining the future needs of many inpatients. This area could also be utilised as a small day hospital. This type of facility can be especially helpful for patients who are at some risk of self-harm, or to facilitate discharge. A day hospital could also raise revenue from appropriate privately insured patients. This should also ideally be easily accessed on a ground floor.

Offices for consultation-liaison psychiatry staff. (Future-proofing the hospital may involve a review of the consultation-liaison psychiatry services required, to determine whether any changes are required to staffing levels).

The Helpline.

An inpatient detoxification unit. (see below).

In order to design such a centre, a working group would need to be formed, so that consultation with all stakeholders was not only robust, but intimate and ongoing. Stakeholder groups would include but would not be limited to: representatives of Mental Health Services management, senior medical, nursing and allied health clinicians, consumer and carer representatives, and representatives from all appropriate peak bodies including the Australia Nursing and Midwifery Foundation, the Australian Medical Association, Flourish, the Mental Health Council of Tasmania, Mental Health Carers Tasmania, the Royal Australian and New Zealand College of Psychiatrists, and the Australian College of Mental Health Nurses.

Recommendations to consider

(1) Greenfield site for the RHH, development of a Centre of Excellence

The utilisation of a greenfield site for the RHH would be the ideal scenario from the perspective of inpatient psychiatric care. Such a site would allow for much more contemporary unit design, and a larger overall footprint, both of which are necessary if a truly therapeutic focus is to be taken.

Such a centre could be situated on the periphery of the hospital. The centre could then embrace the design principles of being predominantly on the ground floor, with easy access to both open and green spaces, factors that are critical in the creation of a therapeutic environment.

Use of a greenfield site would also allow for the mainstreaming and co-location of patients currently in medium-term beds at the MRC. There are now less than 20 stand-alone public psychiatric hospitals in Australia and it would appear difficult to justify another such hospital at some distance from the RHH. With more frequent and higher level oversight, and with the transfer of some patients to high level supported accommodation facilities with embedded clinical staff, fewer overall beds will also be needed, leading to significant recurrent savings. The total number of beds in the acute and medium-term units, exclusive of recent reductions enforced by the current Redevelopment process, has been 79 (DoP 34, PICU 8, Mistral 10, MRC 27). Co-location of all patients would allow for a modest reduction in beds overall, particularly if high-level supported accommodation facilities with embedded clinical staff can be utilised for some patients currently treated in the MRC. The exact number of beds required could only be determined via a consultation process, but it is envisaged that approximately only 65 beds would be needed. This number would ideally increase to 75 beds if a detoxification unit was added. This would be the ideal situation as mental health and drug and alcohol patients have much in the way of co-morbidity, as the patients in both units are in general ambulatory and the therapeutic requirements of the physical environment are somewhat similar, as the services are now aligned within a larger organisational structure, as co-location would allow for the most flexible utilisation of beds, and as co-location would also assist with staffing and skill mix.

Co-location of all acute and medium-term beds would allow for a total reduction in bed numbers, but with the flexibility to continue acute admissions at present numbers, whilst diminishing the number of medium-term beds with the assistance of community care units. This scenario would more safely future-proof the RHH with respect to psychiatric inpatient beds.

Co-location of all acute and medium-term patients would also allow for the management of all agitated patients in one large intensive care area, ideally with the type of de-escalation unit referred to above, in lieu of or in addition to seclusion rooms.

If the Mistral Place step-up, step-down unit, and the detoxification unit were to stay in their current locations, 55 beds may be sufficient.

In this proposal, the SMHU would stay in Risdon Vale. This discussion paper suggests that, although it is a very complex issue, it is felt that any move of acute or medium-term patients to the vacant beds at the SMHU would have long-term stigmatising and anti-therapeutic effects on those patients. In addition, managing the mix of patients would be very challenging.

(2) Fundamental re-design of mental health units at the current RHH site, to provide for both acute and medium-term beds, development of a Centre of Excellence

Under this proposal, to be considered only if a greenfield site is not envisaged, acute and medium-term beds would still be co-located, but at the current RHH site. However, all contemporary design principles would still be followed, especially those requiring a sufficiently large footprint for a population that is primarily ambulatory, a predominantly ground floor location, and substantial contiguity with both open and green spaces. For such a proposal to go ahead, a completely new site would need to be found and all units would need to be re-designed.

(3) K block with plans re-drafted, with an additional new medium-term unit nearby

It has previously been stated that the current plans for K block have been deemed not fit for purpose by many stakeholders. Should there be no possibility of either a greenfield site or a fundamental re-design of mental health units at the current RHH site, the least favoured scenario would be a complete re-drafting of the plans for K block. This option is the least favoured because it will not involve the mainstreaming and co-location of medium-term patients currently at the MRC, it will not create either a critical mass of patients or staff to raise clinical standards, it may lead to long-term bed block, the design principles do not allow for an appropriately sized footprint, for the units to be predominantly on the ground floor, or with sufficient contiguity to both open and green spaces, and as the second stage development plans for acute mental health units are unfunded, this situation may persist for many years or even decades.

As such, any re-drafting of K block plans would have to occur in parallel with the development of plans for a new medium-term facility to replace the MRC. Any such facility should be within 5-10 minutes vehicular travel of the RHH. This centre should also cater for any over-flow of patients from the acute units at the RHH.

The K block plans would need to be re-drafted. Any re-drafting would need to begin with the psychiatric intensive care unit. This unit must be designed with sufficient space to safely manage agitated and aggressive patients. Ideally an area in this unit is designed as a de-escalation suite (see above). Very careful attention must be paid to design by skilled and experienced architects to both ensure that there is both sufficient space, a sense of sufficient space, and a green space. Attention must be paid to designing units with beds clustered in small pods, each having their own dining, lounge and recreation areas. If the current footprints for level two and three on K block are the only

space available for the acutely mentally ill, it is envisaged that even more beds will need to be removed to provide an adequately therapeutic space.

Under this proposal, the SMHU would stay in Risdon Vale, for the reasons given above.

(4) Comment about any future decanting requirements

The AMA realises that some sort of decanting may be required for psychiatric inpatients in a future Redevelopment. The AMA would support a decanting process with other craft groups to a single site if there was a critical mass of staff to safely respond to code blacks for aggression and code blues for medical emergencies.

Caveat re plans, figures, costings and construction risks

This document was prepared by the AMA. Those who contributed to the document may not have had access to all current plans or figures. However, those involved in the preparation of this paper have many years' experience in the local services, and have completed this document in good faith, with the aim of enhancing the care provided to psychiatric inpatients.

It should also be noted that reference is not made in this document specifically to any detailed costings. Obviously there will be costs associated with any significant capital works. It should be noted however that the MRC premises are not owned by government, and involve ongoing and substantial lease fees. It should be noted that the most highly favoured option in this document would lead to substantial recurrent savings, with no lease fees if government owned, and lower overall bed numbers in medium-term care. It is also noted that new hospitals built on greenfield sites are cheaper to run in the long-term than older, redeveloped hospitals.

It should also be noted that those who contributed to this document acknowledge that they have no particular expertise in construction risks.

Finally it should be noted that there are two private psychiatric hospitals in Hobart. They have not been mentioned at any length because the patient group that they provide care for has little overlap with the patient group receiving care from the public sector. It should be mentioned however that contemporaneously designed acute and medium-term facilities may raise more revenue for the public system via insurance and third party billings for inpatients, the billing of clozapine and other outpatients, ECT for private patients, possible day hospital care etc.

# Principles for Acute Mental Health Unit design

# Prepared by the Tasmanian Mental Health Stakeholder Consortium

1. **All Stakeholders must be meaningfully consulted:**

   The Consortium should be intimately involved in the consultation and sign-off process for all new units. The Consortium believes that at the very minimum this must include both AMA and ANMF representatives being members of both the Users Group and the Executive Users Group; the latter group currently comprises management staff only. AMA and ANMF representatives will feedback to and consult with the wider Consortium group on a regular basis, both face-to-face and via email correspondence.

2. **Bed numbers and floor space:**

   The very basics of acute mental health unit design are two-fold. First, all units must contain sufficient beds. The Consortium believes that to avoid discrimination against the mentally ill, the THO-S should have sufficient beds to at least match the national average, ie 21 per 100,000 population. This equates to over 50 acute beds for the population of Southern Tasmania. Second, all units must have sufficient horizontal space. The Consortium recommends that the guidelines produced by the Australasian Health Facility Alliance be strictly adhered to.

3. **Contemporary design principles:**

   All units must be designed following contemporary principles. The United Nations statement on the "Protection of persons with mental illness and the improvement of health care", 1991, states that, "The environment and living conditions in mental health facilities shall be as close as possible to those of normal life of persons of similar age and in particular shall include facilities for recreational and leisure activities, facilities for education, facilities to purchase or receive items for daily living, recreation and communication, and facilities and encouragement to use such facilities for a patient's background and for appropriate vocational rehabilitation measures to promote re-integration into the community". The Consortium believes that contemporary design should mean the following:

   a) That units are primarily therapeutic and not primarily containing in nature
   b) That all units are primarily trusting of patients, thereby maximising the locus of control for patients. This involves minimising the use of barriers between patients and staff, and allowing day –to-day items to be readily available
   c) That all units are open, with the exception of the HDU/PICU area
   d) That all units take into account social and cultural considerations
   e) That all units must have access to both outdoor and to green spaces
   f) That all units are as "domestic" in feel as is practicable

g) That all units use as much natural light as possible
h) That all units must be decorated with warm colours, and with appropriate artworks

**4. Siting of units. (Ground Floor):**

All contemporary units should be sited on the ground floor. This is both for the obvious safety reason as well as so that there can be optimal access to outdoor areas. Any units not on the ground floor need to be very carefully designed so that all safety issues can be addressed without adversely affecting aesthetics, and so that all patients can have access to outdoor areas. Small outdoor areas that are difficult to access must not be included. Rather, the Consortium favours the inclusion of "tear-drop" shaped outdoor areas, along one side of a unit, that are contiguous with other open areas.

**5. Palm and fingers design:**

All units should be designed such that open spaces are contiguous, to maximise both the actual space available to patients, and the perception of space. Designs utilising the "palm and fingers" approach are to be favoured. At the base of the palm is the nursing station; this provides optimal sightlines for staff. The middle of the palm includes several semi-circular contiguous spaces, primarily for patients to eat, relax and socialise in. The "fingers" include bedrooms, treatment, recreational and outdoor areas. These requirements should be balanced with the need for bedrooms to have external views; it is critically important to remember that psychiatric patients are primarily ambulatory, spending the majority of their time outside their bedrooms.

**6. Availability of therapeutic space:**

All patients in all units must have access to all-weather outdoor areas, lounge/dining areas, recreational areas, exercise areas, educational areas, computer areas, creative areas, and treatment areas. Sufficient interview and office space must also be available. The importance of access to outdoor space cannot be overstated and the above guidelines for health facility design state, "Courtyards or terraces, ideally with views, are integral components of a mental health unit and are essential to the consumer's treatment and well-being. As much design effort and attention to detail should be given to these areas as to internal spaces."

**7. Accommodation configurations:**

Almost all rooms should be single rooms with ensuite bathrooms, there should be only a small number of double rooms, and no quad rooms. All units should be configured so that there is flexibility to cater for age and gender specific groups.

8. **Locus of control to patient:**

All units should be designed to give the locus of control to the patient as much as possible. For example, all patients should be able to lock themselves in their bedrooms, and patients should also be able to open and close their own windows; safe designs are available

9. **Seclusion and de-escalation:**

The reduction of rates of seclusion is both a National and an International priority. As Tasmania currently has very high rates of seclusion, the Consortium believes that is time for the move to new paradigm – the move to a de-escalation suite. Seclusion in a single room must become a treatment of last resort. As such, the move to a de-escalation area rather than a single seclusion room must occur. Such an area would include – bedroom, lounge and dining area, bathroom, and an outdoor area. Patients could be treated for agitation in such a zone with or without nursing staff. Patients could also opt to use the area for "time-out". The area should also include a chill-out room that patients can access at any time. All areas should be multi-purpose. Ideally, the entire area would be shared between HDU/PICU and the open ward, with multiple entry points.

AMA Submission to the Legislative Council Government Administration Committee 'A'

Subcommittee Inquiry into Health Services in Tasmania

Psychiatric Services/Mental Health

August 2017

APPENDIX B

Part 2

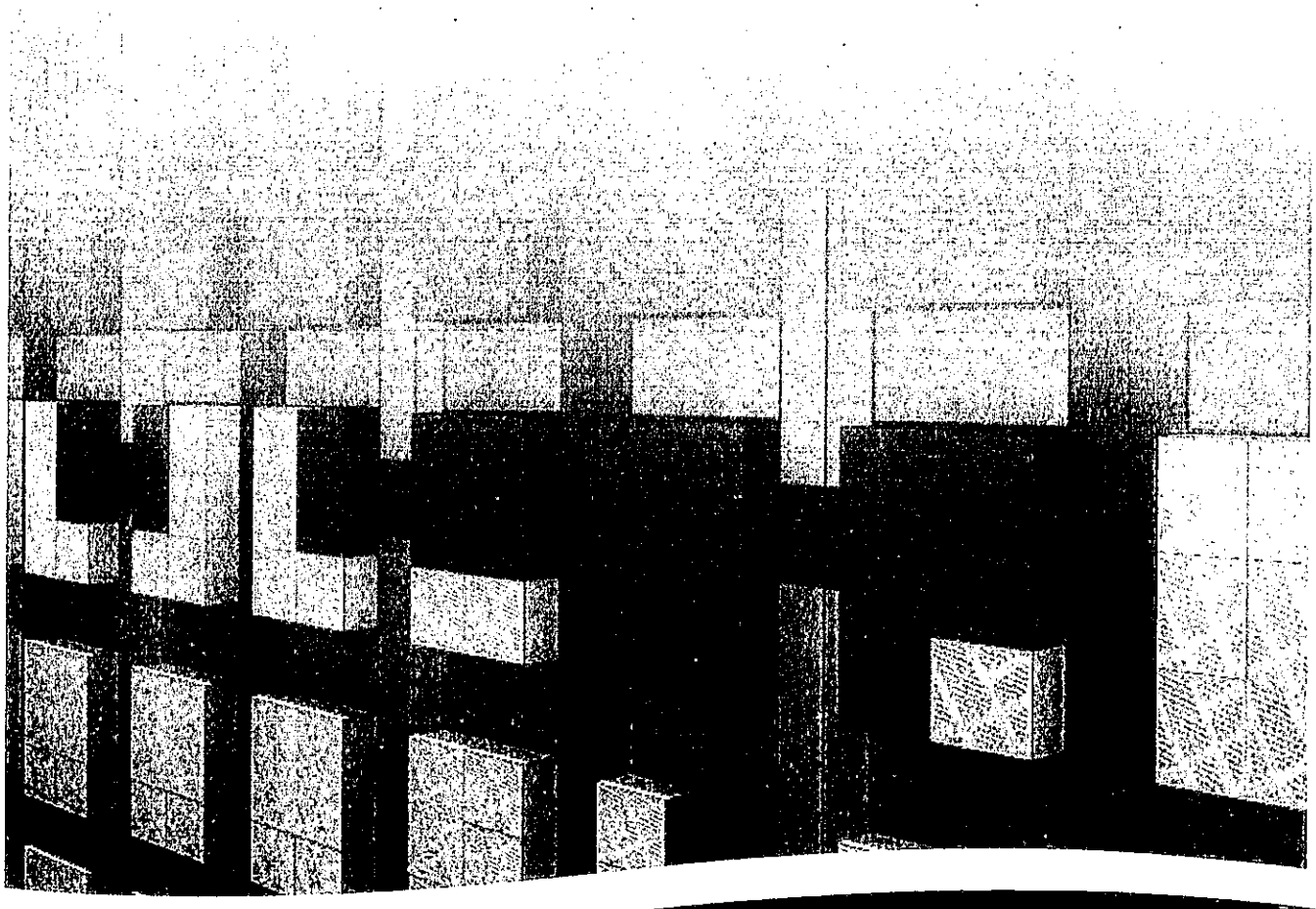
Related Documents in Chronological Order

RHH Redevelopment Rescue Taskforce

# RHH REDEVELOPMENT PROJECT

## KEY FINDINGS AND RECOMMENDATIONS

**28 NOVEMBER 2014**



Tasmanian Government


Campbell Street | K-Block façade. Image courtesy of Lyons with Terroir.

CONTENTS

# FOREWORD

The Royal Hobart Hospital (RHH) has been serving Tasmanians for almost 200 years. Redeveloping the site has been integral to ensuring the hospital could continue to meet the changing health needs of our community.

The RHH is again in need of redevelopment and expansion. It is well known that many of the hospital's buildings are near the end of their functional life. It is increasingly difficult to provide contemporary health services because of the condition and configuration of the current buildings. Consequentially, a Master plan was developed in 2011 to provide a longer term vision for the progressive redevelopment of the existing RHH site.

Australian and Tasmanian Governments have allocated $586 million to the current RHH Redevelopment project (the project).

This substantial investment provides an opportunity to transform Australia's second oldest hospital so that it can deliver health services to Tasmanians into the future.

Tasmanians already have access to many new facilities and services completed under Phases 1 and 2 of the project.

The majority of the projects funded under Phase 1 were completed during 2012-13. For example, the new assessment and planning unit opened providing more streamlined assessment for acute medical patients. The new $5.8 million production kitchen began delivering improved patient food services. The new $9.3 million medical imaging facility opened providing new ultrasound suites and modern equipment including Tasmania's first public PET/CT scanner, funded by the Australian Government. The $13 million Wellington Clinics were also opened, providing improved access to outpatient services.

During the 2013-14 financial year, the $14 million Phase 1 redevelopment of the department of critical care medicine was opened providing the capacity for an additional 11 beds in larger bed bays, an external patient area, new reception area and staff facilities. The Phase 2, $25 million THO-South Cancer Centre was also completed providing improved care for oncology patients and delivering increased access to patient support services.

Phase 3 is the proposed construction of the inpatient precinct known as K-Block.

There are significant benefits of the proposed K-Block.

Consistent with contemporary health services delivery models, improved patient care and operating efficiencies will result from bringing together services in 'precincts' such as women's, adolescents and children's services; mental health services; medical services; and surgical services. It will also allow for increased flexibility in the use of the facilities. Models of clinical care have been developed with clinicians to reflect contemporary service attributes, and improve the pathways for patients from, and back to, community settings.

A redeveloped RHH will enhance health outcomes and provide improved patient amenity via modern clinical facilities where contemporary models of care can be practiced.

Issues associated with project governance and successive design changes have frustrated progress and delayed the project. However, valuable work has been undertaken and design work in particular, is now well advanced.

But it is a complex project and a number of issues were identified which are material to ensuring that K-Block can be delivered on time, with established cost estimates that provide confidence to the budget, and with minimal disruption to existing health services. Construction can only commence after these matters are resolved.

Resolving these issues will position the project for success.

These matters formed the basis of the Terms of Reference for the RHH Redevelopment Rescue Taskforce (the Taskforce) commissioned by the Minister for Health on 7 May 2014.

The Taskforce submitted their final report to Government on 28 November 2014.

*RHH Redevelopment Project Key Findings and Recommendations* outlines the conclusions and recommendations from the investigation, along with details of some of the significant issues of interest to clinicians and other key stakeholders, considered by the Taskforce.

# EXECUTIVE SUMMARY

The Taskforce was commissioned to resolve the outstanding issues facing the project so the new K-Block could be constructed.

To inform the investigation, the Taskforce conducted broad consultation including receiving important input from THO-South clinicians, commissioned expert advice and was supported by a Professional Reference Group of stakeholders with an interest in the project.

The findings and recommendations address the Terms of Reference of the Taskforce. They also include consideration of the two important matters which the Taskforce identified needed immediate confirmation:

- the appropriateness of pursuing the redevelopment on the current RHH site and
- the scope of the proposed K-Block design.

If the project had gone ahead earlier, it would have exposed patients, staff and the general public to significant risks.

The key findings and conclusions of the Taskforce are summarised as follows:

- The redevelopment of the RHH is feasible and can proceed.
- Substantial time, energy and money has already been invested in the redevelopment of the RHH site. Moreover, the time and costs of an alternative greenfield development are prohibitive.
- The scope of the project is consistent with the Commonwealth-State Intergovernmental Agreement (IGA) requirement to provide 195 overnight beds and other outputs.
- A new construction methodology has been determined which provides better outcomes for patients, is safer and has the shortest construction program for K-Block.
- If the new methodology is supported, the new completion date of late 2018 would need to be renegotiated with the Australian Government.
- Work could commence early in 2015, potentially sooner.
- The total cost for the three phases of project would be $657 million or $552 million for Phase 3. This would require a further investment of $71.9 million. This includes the costs of decanting, an improved design for mental health services and installation of a helipad.
- The project would support the delivery of contemporary models of care for services located in K-Block. K-Block will provide enough flexibility to accommodate changes identified during health reform planning and changes to models of care over time, or in response to future demand.
- The original design of K-Block was based on significant clinical consultation but a small number of outstanding concerns remain which could be largely redressed by the design proposed by the Taskforce:
  - an increase in single beds for women who have had caesarean or complex births could be accommodated through limited redesign and
  - a more contemporary design for mental health inpatients would provide more outdoor recreational space.
- The inclusion of a helipad is supported by clinicians and Ambulance Tasmania and is proposed.
- Opportunities to progress the Master plan should be explored.
- The close proximity of the hyperbaric chamber to the construction site presents risks to its continued availability for patient care. It is at the end of its 25-year design-life and will need to be replaced during the period of construction of K-Block. Its replacement should be immediately progressed.
- The decanting plan required to support the preferred construction methodology would include 19 service relocations and 29 refurbishments. The implementation cost of $51.04 million is included in the budget.

**Project Construction Cost Estimate (PCCE) is the figure below which the Managing Contractor must deliver its GCS Offer.**

- The significant work undertaken by the Taskforce on the construction methodology, design and budget analysis means the Guaranteed Construction Sum (GCS) Offer provided by the Managing Contractor would need to be revised.
- The project would need to be reset by agreeing a contract variation with the Managing Contractor so a revised GCS Offer can be requested.
- The first step towards a revised GCS would be to agree a new Project Construction Cost Estimate (PCCE).
- Once the Managing Contractor Contract has been reset, critical works can commence including the removal of hazardous materials, refurbishments and early works. Starting these works would avoid delays to the K-Block construction program.
- A new governance framework would be needed that is suitable for a construction project. An Executive Steering Committee (ESC) is proposed that would provide strategic leadership and oversight, reporting directly to the Minister for Health and the Treasurer.
- The Project Director would be responsible to the ESC for delivery of the project.

The findings and recommendations provide a clear pathway for construction and decanting patients that would mitigate risk and optimise space for clinical services. They underpin a project that could be managed to budget and delivered on time and with minimal disruption to patients.

The recommendations reset the project so that the contract arrangements are contemporary and could take the project into the construction phase.

It is through these steps that the project could proceed and the proposed K-Block could be constructed.

The findings and recommendations are further outlined in this report.

# BACKGROUND

The former ESC for the project commissioned a *Project Status Report* (April 2014) to provide advice to the Tasmanian Government about the status of the project including key risks that needed to be addressed going forward.

The *Royal Hobart Hospital Redevelopment Project, Project Governance, Authorisations and Financial Delegations Instrument Version 2* (the former Instrument) required that the former ESC recommend to the Minister whether to accept or reject the GCS Offer from the Managing Contractor.

In considering the proposed GCS Offer, the ESC agreed not to reject the GCS Offer. Instead, they identified five key issues that required resolution before a recommendation could be made that the Minister accept the GCS Offer. These were governance, risk and design management concerns, the appropriateness of the project budget as well as evidence of a comprehensive decanting and refurbishment plan. These issues are reflected in the Terms of Reference for the Taskforce.

During the period of the investigation of the Taskforce, the Managing Contractor, John Holland Fairbrother Joint Venture, agreed to hold open the intent of the GCS Offer of 5 February 2014 subject to understanding the impact of any future changes to scope and program.

Additionally, the Joint Venture agreed to work with the project team and Taskforce until the resolution of the Taskforce investigation to minimise project related risks including potential cost escalations.

## Other Reports

The Tasmanian Health Commission released their report, *The Commission on Delivery of Health Services in Tasmania – Working towards a sustainable health system for Tasmania* (April 2014). It recommended that the project be placed on hold to ensure that a full and comprehensive service plan was developed in the context of resources available to build and operate the service as part of a statewide health system (Recommendation 52).

The issues raised in the ESC's report and the Tasmanian Health Commission report facilitated a decision by the Tasmanian Government to place the project on hold and to commission the Taskforce investigation.

# APPROACH TO THE INVESTIGATION

## Context

In his Ministerial Statement to Parliament on 7 May 2014, the Minister for Health, the Hon. Michael Ferguson MP announced the establishment of the RHH Redevelopment Rescue Taskforce. The Terms of Reference for the Taskforce can be found in Appendix 1.

The Taskforce was commissioned to undertake an independent investigation and provide recommendations on how to best continue the project, reporting to Government by the end of November 2014.

The scope of these recommendations included:

- capital and operational risk profile of the project and the RHH
- construction methodology
- decanting requirements
- governance and project management
- GCS Offer presented by the Managing Contractor and
- other related matters.

Mr John Ramsay chaired the Taskforce and was joined by colleagues Ms Jo Thorley and Dr Dan Norton AO. The Taskforce was convened with the Minister for Health on 22 May 2014 and held its first business meeting on 6 June 2014. Further information on the Taskforce membership can be found in Appendix 2.

In his Ministerial Statement, the Minister for Health anticipated the costs of the Taskforce for the six month period of the investigation were not expected to exceed $1 million. The cost of the Taskforce was $682 194 which included member fees, and expert advice and studies commissioned to support the investigation.

## Investigation Methodology

The early work of the Taskforce focused on the identification and investigation of important project issues; instituting governance arrangements and determining the parameters for the project while it was in care and maintenance; and, defining the work program for the investigation.

The work of the investigation included: governance and project management, site appropriateness, project scope, construction methodology, and capital and operating financial risks.

The Taskforce was supported by a Professional Reference Group (PRG) who provided input into the investigation.

The PRG members were: Neroli Ellis, Australian Nursing and Midwifery Federation; Dr Tim Greenaway, Australian Medical Association; Michael Kerschbaum, Master Builders Association; and Andrew Wilkie MP, Independent Federal Member for Denison.

The Taskforce commissioned work from a number of consultants to inform its advice to government. This work included: risk, governance and project management, the feasibility of installing a helipad on the roof of K-Block, contract negotiation, financial management, design and programming.

Stakeholder engagement was central to the approach of the Taskforce. Specifically, consultations with clinicians, other THO-South staff and key stakeholders informed the breadth of work conducted on the appropriateness of the scope of the project.

During the care and maintenance period, the Taskforce continued to oversight the works required to finalise Phase 1 of the project and works that would benefit the RHH whether or not the project was to proceed.

## Work Program

The work program of the Taskforce identified five streams of work.

1. Appropriateness of Redeveloping the Current RHH Site and Scope (Alignment)

   This examined the barriers to progressing the project on an alternate site. It also examined whether the proposed scope for the redeveloped RHH was aligned with relevant health and clinical services plans, and whether the project would meet the terms of the IGA between the Tasmanian and Australian Governments.

2. Scope – (Models of Care and Facilities Management Plan)

   This considered the extent to which the scope of the project was appropriate in meeting the health needs of Tasmania into the future. It confirmed that clinical models of care for the new inpatient precinct had been developed previously. It also examined the opportunities for the redeveloped RHH to increase the efficiency of health service delivery in southern Tasmania.

3. Construction Methodology

   This examined the risks of the two previously identified construction methodologies focusing on construction, clinical (including decanting), delivery, program and cost related risks.

4. Capital and Operating Financial Risk

   This examined the level of capital and ongoing financial risk to the State related to the construction and operating costs of K-Block. It also considered how the Crown should approach the status of the GCS Offer presented by the Managing Contractor.

5. Governance and Project Management

   This examined appropriate governance during the operation of the Taskforce and considered the necessary governance framework for the next stage of the project if it were to proceed.

This work program addressed the Terms of Reference of the Taskforce.

# FINDINGS AND RECOMMENDATIONS

## Redeveloping the RHH Site

Work undertaken for the *New Royal Project* (2006-2007) demonstrated that the preferred location of the RHH was in the vicinity of the CBD and the costs associated with a greenfield development were prohibitive. These conclusions remain valid.

While opportunities to redevelop the current RHH hospital site for commercial and retail enterprise were not tested in this investigation, a significant consequence of relocating the hospital would be the impact on the economy of Hobart's CBD.

There has been a substantial investment of time, energy and money in the design and development of the current project. Little if any of the investment in the design and related subsequent development would be transferrable to an alternate project.

There has also been a significant investment of time and commitment by the clinicians and staff of THO-South to plan for, and provide advice on the current project. For around eight years, they have continued to provide quality health care to Tasmanians whilst providing input into the work required to build a new hospital and are exhausted and frustrated by ongoing processes.

Moreover, there would be a significant delay in the construction of a new hospital if the government chose to terminate the current process and start a new procurement process.

It is also highly likely that further capital investment would be required in the existing RHH site to support tertiary services during an extended period of time required to establish an alternate hospital project.

The Taskforce concluded that the project could proceed on site.

However, the Taskforce noted that the proposed project is a substantial investment in a site that inevitably will require further redevelopment and ongoing maintenance costs for the existing building stock. In order to optimise benefits from the proposed K-Block, the redevelopment of the entire RHH site as outlined in the *RHH Master plan 2011* would need to be progressed.

### Recommendation One

**That considering the significant barriers of both cost and time, the significant investment in the current site, and the likely impacts on the CBD of relocation, every effort should be made to proceed with the current project.**

## Scope of the Project

The design of the proposed K-Block is consistent with the Commonwealth-State IGA requirement to provide capacity for an additional 195 overnight beds and other specified outputs. The use of these beds, and space vacated in other RHH buildings by the commissioning of K-Block, remains a matter for the THO-South, and the Tasmanian Government.

There are feasible options available to government to maximise the utilisation of the vacated capacity within existing RHH buildings on completion of K-Block. Further financial evaluation of these options within the context of state health reform should be undertaken before implementation.

The project design will support the delivery of contemporary models of care for services that will be located in K-Block. It will allow sufficient flexibility to accommodate any required changes identified during the health reform planning process, changes to models of care or in response to future demand. However, any future changes to the configuration of services within K-Block should seek to optimise the efficiencies gained in the current design, including the precinct model of co-locating like-services.

A number of design concerns were raised during consultation. These have or can be addressed if the advice of the Taskforce is accepted.

The proportion of single bed rooms on commissioning of K-Block is adequate. However, any future consideration of a reduction in the number of single bed rooms should be cognisant of infection control principles.

The current design for the women's, adolescents and children's services precinct is not optimal. However, there are opportunities to increase the number of single bed rooms available for women who experience caesarean or complex births consistent with contemporary models of care. There is a redesign option available that would deliver this result for minimal cost.

A redesign is also achievable for mental health inpatients that will improve the capacity to provide contemporary models of care in K-Block. The Taskforce noted that the preference for mental health inpatients is a ground floor location with increased access to outdoor space. This remains unresolved and is the basis for some sustained stakeholder concern. Access to ground floor space is not possible but it would be possible to achieve access to more outdoor recreational space on levels 2 and 3. Costs in relation to the proposed redesign are included in the revised budget for the project.

It is common for redevelopments of tertiary hospitals of this scale to include a helipad. Advice of THO-South clinicians and Ambulance Tasmania is that clinically, a helipad should be provided at the RHH as soon as possible. Engineering advice has confirmed that installation of a helipad on the roof of K-Block is feasible. The additional cost of installing a helipad is $10.5 million.

Further information on these design issues can be found in the K-Block Design section.

**The Taskforce concluded that the project could proceed on site.**

**A number of design concerns were raised during consultation. These have or can be addressed.**

### Recommendation Two

**That work continues on the redesign of the women's, adolescents and children's services precinct to increase the number of single beds available for women experiencing caesarian or complex births (noting possible cost implications).**

### Recommendation Three

**That levels 2 and 3 designated for mental health services be redesigned to deliver improved outcomes for mental health patients. This recommendation should be considered in conjunction with Recommendation Five.**

### Recommendation Four

**That the installation of a helipad on the roof of K-Block be considered as part of the current redevelopment. This would require an additional investment.**

**Under methodology C, the proposed program for the construction of K-Block could commence early in the New Year and is expected to be completed in late 2018.**

**Decanting is used to refer to the relocation of hospital services so that B-Block can be demolished and the proposed K-Block constructed.**

**The investigation has increased the visibility of the true project costs. This represents a significant decrease in project risk.**

## Construction Methodology

Construction and clinical risks were the primary influences on the Taskforce's deliberations on a preferred construction methodology.

Two construction methodologies were considered. Construction methodology A proposed a two stage build. Construction methodology B proposed a single stage build.

On balance, in the absence of an alternative, methodology B would have been excluded on the basis of the clinical risks associated with offsite decanting of mental health inpatients and the acute older persons' unit (AOPU). However, methodology B has less construction risk and can be completed nine months earlier. On this basis, further work was undertaken to identify alternate options that would provide onsite decanting solutions for a single stage construction methodology.

A new construction methodology (methodology C) was identified by the Taskforce. It is a single stage construction methodology which includes the construction of a temporary facility above the RHH Liverpool Street forecourt to support onsite decanting during construction.

It is preferred because it has the lowest risk profile across the five risk categories considered. It has another advantage in that a further investment of an additional $2.4 million will allow an improved design solution for mental health to be implemented. This would deliver superior clinical outcomes than what is anticipated in the existing design.

Under methodology C, the proposed program for the construction of K-Block could commence early in the New Year and is expected to be completed in late 2018.

Some stakeholders remain concerned about any design for mental health inpatients that is not located on the ground floor. Similarly, some stakeholders have expressed their preference for the rehabilitation unit to be moved to another location onsite. However, THO-South has management plans appropriate to mitigate the associated clinical risks of moving the unit offsite.

Construction will occur in close proximity to the hyperbaric chamber. The proximity presents risks to its continued availability for patient care. It is at the end of its 25-year design-life and will need to be replaced during the period of construction of K-Block.

### Recommendation Five

**That the project proceeds as a single stage construction methodology that includes the building of a temporary facility in the Liverpool Street forecourt that will accommodate mental health and general and women's surgery; and the reorientation of levels 2 and 3 of the K-Block design. This would require an additional investment.**

### Recommendation Six

**That the scheduled replacement of the hyperbaric chamber be brought forward to eliminate construction risk and ensure continuity of service. This would allow for its construction to be aligned with the decanting and refurbishment program of the project.**

## Decanting Plan

A decanting plan to relocate hospital services has been prepared to support construction methodology C. The plan is feasible, is appropriately costed and contains minimal clinical risk to patients.

It includes 19 service relocations and 29 refurbishments, 18 of which are for long-term location of services. The total cost of implementing the decanting plan is $51.04 million and is included in the project budget.

Consultation with THO-South staff on operational strategies and coordinated communications between all stakeholders will be key to the successful implementation of the decanting plan.

### Recommendation Seven

**That the proposed decanting plan be implemented to support the preferred construction methodology.**

## Budget Management

The investigation has increased the visibility of the true project costs. This represents a significant decrease in project risk.

The project is expected to exceed its current budget by approximately $61.4 million ($71.9 million including the installation of a helipad). These increased costs are illustrative of the uncertainties that were inherent in the project before the Taskforce was commissioned.

Had the project proceeded, it is likely that it would have incurred significant delay costs associated with the Managing Contractor not being able to access the site to commence construction. These costs would likely have been at least in the order of the budget overrun predicted prior to the commissioning of the Taskforce.

Significant work undertaken to reduce the capital risks facing the project and to reduce the expected budget overrun will help provide certainty around some of the provisional sums that were included in the GCS Offers presented by the Managing Contractor in December 2013 and February 2014.

A contractor should be engaged immediately to remove hazardous materials common on sites of this age to allow construction to start as soon as possible.

ICT systems for hospitals are complex; their capability and requirements will develop over the duration of the project. It is critical that further work be undertaken to provide certainty around the ICT budget to reduce risk to the project budget. The budget management for ICT will require ongoing vigilance.

Good project management closely monitors risk through the life of the project. An external risk management specialist will also need to be engaged to undertake a regular review of the project's risks and mitigation strategies and treatment plans for the next stage of the project.

The additional $61.4 million (or $71.9 million including the installation of a helipad) that would be needed if the project were to proceed in accordance with the recommended design, includes $45.2 million in contingency allowances. These contingencies must be actively managed and any savings returned to government.

Some additional operational costs are anticipated by the THO-South as a result of the additional adolescent beds and an increase in the hospital site floor plate.

It is anticipated that some of these costs will be offset by THO-South services co-locating on the RHH site, thereby achieving savings associated with offsite leases.

However, any additional operational costs will need to be carefully managed through a service agreement with the new Tasmanian Health Service (THS) on completion of the project.

### Recommendation Eight

**That an additional $61.4 million be allocated to the project to allow it to proceed in accordance with the recommended design. This includes the $2.4 million required to improve the outcome for mental health services.**

**The Guaranteed Construction Sum (GCS) is in the Managing Contractor's GCS Offer and is accepted by the Crown as the maximum price that may be payable to the Managing Contractor to perform all construction work in accordance with the provisions of the Managing Contractor Contract.**

**In lieu of a GCS Offer being available at this time, a new PCCE should be agreed with the Managing Contractor.**

## Guaranteed Construction Sum

The significant work undertaken on construction methodology, design and budget analysis means the project is better positioned to proceed. These developments mean the GCS Offers from December 2013 and February 2014 are no longer current. As such, it is no longer appropriate to re-engage with the Managing Contractor on the terms presented in these earlier GCS Offers.

A contract variation should be agreed with the Managing Contractor to allow the Crown to request a revised GCS Offer at the appropriate time.

In lieu of a GCS Offer being available at this time, a new PCCE should be agreed with the Managing Contractor. The agreement of a PCCE will then form the basis of the future GCS Offer.

In the period leading up to securing a revised GCS Offer, critical works should be authorised to:

- maintain momentum of the project and avoid further delays in the commencement and completion of the project and
- ensure that the project consultants are productively engaged on the project to avoid increases in the overall cost of the project.

### Recommendation Nine

**That a contract variation be agreed with the Managing Contractor to reset the project and allow the Crown to request a revised GCS Offer.**

### Recommendation Ten

**The Managing Contractor be asked to agree a new Project Construction Cost Estimate as the initial step towards a revised GCS Offer.**

### Recommendation Eleven

**That critical works are commenced as soon as possible to avoid delays to the program of works for the project. For example, the removal of hazardous materials and refurbishment works.**

## Governance and Project Management

Governance and project management is vital to the success of the project. Without proper oversight and decision-making, financial and construction risks can occur.

The project will require a project governance and management structure that includes:

- clearly defined roles and responsibilities
- appropriate levels of accountability to ensure empowered decision-making

- allocation of the roles of 'project owner' to DHHS and the 'client' to the THS, specifically the RHH. The THO-South will fulfil this role until the THS is established in July 2015
- ensuring the right skills mix across the project, including the procurement of specialist project management resources and
- ensuring balanced representation across the governance committees having regard to both the skills and expertise required.

The project requires direct oversight and strategic leadership after the Taskforce is decommissioned to manage ongoing contractual obligations and project requirements. Interim arrangements would be needed to progress crucial tasks while ongoing governance arrangements are established and key positions recruited. Interim governance would also be required if a decision was made to wind up the project.

### Recommendation Twelve

**The proposed governance and management approach be approved which is characterised by:**

- **an Executive Steering Committee with an independent Chair; specialist hospital construction expertise; and representation from THO-South (the client) to ensure a service delivery focus, DHHS the project and asset owner, and the Department of Treasury and Finance, given the financial significance of the project**
- **direct reporting from the Executive Steering Committee, through the independent Chair to the Minister for Health and the Treasurer**
- **a Project Director who is an employee of the State and is responsible for the delivery of the project within scope, budget and timeframes as well as project resources and processes and**
- **a Project Manager and project management resources with the necessary technical, contractual, and consultant and contractor management experience to deliver the project.**

### Recommendation Thirteen

**That the interim governance arrangements be established including an interim Chair, interim Project Director and interim Deputy Project Director, in addition to the existing care and maintenance project team resources and Taskforce Secretariat.**

**The GCS Offer is defined in Schedule 14 of the Managing Contractor's Contract and must include the GCS, time for practical completion, design documentation that forms the basis of the GCS, a cost plan, proposed trade package break up and budget for each trade package, and a daily maximum rate for damages for delays caused by the Crown.**

# K-BLOCK DESIGN

## Introduction

Design project management generally moves from the concept phase through an iterative process with increasing levels of detail at each stage. The Taskforce noted that the current project has transitioned through the following stages:

- the development of a sitewide Master plan (2011)
- schematic design for the project including a high level floor layout and considering high level models of care (2012-2013) and
- design development including detailed design such as room data sheets (2013-2014) which informed the Managing Contractor scope and was reflected in the GCS Offer.

Early design development included consultation with six discipline-based clinical and user groups. Each group included representation from heads of department, group managers and nurse unit managers. Beneath each group, a number of working groups were established. Meeting schedules for early 2013 provided to the Taskforce indicate a highly consultative process.

However, the design that was developed during 2013 was considerably over budget and a subsequent value management process was undertaken between May-August 2013. The Taskforce observed that this process had the most significant impact on the design, resulting in a reduction in the number of floors, a subsequent repeat of the 'blocking and stacking' of the services and a vertical slice of the building which removed 2 400 $m^2$ from the floorplate. The Taskforce noted that the reduction in clinical space was minimised through reducing the number of stairwells required as well as relocating some training and breakout spaces on each floor to a shared space.

At the time, user groups were briefed regarding the impact of the revised blocking and stacking and the vertical slice. A series of meetings were held with the relevant heads of department, nurse unit managers, group managers and clinical directors to ensure that new designs would be fit-for-purpose. Final approval and endorsement of the revised sketches were obtained from clinical leaders.

The Taskforce noted that the redesign occurred over a constrained timeframe and did not demonstrate the breadth of consultations conducted earlier. This was reflected in input from a range of stakeholders who expressed concern to the Taskforce that the consultation process was inadequate and that the new design was a compromise from the design negotiated previously.

The impact of these changes included the reduction of some rooms, combined functionality of some rooms and the reduction of staff areas on individual wards. However, the Taskforce noted that the overall design concept changed minimally and an additional staff amenity area on level 2 of K-Block was included to redress the loss of this space on individual wards. Notwithstanding, the Taskforce identified that a number of clinical areas had outstanding concerns regarding the design of their areas.

The issues raised by clinicians and some stakeholders in consultation included the alignment of the design with infection control principles, provisions in the women's, adolescents and children's precinct, the appropriateness of the design for mental health inpatients and the fact that the helipad was not included in the current stage of the *RHH Master plan*.

## Infection Control

The reduction in the floor plate by 2 400$m^2$ reduced the single bed ratio across K-Block. Maximisation of the number of single bed rooms within acute care facilities is considered by some clinicians to be an essential infection control measure and is supported by specialist infection control clinicians within THO-South.

The Taskforce was advised that, on balance, the single bed ratio in most wards would be satisfactory on commissioning. Exceptions noted by THO-South clinicians included medical subspecialties (with a single bed ratio of 38 per cent) and neurosurgery (single bed ratio of 50 per cent) given the complex nature of the patients usually accommodated on these wards. The Taskforce noted that the flexibility in relation to the configuration of the neurosurgery ward, including six high dependency beds, would increase the number of single bed rooms available daily.

The Taskforce also noted that the design of K-Block would provide an increased number of negative pressure rooms to assist in restricting the spread of airborne pathogens. In addition, an eight bed isolation area within the general medical ward could be completely isolated from the rest of the ward if required.

The THO-South were asked to confirm the number and ratio of single bed rooms in K-Block on commissioning and agreed that the proportion of single bed rooms at 67 per cent was appropriate. Their advice to the Taskforce was that the single bed ratio was appropriate because of factors including:

- it is in the hospital's best interests to maximise the number of single beds
- the RHH has no current funding for additional beds
- there has been no indication in forward estimates to open additional RHH beds and
- operational policies for single room usage would be actioned and reviewed as appropriate.

**The design that was developed during 2013 was considerably over budget.**

**The Taskforce was advised that, on balance, the single bed ratio in most wards would be satisfactory on commissioning.**

## Women's, Adolescents and Children's Services (WACS)

The Taskforce was advised that the reduced floor plate following the vertical slice, and co-location with both transition to home and women's surgery negatively impacted the ability for WACS to deliver a contemporary model of care.

The Taskforce was advised that around 30 per cent of presentations to maternity result in caesarean section. In the current design, women presenting with a normal birth would be accommodated in the eight birthing rooms and women with complex births including caesarean section being placed on the ward. The maternity ward will comprise 17 beds, one of which is in a single bed room. Given a longer length of stay and increased chance of complications with caesarian and complex births, advice was that contemporary practice is for women who have had caesarians or complex births to have access to single rooms.

On the request of the Taskforce, the project team considered the viability of relocating the transition to home beds from level 7 to the space currently occupied by the allied health gym on level 6. This would free up three single bed rooms, increasing the number of single bed rooms within the maternity ward to four.

Relocation of the allied health gym within K-Block poses some difficulties, however two viable options have been presented:

- relocate renal dialysis to the transit lounge area of lower ground, A-Block, allowing the allied health gym to move to level 10 or
- fit out a shell space on either level 2 or 3, made available by a reorientation of the lower levels of K-Block through the proposed redesign in the preferred construction methodology.

**A swing area is a section of the mental health inpatient ward that can be closed off from access by other patients. It is primarily used to provide a clinically appropriate and safe treatment environment for vulnerable patients, such as young people.**

**A step down/step up model of care matches the phase of a patient's recovery with clinical input at the appropriate level of intensity.**

**An option for the redesign of levels 2 and 3 of K-Block that delivers an improved outcome (including outdoor space) for mental health patients has been identified and costed.**

Cost estimates from the project's quantity surveyor indicate that the second option is likely to cost upwards of $0.9 million, excluding design consultant costs. A cost estimate is yet to be sought for the first option; however, early advice is that it is likely to be a cost neutral solution. Any additional cost incurred through a redesign of WACS has not been included in the budget.

Further advice from THO-South will be important ahead of a final decision being made.

## Mental Health Services (MHS)

A number of mental health stakeholders including the Australian Medical Association (AMA) and Australian Nursing and Midwifery Federation (ANMF) made representations to the Taskforce on the appropriateness of the consultation process and the fit-for-purpose design of the MHS precinct in K-Block.

The Taskforce did not find evidence to indicate the consultation on the MHS design was inappropriate or inconsistent with other K-Block design consultation.

However, the Taskforce was of the opinion that there was considerable uncertainty about the MHS design. The key issues were: the location of MHS, the amenity and fit-for-purpose design of the Psychiatric Intensive Care Unit (PICU), recreational space including outdoor space, an area for vulnerable patients, bed configuration and a number of more minor matters.

The project team reviewed the detailed design at the request of the Taskforce. Overall, the review noted that the K-Block design would deliver improved amenity over the current inpatient facility including through the provision of natural light, views through large windows, more single rooms with ensuites and scaled domestic spaces. Additionally, the total bed numbers are not inconsistent with the current MHS bed numbers.

It also confirmed that the approved design exceeded the Australian Health Facilities Guidelines for indoor recreational space but did not meet the outdoor space guidelines. However, it did identify an unallocated or void space that could be used as an additional indoor recreational space in the PICU. It noted that the current design also allowed for a swing area for vulnerable patients.

The Taskforce met with MHS management to discuss the appropriateness of the K-Block design who confirmed stakeholder concerns that the design was not well aligned with contemporary practice. Their previous support for the design had been contingent on their understanding that stage two of the Master plan would be expedited where a purpose-built mental health inpatient is planned.

The Taskforce requested further consideration of the MHS design and facilitated a design meeting with MHS management representatives and the design consultants where a number of amendments were proposed in a redesign of the inpatient facility to better align it with contemporary care for mental health inpatients.

The redesign proposes a move away from the PICU to a step down/step up model with high dependency beds. The current statewide service function would be incorporated into the secure unit. The redesign would provide an additional bed (from four to five beds) and incorporate a de-escalation area in the high dependency unit, reduce shared offices and co-locate some space for RHH hotel services. It would also incorporate a swing area for the treatment of vulnerable patients that can be made secure from the rest of the ward.

An important issue was the number of single rooms on the open unit of level 2. The redesign proposed would increase the number of single rooms from five to ten. The increase in single rooms has the effect of reducing the total number of beds on level 2 by a maximum of three and a minimum of one – creating a 12-14 bed ward with 10 single bed rooms and two rooms that have capacity for two beds each. The second bed in each of these rooms would not be commissioned unless absolutely necessary. A number of amendments are proposed to staff work spaces and two additional interview rooms were added into the design.

The THO-South advised the Taskforce that flex capacity needed to be maintained in how beds are used across the open and closed wards.

The Taskforce noted that the redesign would encroach on the shared staff amenity area on level 2 by removing the resource room and replacing this with one single bedroom.

The outstanding issue remains the location of mental health inpatients.

The AMA provided the Taskforce with a discussion paper, *The Royal Hobart Hospital Redevelopment, and a proposal of a 'Centre of Excellence' for psychiatric inpatients in Southern Tasmania, October 2014.* This presented three options in order of preference:

- close beds at the Millbrook Rise Centre and a new centre housing both acute and medium beds be built at a greenfield site
- close beds at the Millbrook Rise Centre and both acute and medium beds be housed at the current RHH site, at a new facility to be determined and
- house only acute patients in K-Block after completely redrafting the floor plans. With additional new medium term units provided close by.

The Taskforce noted that the first two options were not within the scope of the Taskforce investigation.

The AMA (in conjunction with a number of key stakeholders) subsequently wrote to the Taskforce to formally note their concerns, chiefly that mental health inpatients were not accommodated on the ground floor with access to open or green spaces. It recognised that treatment in the community was the ultimate goal for mental health patients however inpatient beds should be maintained while investment in the community was increased.

The Taskforce agreed that the preferred location for mental health inpatients would be in a ground floor design but that this could only be incorporated in a subsequent stage of the Master plan. On this basis, the Taskforce noted that opportunities to progress the Master plan should be explored so as to provide the most appropriate level of contemporary care to mental health inpatients.

In the interim, the Taskforce has identified an option for the redesign of levels 2 and 3 of K-Block that delivers an improved outcome (including outdoor space) for mental health patients that has been costed at $2.4 million.

## Helipad

On the basis of representations from some senior clinicians, the Taskforce agreed to review the decision not to include a helipad in stage 1 of the Master plan (the project). Clinicians advised that the consultation regarding the appropriateness of the helipad was inadequate, and that the decision not to include it in the project was a financial decision, rather than a decision based on patient welfare.

The Taskforce is aware that the installation of a helipad has previously been identified as appropriate (*Tasmanian Medical Retrieval Services External Review,* 2007), and the *RHH Master plan* contemplated its inclusion in a future phase as funding became available. The Taskforce reviewed the considerations of previous project governance bodies. A previous decision by a RHH-led management committee rated installation of a helipad as a low priority. Subsequent governance bodies ratified this decision, noting that provision had remained in the design for future installation of a helipad.

**However, noting both the acoustic and rotorwash considerations, further analysis should be undertaken before a final decision to install a helipad was made.**

To review the previous work on this issue, the Taskforce requested advice from Ambulance Tasmania which supported the clinical need for a helipad. PSNK Aeronautical Services (in conjunction with the project's design consultants) were also commissioned to undertake a feasibility study for inclusion of a helipad within the scope of the project. The costing estimates were reviewed by the quantity surveyor.

PSNK Aeronautical Services advised the Taskforce on acoustic issues (impact of helicopter landing noise for K-Block, other adjacent hospital buildings and neighbouring buildings) and rotorwash, which is the physical impact of a helicopter arriving and departing on other adjacent hospital and neighbouring buildings.

The Taskforce understands that while the acoustic impact across most of the hospital can be mitigated with acoustic treatments, there are some areas that would not achieve the nominated noise level criteria. However, THO-South advised that the sound levels would be manageable.

In the absence of Tasmanian noise guidelines for helicopters, the acoustic impact on neighbouring buildings is less clear. However, the Taskforce was advised that the general Australian noise standards are considered too stringent to apply to surrounding buildings, especially given the likely infrequent use of the helipad and the community benefits anticipated.

PSNK Aeronautical Services advised that in regard to rotorwash, the addition of the helipad appears feasible, with wind velocities associated with an incoming and departing helicopter anticipated to be within normal construction standards for buildings in Hobart. However, noting both the acoustic and rotorwash considerations, further analysis should be undertaken before a final decision to install a helipad was made.

The quantity surveyor advised the Taskforce that installation of a helipad would cost $10.5 million. This cost would include installation of a helipad deck, extension of concrete columns, acoustic treatments to K-Block, lift shaft fitout, provision of services, precast concrete for lift shaft and escape stairs, contractor and consultant fees as well as a contingency and escalation allowance.

The Taskforce noted that there would be additional ongoing recurrent costs associated with an expanded aeromedical retrieval service. The Taskforce did not seek further advice on this matter. The nature of any new service would need to be developed by Ambulance Tasmania and DHHS in the context of any revised health service plan and the funding issues addressed through the usual budgetary processes.

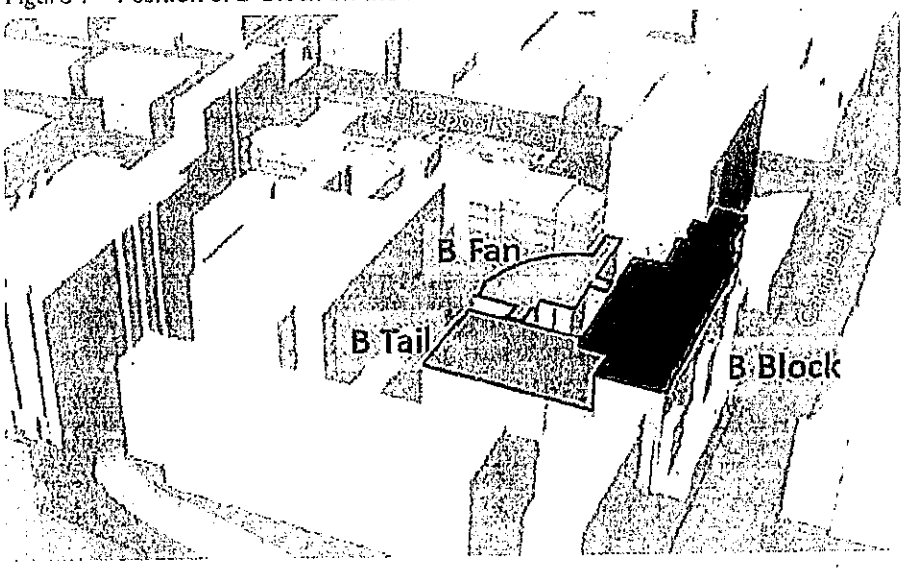
The Taskforce noted that planning approval would be required from Hobart City Council.

# CONSTRUCTION METHODOLOGY

## Introduction

The construction of K-Block requires the demolition of B-Block which comprises three sections: B-Fan, B-Tail and B-Block, as shown in figure 1.

Figure 1 – Position of B-Block on the RHH Site




Two methodologies were identified as appropriate for the construction of K-Block. The distribution of risk between these two methodologies has been a matter of public discussion and the primary focus of the Taskforce during its investigation of the project.

A two stage construction methodology (methodology A) was developed to facilitate onsite works with minimal disruption to the existing hospital. This was a requirement of the RHH at the time. In response to concerns regarding construction risks associated with the two stage methodology, an alternate single stage methodology (methodology B) was developed.

However, construction methodology B increased the cost and clinical risks for those services that would have to be relocated offsite due to space constraints onsite. The most significant concern was the capacity to manage acute mental health patients and acute older persons in offsite facilities.

## Investigation on the Construction Methodology

Undertaking this review, the Taskforce sought to understand:

- the two construction methodologies, including the key differences
- the construction, clinical, delivery, programming and financial risks of the two construction methodologies
- how these risks could be mitigated through adoption of alternate options
- the difference in cost impact between methodologies and
- the residual risk profile for the project.

The project's design consultants provided a construction methodology feasibility study in consultation with the Managing Contractor. This examined the technical differences between the two proposed construction methodologies. Issues considered included: project context, engineering requirements, construction programs, façade design, safety, infrastructure requirements, hospital loading provisions, required decanting program, entry wayfinding, clinical review, structural engineering, and re-documentation requirements.

The Taskforce commissioned an analysis of the costs and benefits of the construction methodologies by an independent team of experts not previously engaged by the project. This brought together high-level clinical, construction, engineering and financial skills.

KPMG were engaged to undertake this work. The primary focus included construction, clinical, delivery, programming and financial risks. KPMG were supported by construction firms, Johnstaff (construction and construction delivery), and Taylor Thomson Whitting Structural Engineers (TTW; engineering expertise). KPMG also had senior health and financial management expertise on staff.

## Construction Methodologies Outlined

### Methodology A

Methodology A comprised the following steps:

- decanting of B-Fan
- demolition of B-Fan
- erection of safety trusses across B-Block, facilitating lift of materials from Campbell Street onto the site
- erection of spanning structure across B-Tail (see figure 2) and
- build K-1 (see figure 3)
- decant from B-Tail and B-Block into K-1
- demolition of B-Tail and B-Block
- build K-2, and therefore completion of K-Block (see figure 4)
- refurbishment of wards in K-1 consistent with final blocking and stacking and
- decant services into K-Block.

Figure 2 – Spanning Structure Across B-Tail

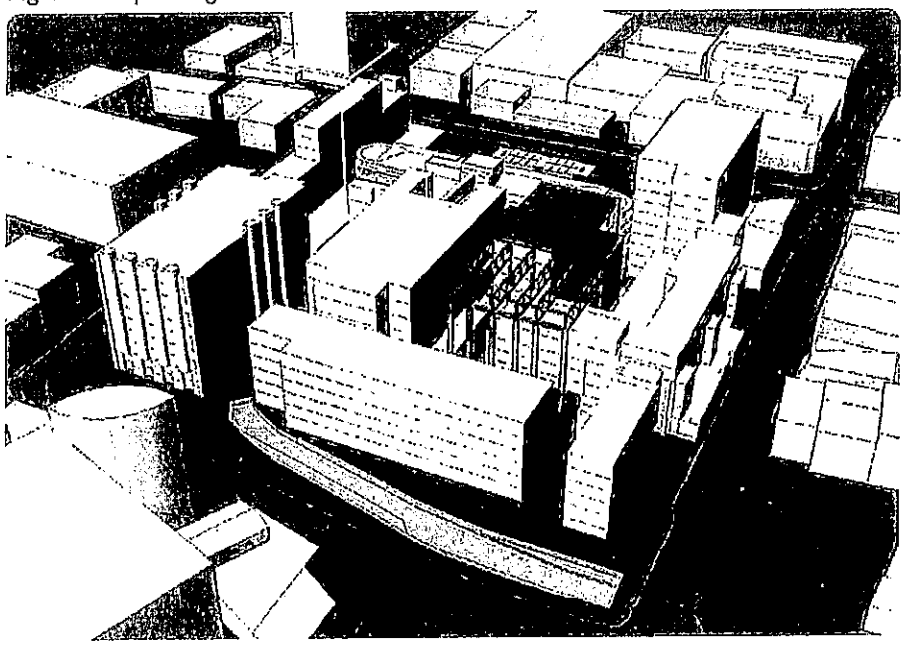


Figure 3 – Build K-1

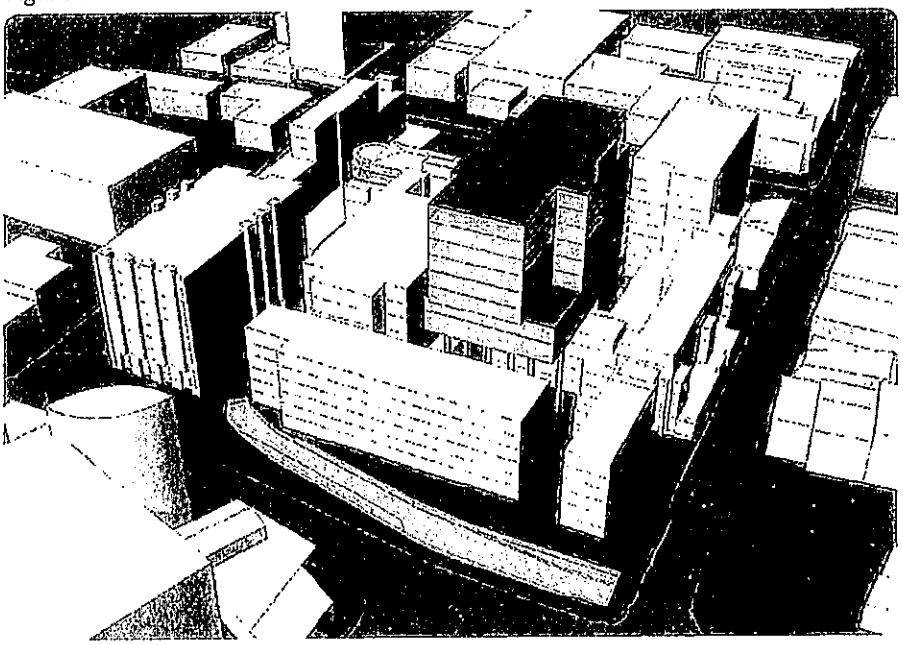
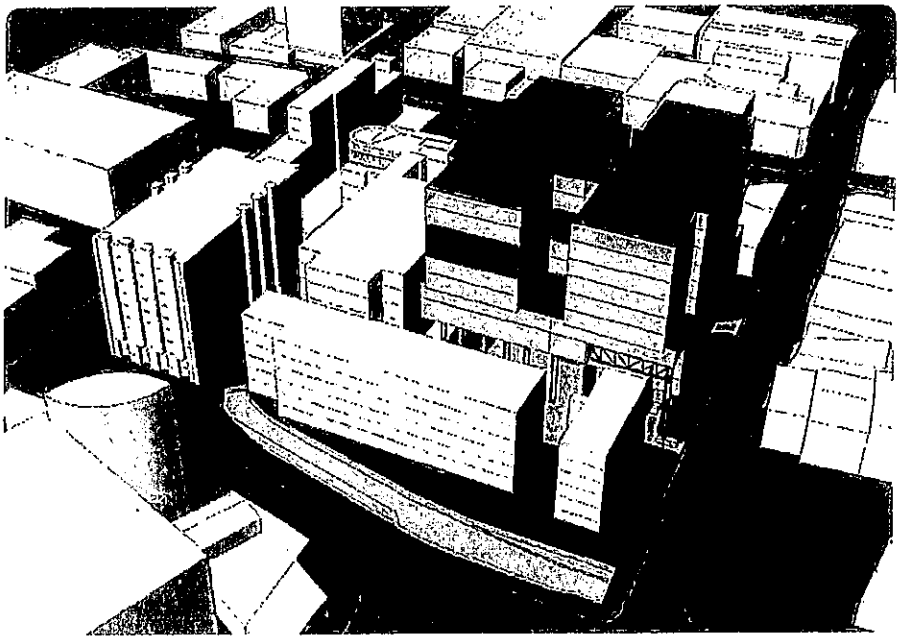


Figure 4 – Build K-2 and Complete K-Block



Methodology A would accommodate ongoing delivery of services located in B-Tail and B-Block. In the first stage of construction, K-1 would be built directly over the top of B-Tail. Completion of K-1 allowed the necessary decanting prior to the demolition of the B-Tail (and remaining B-Block). A void under K-Block reflected the space that the B-Tail occupied prior to its demolition.

The base case decanting plan for methodology A required MHS to move temporarily to level 7 of K-1 before moving back into levels 2 and 3 of K-Block. These lower levels (all floors beneath level 4 of K-Block) would have a reduced floor plate as a result of the void, and would preclude a direct decant of MHS into their final location.

**Methodology B**

There were fewer steps required in methodology B because it involved the upfront demolition of B-Block. The process is as follows:

- refurbish numerous sites to support decanting of B-Block
- decant all services from B-Block (including some offsite decanting of acute services)
- demolish B-Block
- construct K-1 and K-2 concurrently and
- decant services into K-Block.

## Risk Assessment Findings

### Construction Risk

The assessment of construction risk was considered including: lifting over occupied buildings; noise, dust and vibration; and hazardous materials..

Methodology A presents a unique construction method without known precedent in that it constructs over but not attached to an existing building. However, there are many precedents of major redevelopments to existing hospitals over the past ten years, in which construction works have been completed in close proximity, around and above operating hospitals in other jurisdictions.

The Taskforce noted the KPMG advice that the risk of a crane dropping its load during a lift above an operating hospital was considered very low, with the risk further reduced by the spanning structure (gantry) considered under methodology A. The Taskforce received advice that the Managing Contractor's proposal to install a gantry over large portions of B-Block would mitigate construction risks beyond industry standards and further, had not been considered necessary for similar projects nationally. The resultant residual risk was considered very low and not a significant factor in assessing the preference of construction methodology A or B.

The Taskforce noted that noise, vibration and dust were assessed by KPMG as the most significant comparative risk. Every hospital redevelopment creates noise, dust and vibrations with potentially significant serious clinical risks. While these risks could not be eliminated totally, effective mitigation strategies are implemented routinely in hospitals across the country. The Taskforce was satisfied with the advice that these measures were sufficiently well established nationally to effectively mitigate these risks for the project.

The Taskforce noted that the shorter program associated with methodology B would reduce exposure to noise, dust and vibration. However, there is a converse risk that the increased decanting requirements associated with a single stage methodology would increase exposure to hazardous materials without appropriate mitigation strategies. Early laboratory test results indicate the presence of asbestos in concealed locations through a number of areas that require refurbishment to support the decanting plan. The Taskforce recommends that procurement of a contractor to remove hazardous materials be expedited to minimise delay damages.

**The Taskforce recommends that procurement of a contractor to remove hazardous materials be expedited to minimise delay damages.**

## Hyperbaric Chamber

The Taskforce commissioned additional work on the risk associated with the hyperbaric chamber.

The hyperbaric chamber is located within 2-3 metres of the proposed K-Block pillars. Concerns have been expressed regarding stress from construction activity, the impact of noise and vibration on patients and staff and the potential for a crane drop to cause catastrophic failure of the chamber.

Advice provided indicated that any pipe fracture and/or compromise to the integrity of the chamber could cause rapid decompression of the chamber and decompression illness for patients and clinical staff. At worst case, death of the chamber occupants would occur.

In the event of an explosive decompression, the likely impact is significant and could include damage to surrounding buildings, human injury and death. There could also be an impact on the hospital's oxygen tower.

The Taskforce sought advice from the project's engineers, AECOM, on the construction risks to the hyperbaric chamber.

AECOM provided a range of recommendations to address potential noise and vibration impacts on staff and patients and risks arising from falling materials. They advised that piling or excavation for the foundations near the hyperbaric chamber should be undertaken outside of the hyperbaric chamber's operating hours. Further investigation should also be undertaken to assess the noise and vibration impacts from nominated construction activities prior to the commencement of works.

With regard to the risks associated with falling material, AECOM advised that an overhead gantry should be installed above the hyperbaric chamber, similar to those installed where cranes are working over footpaths.

AECOM engaged a specialist engineer, Tawfik, to assess the risks associated with metal fatigue in pipes under pressure. Tawfik was not able to provide definitive advice on these risks but advised that further engineering investigations would be warranted before construction commenced.

Notwithstanding the advice from AECOM that the risks can be managed (at significant cost), the Taskforce noted that the hyperbaric chamber has been in clinical operation since 1991. The chamber was built and installed under the then current Australian and international standards which allows the chamber to continue to operate under a grandfather clause. The chamber no longer complies with current standards in many areas.

The hyperbaric unit advised that the chamber will be beyond its design life by 2016 and would need to be replaced. Furthermore, should any part of the unit or chamber be modified or altered in any way, it will be necessary to adhere to the current standards. The hyperbaric unit has received advice that it is not possible to refit and modify the chamber to comply with current requirements of hospital hyperbaric facilities. There is a significant risk, therefore, that a relatively minor fault could cause the chamber to shut down permanently or for a prolonged period of maintenance.

If the hyperbaric chamber was unavailable for any period of time, there would be no provision of medical treatment for hospital patients or emergency care for diving incidents and the like. This would have a significant impact on the Tasmanian aquaculture, abalone, dive training and recreational diving industries.

The hyperbaric unit advised that the cost of moving the current facility to F-Block and replacing the hyperbaric chamber is $3 to 4 million. Further costs could be incurred if a new purpose built facility is required (up to $9 million).

As it appears that the hyperbaric chamber will need to be replaced during the period of construction of K-Block the Taskforce recommends that planning proceeds for its replacement as a matter of priority so that the work can be progressed during the project's decanting and refurbishment period (during 2015). This would avoid unnecessary costs associated with delays in the main construction program caused by risk mitigation measures during the operation of the hyperbaric chamber, ongoing inspections of the hyperbaric chamber infrastructure or conflicts between the construction program for K-Block and any construction required to eventually house a new hyperbaric chamber.

## Clinical Risk

On the request of the Taskforce, the THO-South provided a base case decanting plan which provided sufficient information to KPMG to assess the clinical risk of decanting. This focused on the offsite decanting of: MHS, the rehabilitation unit, AOPU, and the transitional care program. It also considered the proposed service change which would replace PICU with an eight bed Psychiatric Assessment and Planning Unit (PAPU) because of a reduction in floor space available to MHS in methodology A initially proposed.

The Taskforce concurred with the concerns raised by the ESC in its *Project Status Report*, regarding the decanting plan.

KPMG determined that the key considerations for offsite decanting included legislative and/or accreditation standards, role delineation, emergency response capacity and service efficiency.

Both construction methodologies require service relocations. The key difference between the methodologies is the requirement for methodology B to decant significant acute clinical services offsite. However, the Taskforce noted that while MHS would remain onsite during construction under methodology A, the PAPU would be relocated adjacent to the emergency department.

The key clinical concern was the proposal to locate acute mental health services offsite. The Taskforce received advice that there was no current comparable example from South Australia, Victoria or New South Wales for locating inpatient mental health beds standalone and separate to an acute hospital site. In its report to the Taskforce, KPMG noted significant concerns with regards to accreditation requirements, resourcing and the safety of staff and patients. Safety was also a serious concern raised by consumers and clinicians during stakeholder consultation, who did not feel confident in the development of appropriate mitigation strategies.

KPMG further advised the Taskforce that decanting of the rehabilitation and AOPU to the Repatriation Centre, while not desirable was considered manageable.

The Taskforce noted that the key clinical risk identified by KPMG with methodology B was the impact of offsite decanting to respond appropriately to service emergency calls. This was also highlighted to the Taskforce during stakeholder consultations. The key risks are code black, threat to personal safety in MHS and code blue, a medical emergency, for both AOPU and MHS.

There are significant staffing costs associated with facilitating appropriate non-medical emergency response services (for codes black, escort and patient assist) at offsite locations. Medical emergency response services (code blue and the Medical Emergency Team) would require ambulance transport to the RHH. The Taskforce noted this could be a particular risk for acute older persons who may experience significant adverse consequences as a result of not being collocated with the hospital.

## Delivery Risk

Delivery risk includes risks associated with the skills and resources required to manage the construction and decanting programs (including clinical staff).

The Taskforce noted the advice that there was little difference in delivery risk between the two construction methodologies and noted the previous success of joint ventures in Tasmania between John Holland and Fairbrother such as the new University of Tasmania medical science precinct. However, KPMG did caution that methodology B may be associated with increased clinical delivery risk given that recruitment of additional clinical and support staff for offsite locations may be difficult, especially for highly specialised roles.

Whilst both methodologies could be delivered, it was noted that methodology A would involve a longer construction program. The construction methodology feasibility study undertaken by the design consultants in consultation with the Managing Contractor indicated that labour availability would be more easily managed over a longer program (including site amenities) and that there would be a requirement for shared access to the site and emergency planning due to the integration of works associated with a single stage construction (methodology B).

**Hazardous materials represented a significant program risk for both methodologies and had the potential to delay the project.**

## Programming Risk

KPMG advised that a *Part 6 Asbestos and Hazardous Materials Audit* needed to be conducted because its advice represented a significant program risk for both methodologies and had the potential to delay the project. Moreover, this risk could be mitigated by expediting the procurement of a contractor to remove the hazardous materials that had been identified.

The Taskforce commissioned the *Part 6 Asbestos and Hazardous Material Audit.*

The Taskforce noted that methodology A faced the greatest risk to delayed project completion. This was due to the staging of refurbishment works and decanting, specifically the commissioning of K-1 to allow for demolition of B-Block, before K-2 could be built.

Conversely, methodology B faces greater upfront programming risk due to the increased complexity associated with decanting refurbishment work that must be completed in advance of commencing the full demolition of B-Block.

Given the complexities of the risks associated with both methodologies A and B, there is no clear preference to a construction methodology based on programming risk. All of these risks would need to be considered carefully and managed to prevent an extension in the project's program.

Notwithstanding, the Taskforce noted that adoption of methodology B would have a net program reduction of nine months when compared with methodology A.

It is estimated that the single stage methodology will take 44 months to complete. If the project is to proceed and a new program negotiated, a new completion date would need to be negotiated with the Commonwealth Government.

## Financial Risk

Financial risk across the two construction methodologies included capital cost and operating cost during the life of the project.

Based on the scope of the base case decanting plans, the capital cost for decant refurbishment for construction methodology B is higher than methodology A. This is largely due to the significant operational costs associated with establishing decanted acute services at St John's Park and the Repatriation Centre proposed in the base case decanting plan. With these costs included, the costs for methodology B would be significantly higher.

The capital cost for decanting and refurbishment for methodology A is lower, due to the smaller program of works required. However, this should be considered in the context of an estimated increase in the costs of the construction of K-Block in two stages due to the longer program and more complex construction process. The operational costs for decanted services as part of a two stage methodology would only be marginally higher than current RHH operational costs. If offsite decanting was required the operational costs are significantly increased.

## Summary of Risk Profile

The Taskforce agreed that construction methodology B was the preferred construction methodology. However, the clinical risks associated with offsite decanting were detrimental and an alternative should be found. The clinical risks relate to the need to provide emergency medical and security responses to acute older persons and mental health inpatients.

Methodology A had fewer decanting issues and it was considered that the construction risks would be manageable. However it would take longer by nine months, there was a risk of mid-program delay and would have increased impacts from noise, vibration and dust.

During the KPMG assessment hybrid alternatives for both methodologies were identified. The Taskforce determined that further exploration of the hybrids were warranted.

**The clinical risks associated with offsite decanting were detrimental and an alternative should be found.**

## Methodology A Hybrid – Demolish B-Tail

The investigation of the Taskforce led to the development of hybrid methodology A which would involve the early demolition of the B-Tail building and avoid the cost of the protective structures required if the building remained in place. It would also allow for the construction of a larger floorplate to accommodate MHS in its final location earlier in the program.

The costs uniquely attributable to building over B-Tail building and undertaking a temporary decant for MHS are $1.63 million in additional fitout costs and $1.54 million in works to build a gantry over B-Tail.

Construction risk can be minimised and the outcome for MHS improved by exploring a refinement to methodology A. This would provide additional floor space and remove the need for trusses to span B-Tail required by this methodology. This hybrid can be summarised in the following steps:

- decant B-Fan and B-Tail
- demolish B-Tail and B-Fan concurrently
- reorient the lower levels of K-1 to provide additional floor space and an optimised mental health floor plan at a cost of approximately $2.4 million and
- decant Mental Health earlier, avoiding a double decant.

The design consultants advised that the option is feasible. The quantity surveyor advised that there is a net cost reduction to construction methodology A of $0.8 million. THO-South advised the Taskforce that the proposal has preferable clinical outcomes.

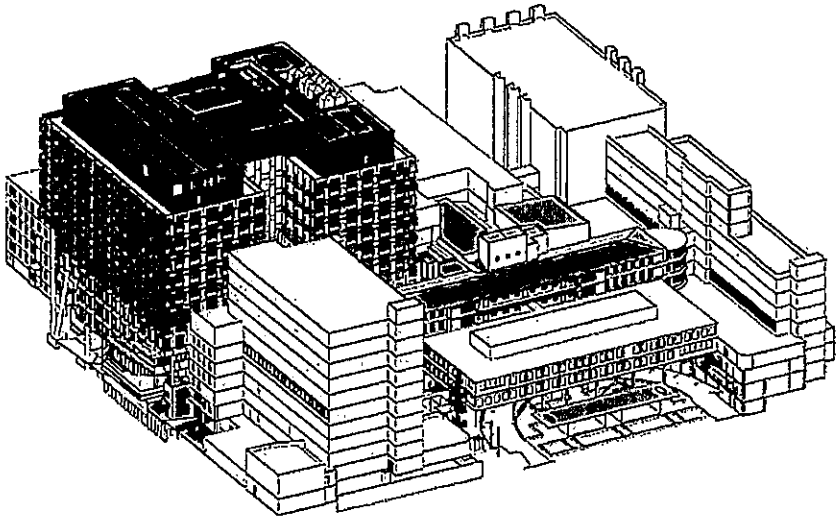
## Methodology B Hybrid – Accommodate MHS and AOPU Onsite

The investigation of the Taskforce led to hybrid methodology B (single stage) which would involve constructing a temporary facility above the Liverpool Street forecourt (see figure 5).

Identification of an onsite option to decant MHS and the AOPU would mitigate the key clinical risks facing the project and allow for the adoption of a single stage construction methodology. The significant costs associated with delivery of services at an offsite location would also be avoided.

The Taskforce has received advice that MHS and the AOPU could be accommodated in a temporary two storey facility to be constructed above the Liverpool Street forecourt of the hospital.

Figure 5 Temporary Facility in the Liverpool Street Forecourt



The design consultants considered the feasibility of a temporary facility and advised that there are no structural or engineering impediments to the construction of a two storey temporary accommodation facility. The temporary facility would be limited to two storeys because of the structural integrity of the Liverpool Street forecourt.

The key features of the temporary facility are:

- it can be constructed offsite reducing timeframes and consequently onsite disruption
- it can be connected directly to C-Block
- similar facilities have been used on other hospital campuses and
- it can be readily dismantled and relocated when required.

The estimated cost of the temporary facility is around $18 million but it will avoid capital and operating costs totaling $29.6 million. This represents a net benefit to the methodology B costs of $11.6 million.

## Methodology C – The Preferred Methodology

Methodology C takes the best aspects of the previous methodologies. This is a single stage construction methodology that includes the construction of a temporary facility in the Liverpool Street forecourt and the reorientation of levels 2 and 3 of K-Block design. Methodology C capitalises on the shorter construction duration of methodology B and optimises clinical outcomes for patients both during construction, and in the design for K-Block.

The construction of the temporary facility significantly reduces clinical risk because it allows MHS and AOPU to remain onsite during construction.

Methodology C would provide more contemporary health planning outcomes for MHS and WACS by optimising available space in the reoriented lower levels of K-Block. This will enable the delivery of improved models of care including providing additional outdoor recreational space for mental health patients.

The proposed change responds to the majority of concerns identified regarding outcomes for MHS in the design of K-Block at a cost of $2.4 million.

The proposed program for the construction of K-Block could potentially commence early in the New Year and is expected to be completed in late 2018. It includes:

- two months for initial start-up and to commence refurbishment documentation (February to March 2015)
- 12 months for decant and refurbishment (running in parallel with design documentation April 2015 to April 2016)
- three months demolition of B-block (April 2016 to June 2016)
- 11 months for construction of foundations and lower levels of K-1 (July 2016 to June 2017) and
- 15-16 months for completion of K-1 and K-2 and the façade (June 2017 to September 2018).

Preliminary advice from the Managing Contractor is that this program would not be affected by the construction of a temporary facility above the Liverpool Street forecourt or the revision of the design for levels 2 and 3 of K-Block. This would, however, need to be confirmed in advance of considering a revised GCS Offer.

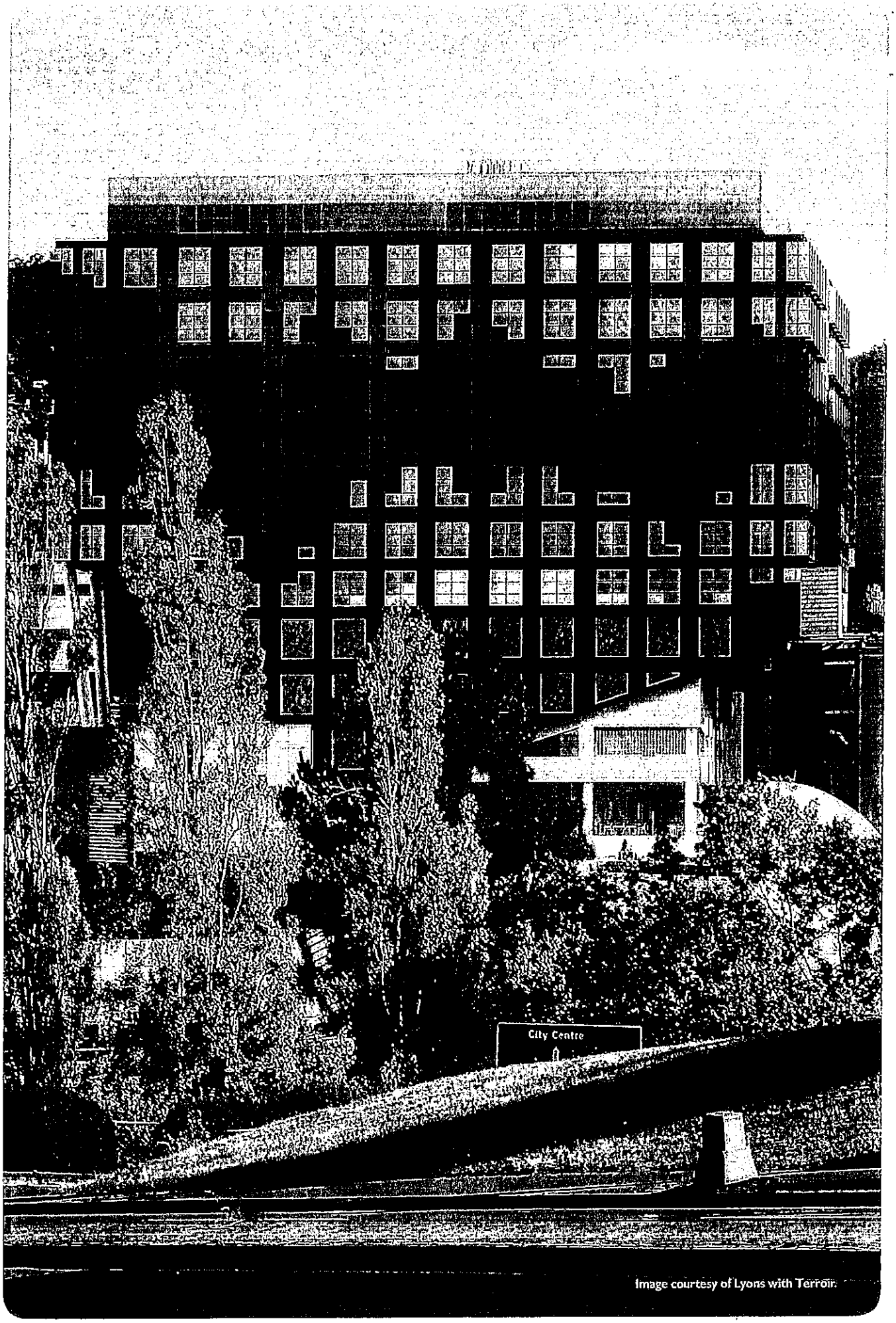



Image courtesy of Lyons with Terroir.

# DECANTING PLAN

## Introduction

Relocating services is not an unusual business requirement of hospital management. However, the decanting required to build K-Block is more detailed. This is because of the number and sequencing of moves, and the breadth of refurbishments necessary including the removal of hazardous materials. Additionally, it must all take place on an operational hospital site.

**The decanting plan for the proposed new methodology requires 19 service relocations.**

The proposed decanting plan was based on the single stage base case developed by THO-South to support the KPMG risk assessment commissioned by the Taskforce. This was subsequently revised by the project team and the design consultants at the request of the Taskforce to reflect the requirements of construction methodology C.

## Service Relocations During Construction

The decanting plan for the proposed new methodology requires 19 service relocations. This involves the relocation of three services to offsite locations: the 1 800 mental health hotline from Mistral Place to make way for the clozapine clinic and the relocation of the rehabilitation unit to the Peacock Building at the Repatriation Centre, Davey Street, Hobart. A small number of relocations also occurred prior to the commissioning of the Taskforce.

A critical feature of the recommended decanting plan is the construction of a 3 000 m², temporary building in the Liverpool Street forecourt above the main entrance and drop-off point of the RHH. This will allow acute mental health patients and the AOPU to remain onsite, negating the significant clinical risk associated with moving these patients offsite. It will also relocate mental health longer stay inpatients from the immediate construction site, significantly reducing the day to day disruption they would have experienced if they had remained in B-Block under the two stage methodology.

The Department of Psychiatric Medicine would be located on level 1 of the temporary building with PICU and general and women's surgical inpatients on level 2. The temporary facility would provide a minimum of 29 mental health beds including five PICU beds, and seclusion and de-escalation areas. It would also include a minimum of 21 surgical beds and a plant room. The facility would have access directly into C-Block at levels 2 and 3 enabling lift access to the emergency department and other clinical services.

The Liverpool Street RHH entrance would be closed during construction of the temporary facility, and disassembly and relocation after K-Block was commissioned. The temporary facility can be dismantled and relocated or sold once it is no longer needed.

Table 1 identifies key clinical service and offices, their current location and new locations for these services to allow the decanting and demolition of B-Block under the proposed plan.

Table 1 – Key Service Relocations During Construction

| Service | Current Location | Service Relocation During Construction |
|---|---|---|
| Clozapine Clinic (outpatients) | Lower Ground, B-Block, opening onto Campbell Street | Ground Floor, Mistral Place, Liverpool Street |
| Mental Health – Psychiatric Intensive Care Unit (PICU) | Lower Ground, B-Block, opening onto Campbell Street | Level 2, temporary building, Liverpool Street forecourt (access to Level 3, C-Block) |
| Mental Health – Department of Psychiatric Medicine | Ground Floor, B-Block | Level 1, temporary building, Liverpool Street forecourt (access to Level 2, C-Block) |
| General Medicine, Respiratory and Infectious Diseases Inpatients | Level 1, B-Block North | Level 9, A-Block plus open additional beds in the APU on Lower Ground, H-Block |
| Iodine Therapy Inpatients (2 rooms) | Level 1, B-Block North | Level 6, A-Block* |
| Q-Class Rooms | Level 1, B-Block North | Level 1, H-Block (DCCM) |
| Sub-Specialty Medicine Inpatients | Level 1, B-Block South (B-Tail) | Level 7, A-Block |
| Rehabilitation Unit including the Rehabilitation Gym | Level 7, A-Block | Level 2, Peacock Building, Repatriation Centre, 90 Davey Street |
| General and Women's Surgical Inpatients | Level 2, B-Block North | Level 2, temporary building, Liverpool Street Forecourt (access to Level 3, C-Block) |
| Stomal Therapy | Level 2, B-Block North | Level 4, C-Block |
| Orthopaedic Inpatients | Level 2, B-Block South | Level 5, A-Block (with Surgical Specialties) |
| High Volume Short Stay (HVSS) | Level 5, A-Block | Level 4, C-Block North (Becomes Extended Day Surgery) |
| Day of Surgery Admissions (DOSA) | Level 4, C-Block North | Level 4, C-Block South |
| Neurology Offices, Neurophysiology Offices, Endocrinology Offices | Level 3, B-Block | Level 3, C-Block |
| Pre-Operative Surgical Interventions (POSI) and Spinal Assessment Centre (SAC) | Level 3, B-Block | Level 2, H-Block |
| Ambulatory Care Centre (ACC) | Level 4, B-Block | Level 2, C- and D-Block |
| Acute Renal Dialysis | Level 4, B-Block | Lower Ground, A-Block (Transit Lounge) |
| Cardiothoracic and Cardiology Offices | Level 2, C- and D-Blocks | Level 2, C-Block |
| Cardiac Rehabilitation Gym | Level 2, C- and D-Blocks | Level 2, H-Block |

**A variation to the location of Iodine Therapy Inpatients is currently under consideration. The proposed decanting plan may be amended to move this service to Inpatient Oncology Level 2, A-Block.*

A number of other minor and short term decants of administrative and other spaces are also required.

Clinical services and offices are currently located in A-, B-, C-, D-, and H-Blocks of the RHH. The blocking and stacking of the hospital campus demonstrates how services are located across floors and buildings to maximise efficiencies in service delivery and make best use of available assets.

The decanting of B-Block would require the relocation of some services from other buildings for optimal blocking and stacking. It includes a number of co-dependencies where wards or offices relocate to make room for the relocation of other wards or offices.

There are a number of additional administrative decants required which would occur in E- and F-Blocks.

The decanting feasibility study produced by the design consultants (September 2014) noted that the decanting and refurbishments would be unlikely to occur without some level of disruption to the operations of the RHH. Staging of refurbishment works would be necessary to mininise this impact.

While construction methodology C is shorter in construction duration it would require a longer refurbishment and decanting program including the construction of the temporary building in the Liverpool Street forecourt.

There are 29 sites that would be refurbished and the majority of works are classified as heavy refurbishments. Heavy refurbishments refer to works to an existing building that include minor demolition of all walls, ceilings, floor coverings and building services with a total refit of the area including new building services and plant.

Due to the staging required to support the decanting plan, refurbishment works would be staged prior to the demolition of B-Block and construction of K-Block. Many refurbished areas would be used by services in the long term.

The total cost estimate to implement the decanting plan is $51.04 million. This includes a provision of 20 per cent for the removal of hazardous materials, and consultant fees.

Current blocking and stacking at the RHH and new locations during construction are depicted in figures 6 and 7.

Figure 6 – Current RHH Clinical Services Blocking and Stacking

| | A Block | B Block | C Block | D Block | H Block |
|---|---|---|---|---|---|
| Level 9 | Vacant for Future Decant | | | | |
| Level 8 | Day Oncology/ Allied Health Inpatients | | | | |
| Level 7 | Rehabilitation | | | | |
| Level 6 | Acute Older Person's Unit | | | | |
| Level 5 | Surgical Specialties/ HVSS | | | Pharmacy | Doctors Quarters |
| Level 4 | Day Surgery/ Endoscopy | Ambulatory Care Centre/ Acute Renal Dialysis | Theatres/ Surgical Services Offices/ DOSA | Theatres/ CSSD | Anaesthetics Depart/ Surgical Offices |
| Level 3 | Paediatrics Unit | Neurology/ Neurophysiology/ Endocrinology/ POSI/ SAC | Vacant for Future Decant (ex-WACS) | Maternity/ Birthing/ NPICU/ TTH<br>Decanting Space | WACS Offices<br>Decanting Space |
| Level 2 | Oncology Inpatients | General Surgical/ Gynae/Gynae Onc Surg/ Orthopaedics | Vacant for Future Decant | Cardiology Offices/ Cardiothoracic/ Cardio Gym | Physio/ Physio Store |
| Level 1 | Oncology Clinics | General Medicine/ Respiratory/ Subspecialty Medicine | Chapel + Misc. Offices | Pathology<br>DCCM Offices | Neurosurgery/ Neurology<br>DCCM |
| Ground | Holman Clinic | DPM | Entrance/ Communications | Kitchen/ Cafeteria | Medical Imaging |
| Lower Ground | Extended Stay Unit<br>Campbell Street Entrance | PICU/ Clozapine Clinic | | Mortuary/ Supply/ Environmental Services | APU/ EMU<br>Paediatrics Clinics |

Note:

- E- and F-Blocks are not depicted because they do not accommodate clinical services or offices.

Legend

WACS

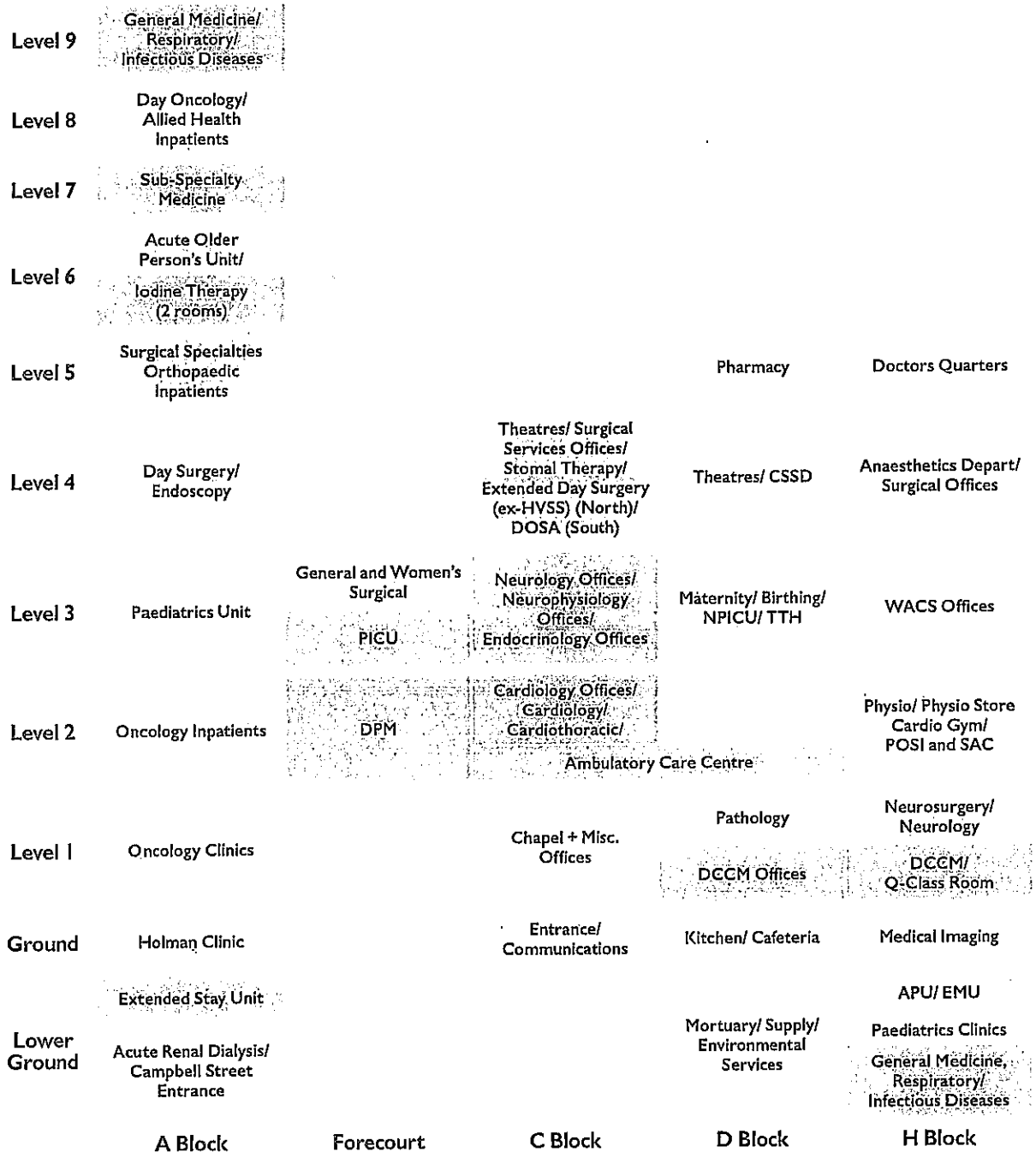
Other

Mental Health

Medicine

Surgery

Figure 7 – Construction Clinical Services Blocking and Stacking




Notes:

- E- and F-Blocks are not depicted because they do not accommodate clinical services or offices.
- Clozapine Clinic relocate to Mistral Place, Liverpool Street.
- Holman Clinic meeting room, staff room and offices to Ground Floor of A-Block.
- Rehabilitation unit including rehabilitation gym to Level 2, Peacock Building, Repatriation Centre.
- Women's ante-natal clinic was relocated to 329 Main Road, Glenorchy prior to commissioning of the Taskforce.
- Continence Clinic was relocated to the Clarence Integrated Care Centre prior to the commissioning of the Taskforce.
- Refurbishment works to relocate the cardiology offices were completed prior to the commissioning of the Taskforce.
- Refurbishment works to relocate the 1800 Mental Health number at the Peacock Centre, Elphistone Road, North Hobart have occurred.

**Management of bed capacity is normal business and THO-South will continue to implement a bed management plan to ensure adequate beds are available for patients.**

## Effects of the Decanting Plan on Bed Capacity

The project team provided advice regarding the number of beds that would be available if the decanting plan was implemented. The project team advised that there would be a small decrease in the number of flexible beds during the construction of K-Block.

However, the majority of these beds are MHS beds and the K-Block design similarly reduces MHS bed numbers. Moreover, THO-South advised the Taskforce that an early reduction of MHS beds had already occurred. In real terms there will be one less flex bed available during decanting.

The ANMF have raised concern regarding the bed capacity of the RHH resulting from the relocation of services and reduced hospital capacity. The THO-South has confirmed the management of bed capacity is normal business and they will continue to implement a bed management plan to ensure adequate beds are available for patients.

## Implementation of the Decanting Plan

The decanting plan will take approximately 12 months to implement. Detailed design requirements will occur in parallel during this time and would be managed by the Managing Contractor.

Coordinated communications between THO-South, the project team, and the Managing Contractor would be essential.

Consultation was a feature of the decanting plans developed by THO-South earlier this year and then again for the base case proposals used in the construction methodology risk assessment. This process sought advice on the issues and risks related to the decanting plans. The Taskforce noted that while consultation involved representative staff groups, further and broader consultation with staff focusing on the effective implementation of the approved decanting plan may be required. Specifically, THO-South have an agreement with industrial organisations to develop formal change proposals to ensure that change and project management is systematically implemented.

## RECOMMENDATIONS

### Recommendation One

That considering the significant barriers of both cost and time, the significant investment in the current site, and the likely impacts on the CBD of relocation, every effort should be made to proceed with the current project.

### Recommendation Two

That work continues on the redesign of the women's, adolescents and children's services precinct to increase the number of single beds available for women experiencing caesarian or complex births (noting possible cost implications).

### Recommendation Three

That levels 2 and 3 designated for MHS be redesigned to deliver improved outcomes for mental health patients. This recommendation should be considered in conjunction with Recommendation Five.

### Recommendation Four

That the installation of a helipad on the roof of K-Block be considered as part of the current redevelopment. This would require an additional investment.

### Recommendation Five

That the project proceeds as a single stage construction methodology that includes the building of a temporary facility in the Liverpool Street forecourt that will accommodate mental health and general and women's surgery; and the reorientation of levels 2 and 3 of the K-Block design. This would require an additional investment.

### Recommendation Six

That the scheduled replacement of the hyperbaric chamber be brought forward to eliminate construction risk and ensure continuity of service. This would allow for its construction to be aligned with the decanting and refurbishment program of the project.

### Recommendation Seven

That the proposed decanting plan be implemented to support the preferred construction methodology.

### Recommendation Eight

That an additional $61.4 million be allocated to the project to allow it to proceed in accordance with the recommended design. This includes the $2.4 million required to improve the outcome for MHS.

### Recommendation Nine

That a contract variation be agreed with the Managing Contractor to reset the project and allow the Crown to request a revised GCS Offer.

### Recommendation Ten

The Managing Contractor be asked to agree a new Project Construction Cost Estimate as the initial step towards a revised GCS Offer.

### Recommendation Eleven

That critical works are commenced as soon as possible to avoid delays to the program of works for the project. For example, the removal of hazardous materials and refurbishment works.

### Recommendation Twelve

The proposed governance and management approach be approved which is characterised by:

- an Executive Steering Committee with an independent Chair; specialist hospital construction expertise; and representation from, the THO-South (the client) to ensure a service delivery focus, DHHS the project and asset owner, and the Department of Treasury and Finance, given the financial significance of the project
- direct reporting from the Executive Steering Committee, through the independent Chair to the Minister for Health and the Treasurer
- a Project Director who is an employee of the State and is responsible for the delivery of the project within scope, budget and timeframes as well as project resources and processes and
- a Project Manager and project management resources with the necessary technical, contractual, and consultant and contractor management experience to deliver the project.

### Recommendation Thirteen

That the interim governance arrangements be established including an interim Chair, interim Project Director and interim Deputy Project Director, in addition to the existing care and maintenance project team resources and Taskforce Secretariat.

# APPENDIX 1 -- TERMS OF REFERENCE

## Objective

The Taskforce is established by the appointment of members by the Minister for Health under Crown Prerogative instruments to review key elements of the Royal Hobart Hospital Redevelopment Project and provide advice and recommendations to the Minister for Health on its future.

## Scope

The Taskforce is to undertake a process of review, investigation and refinement of the Project that:

1. Examines and makes recommendations regarding the overall capital and operating financial risk profile of the Project and the hospital following completion of the works.
2. Examines the construction methodology of the Project and evaluates its achievability, level of risk to patients, costs implications and timeframes against viable alternative methods of construction and makes a recommendation about the preferred construction methodology for proceeding with the Project.
3. Recommends a comprehensive, costed and implementable decanting plan that supports the preferred construction methodology identified through its work.
4. Recommends a project governance and management structure sufficient and able to effectively and efficiently govern and manage the next stage of the project.
5. Provides an overall recommendation on whether to proceed with the acceptance of the GCS Offer presented by the Managing Contractor, to reject that offer or to proceed with another course of action.
6. Examines and makes recommendations on any other matters related thereto.

In undertaking its work, the Taskforce must consider the role of the Royal Hobart Hospital Redevelopment in the broader context of Tasmania's health care system in to the future.

The final output of the Taskforce will be a report to Cabinet, through the Minister for Health, addressing the issues outlined above.

The Taskforce will also oversee care and maintenance aspects of the project and provide strategic advice to the Minister for Health about matters relating to this to ensure that new and emerging risks are not arising in an environment separate from the review and are capable of being addressed.

## Timeframe

It is envisaged that the Rescue take no longer than six months to complete from the time of commencement.

## Reporting

The Taskforce will report to the Minister for Health and will provide monthly reports to Cabinet and the Australian Government during this period through the Minister for Health.

# APPENDIX 2 – MEMBERSHIP OF THE TASKFORCE

## John Ramsay

Taskforce Chair, Mr Ramsay, has significant experience in health and human service delivery in Tasmania. He is the Director and Principal of John Ramsay and Associates Pty Ltd which provides consulting services in health and human services and a former Secretary for the Tasmanian Department of Health and Human Services.

He has legal qualifications and is the Chairperson of the Board of the Environmental Protection Authority of Tasmania and Member of the Tasmanian Planning Commission and Board of the Menzies Research Institute Tasmania.

## Jo Thorley

Ms Jo Thorley, Taskforce Member, brings significant experience in major hospitals redevelopment, project direction, and health services and facility planning, supported by dual qualifications in nursing and architecture.

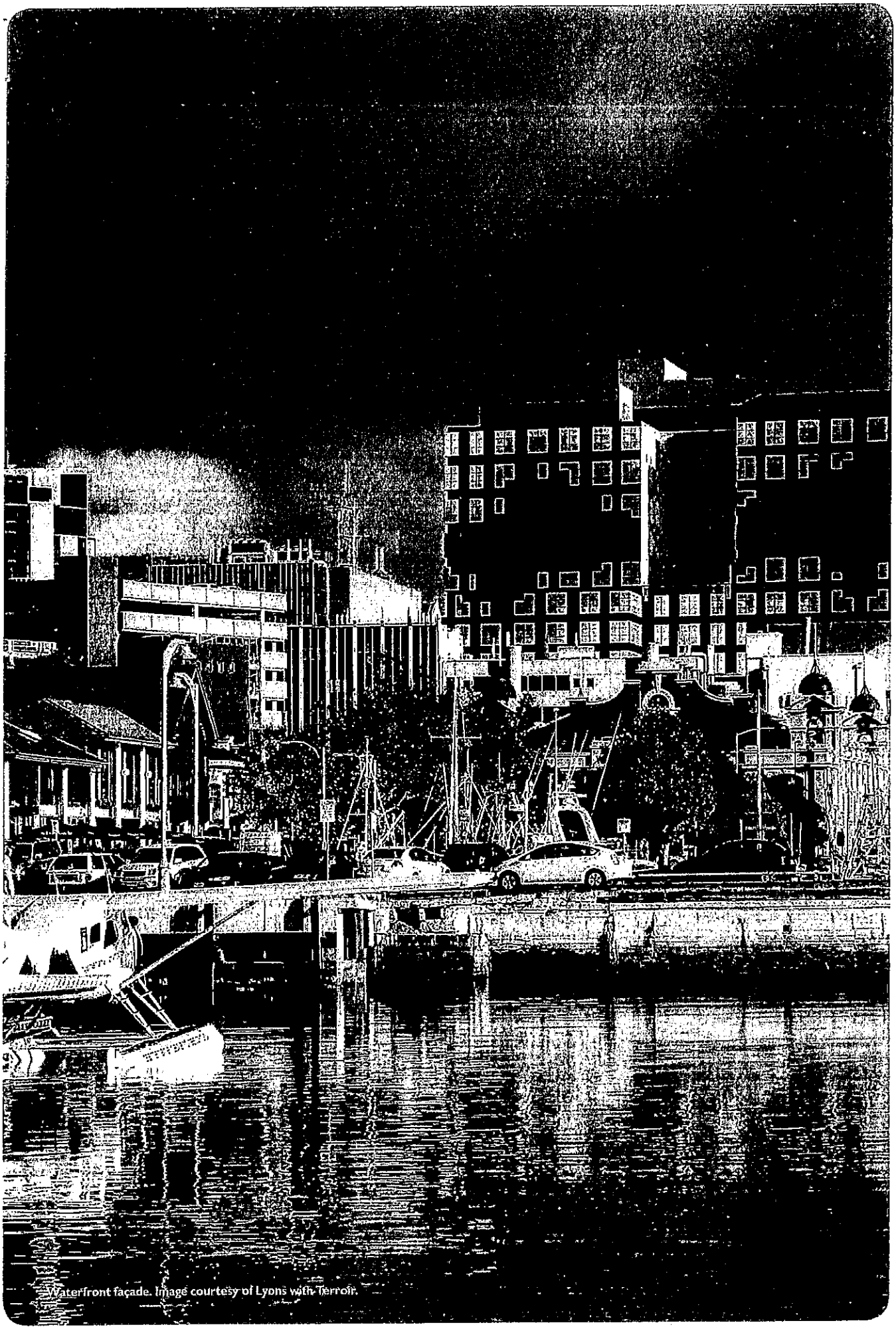
She is currently the Project Director for WA Country Health Service $1.5+ billion dollar program of capital works, has provided project direction of the $1.2 billion Royal North Shore Hospital and Community Health Services Redevelopment, St Leonards NSW and Facility Planning Management of the $440 million Central Sydney Area Health Service Resource Transition Program Redevelopment. She is currently Director Aurora Projects.

## Dr Dan Norton AO

Dr Dan Norton AO, Taskforce Member, has worked in major infrastructure industries, central government and international commodity marketing. His extensive experience includes financial management reform, health research, health services, ICT, public sector management and commercial negotiations.

Dan was Chairman, Menzies Research Institute Tasmania during its redevelopment. He is currently Chairman of TasPorts, Chairman of TasNetworks, Deputy Chairman of TasWater and a Director of WinEnergy Pty Ltd and consulting company Trinitas Pty Ltd. He is also an associate of dandolopartners.

His former positions include Secretary, Department of Premier and Cabinet and Deputy Secretary, Department of Treasury and Finance in Tasmania.



Waterfront façade. Image courtesy of Lyons with Terroir.

# Department of Psychiatry K Block Functional Brief

Tasmanian Health Organisation

South

February 2015



Tasmanian Government

# Table of Contents

# A. MODEL OF CARE

## 1 Service Scope

The target consumer cohort for Department of Psychiatry includes people who may:

- Be experiencing acute symptoms of mental illness that is unable to be managed in the community.
- Have complex needs and require integrated medical and psychiatric assessment.
- Adults aged 18 to 65 years of age. Young people between the ages of 16 and 18 and people older than 65 will be assessed on a case-by-case basis to determine whether the Department of Psychiatry setting is appropriate for their short-term mental health needs. The expressed preferences of young people, older people and their families and carers will be a central part of this assessment process.

- The Department of Psychological Medicine is a significant mental health unit with important interfaces with the Emergency Department, the community and other inpatient and hospital services. Co-ordination and collaboration between all these services will provide a continuum of mental health care that operates under the principle of least restrictive practice is provided in accordance with a consumer recovery orientated framework.
- In adhering to the principle of least restrictive practice, mental health services aim to impose the least personal restriction on the rights and choices of consumers, taking into account their living situation, level of support within the community, and the needs of their family or carer.
- Operating under a consumer recovery orientated framework, the Department of Psychiatry has a strong recovery focus, which from the perspective of the individual experiencing mental illness, means gaining and retaining hope, understanding ones abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self.
- Consumer engagement is another key focus for the Department of Psychiatry. At the core of mental health service delivery is the strength and quality of the engagement between the practitioner and the person using the service. While biological interventions and psychological treatments remain important, empathy, understanding, expert knowledge, trust and compassion are critical to successful outcomes. Effective engagement at Department of Psychiatry will assist in building therapeutic rapport and has the potential to positively influence the consumer and their family's ongoing interaction with mental health services.

### 1.1 Aims

As a specialist acute inpatient mental health service, the Department of Psychiatry aims to:

- Deliver highly specialist and high quality care for individuals who have been admitted during an acute phase of mental illness;

- Provide a safe and supportive environment;
- To incorporate recovery principles into service delivery, culture and practice;
- Providing individuals, carers and families with access and referral to a range of programs which support sustainable recovery; and
- To work closely with other health services, organisations and agencies to ensure a comprehensive bio-psycho-social approach to consumer care and the provision of integrated services.

## 1.2 Objectives

The objectives of the unit are:

- To provide timely, comprehensive, age-appropriate, multidisciplinary, evidence-based acute inpatient mental health treatment for people who are in the acute phase of a mental illness or disorder.
- To facilitate consumer's access to the most appropriate, least restrictive mental health services consistent with their needs, wishes, aspirations and goals upon discharge from Department of Psychiatry.
- To ensure the engagement and participation of the person accessing Department of Psychiatry services, their family, carers or significant others in assessment, treatment and care planning.
- To improve patient experience of acute inpatient care.

## 1.3 Principles

The principles guiding mental health service delivery in Department of Psychiatry are:

1. To respect, observe and promote the inherent rights, liberty, dignity, autonomy and self-respect of persons with mental illness;
2. To provide treatment in the least restrictive way possible to the extent that it is consistent with the protection of the individual and the community;
3. To provide a service that is comprehensive, accessible, inclusive, equitable and free from stigma;
4. To be sensitive and responsive to individual needs (whether as to culture, language, age, religion, gender or other factors);
5. To emphasise and value promotion, prevention and early detection and intervention;
6. To seek to bring about the best therapeutic outcomes and promote patient recovery;
7. To provide services that are consistent with patient treatment plans;
8. To recognise the difficulty, importance and value of the role played by families, and support persons, of persons with mental illness;
9. To recognise, observe and promote the rights, welfare and safety of the children and other dependants of persons with mental illness;

10. To promote the ability of persons with mental illness to make their own choices;
11. To involve persons receiving services, and where appropriate their families and support persons, in decision-making;
12. To recognise families, and support persons, of persons with mental illness as partners, with mental health service providers, in the provision of their treatment and care to the extent that this is appropriate and consistent with their own wishes;
13. To respect the wishes of persons receiving services, and the wishes of their families and support persons, to the maximum extent consistent with the health and safety of those persons and the safety of others;
14. To promote and enable persons with mental illness to live, work and participate in their own community;
15. To operate so as to raise community awareness and understanding of mental illness and to foster community-wide respect for the inherent rights, liberty, dignity, autonomy and self-respect of persons with mental illness;
16. To be accountable; and
17. To recognise and be responsive to national and international clinical, technical and human rights trends, developments and advances.

# 2 Service Profile

## 2.1 Current Hospital Inpatient Activity

This section provides a snap shot of selected data for the past three years (July 2011 to June 2014) on the occupancy rates, average length of stay, weighted averages and the top 20 Diagnostic Related Groups (for 2013/14) for both the Department of Psychological Medicine and the Psychiatric Intensive Care Unit.

The data shows a downward trend for both units over this period which may be reflective of the increased focus on community based care for mental health clients in Tasmania. In recent times a number of strategies have been implemented across Southern Mental Health Service that are designed to maintain and support clients in community based care to avoid or delay the need for an acute inpatient admission. Some of these strategies include:

- Strengthening clinical communication between inpatient and community services;
- Tweaking community based care services to better manage and provide medical support to clients (to keep them in the community);
- Securing the role of the Psychiatric Emergency Nurse who divert many clients away from acute care and towards community care; and
- Enhancing advanced packages of care to maintain clients within community settings.

The effectiveness of these strategies is reflected in the data below.

### 2.1.1 Occupancy Rates

#### *2.1.1.1 Department of Psychological Medicine*

Table 1 below shows the monthly occupancy rates for the Department of Psychological Medicine for the past three years, July 2011 to June 2014. The data shows that there has been a slight downward trend in the occupancy rate over the past three years. This trend is further exacerbated when taking into account that bed numbers for the Department were reduced in August 2013 from 34 to 30.

*Table 1: Department of Psychological Medicine, Monthly Occupancy Rates, July 2011 to June 2014*

| Year | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2013-14 | 79.1 % | 86.0 % | 91.4 % | 90.8 % | 79.9 % | 78.4 % | 60.9 % | 84.3 % | 78.9 % | 90.5 % | 81.3 % | 79.9 % |
| 2012-13 | 92.7 % | 88.3 % | 85.9 % | 83.6 % | 82.5 % | 86.8 % | 84.9 % | 79.1 % | 81.6 % | 80.0 % | 80.7 % | 73.7 % |
| 2011-12 | 95.4 % | 90.5 % | 96.5 % | 98.0 % | 83.8 % | 80.9 % | 95.3 % | 96.0 % | 97.0 % | 94.2 % | 93.5 % | 90.2 % |

Figure 1 below further highlights the downward trend of the occupancy rate over the past 3 years. The increase in August 2013 is attributable to the reduction of bed numbers for the Department. The rate declined significantly in November 2013 to Jan 2014 which correlates to similar seasonal fluctuations for that period in previous years (although the more recent figures represent a larger decline in the occupancy rates than was experienced in previous years). Since that time the occupancy rate has increased but continues to trend downwards over the longer period.

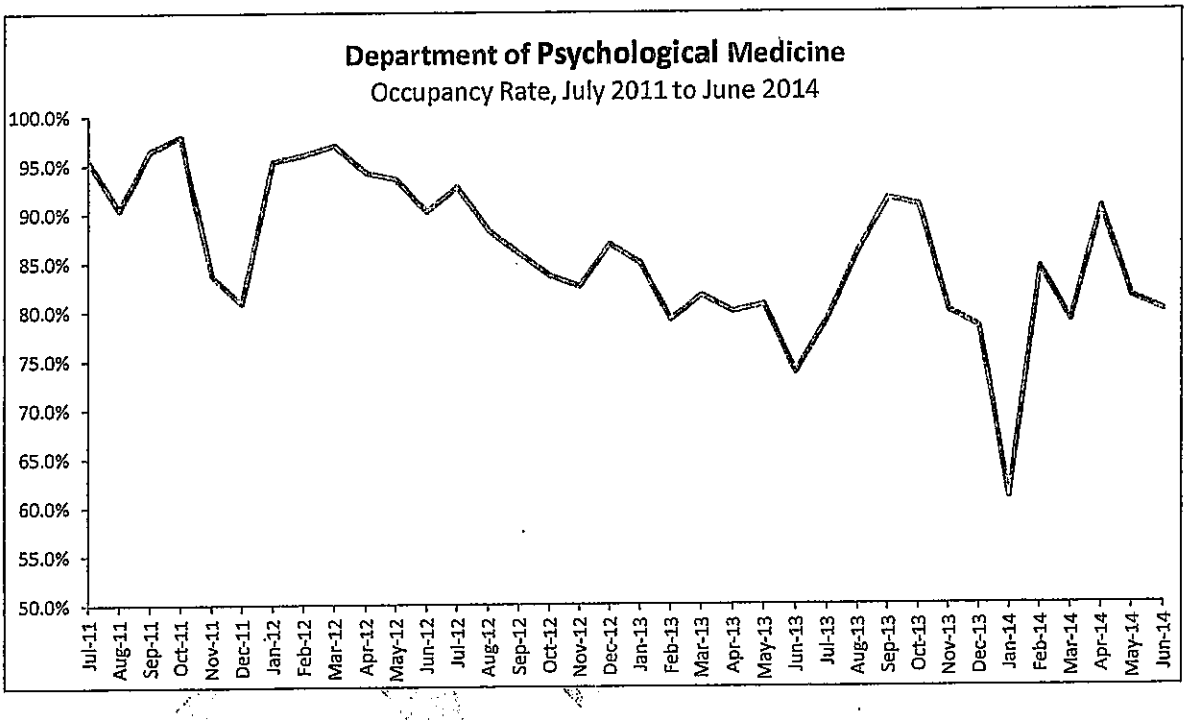



*Figure 1: Department of Psychological Medicine Occupancy Rate July 2011-June 2014*

### *2.1.1.2 Psychiatric Intensive Care Unit (future High Dependency Unit)*

Table 2 below provides the monthly occupancy rates for the Psychiatric Intensive Care Unit for previous three years, July 2011 to June 2014.
The small numbers of beds in the Unit creates a level of volatility in the occupancy rates which explains, in part, the peaks and troughs that occurred from month to month. The occupancy rates have remained fairly constant (despite the volatility) at between 80% to 95% occupancy until a significant decline was recorded in January 2014 and again in June 2014.

[redacted]

*Table 2: Psychiatric Intensive Care Unit, Monthly Occupancy Rates, July 2011 to June 2014*

| Year | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2013-14 | 93.3 % | 90.1 % | 96.3 % | 86.1 % | 86.5 % | 85.1 % | 67.4 % | 77.8 % | 79.4 % | 94.1 % | 82.2 % | 61.7 % |
| 2012-13 | 95.0 % | 98.0 % | 96.6 % | 94.6 % | 80.7 % | 94.9 % | 92.8 % | 80.8 % | 82.4 % | 91.6 % | 84.1 % | 79.9 % |
| 2011-12 | 92.6 % | 81.7 % | 86.8 % | 96.6 % | 83.5 % | 83.8 % | 94.8 % | 92.7 % | 95.8 % | 95.3 % | 91.0 % | 95.3 % |

Figure 2 below clearly highlights the volatility in the data from month to month where it is not unusual for the rates to change by ten percent of more. The trend in reduced occupancy rate has occurred with the introduction of this new model of care in the Department of Psychiatry.

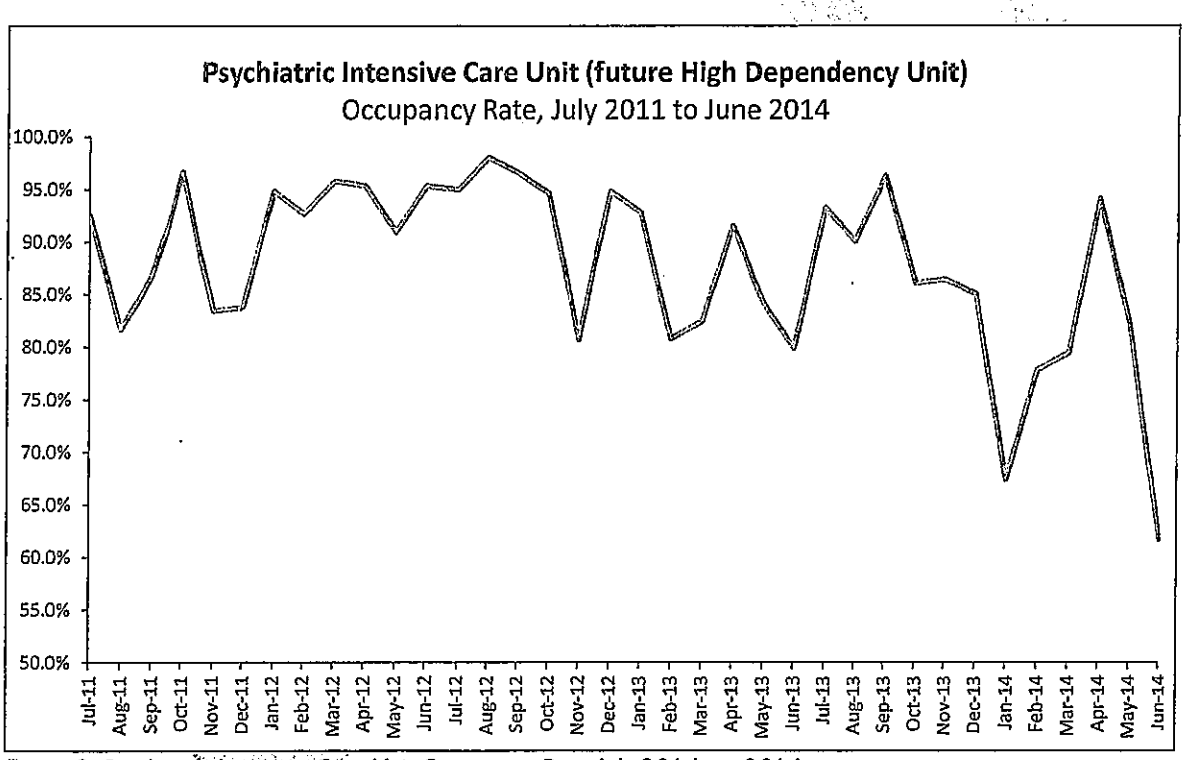



*Figure 2: Psychiatric Intensive Care Unit Occupancy Rate July 201-June 2014*

### 2.1.2 Length of Stay

#### *2.1.2.1 Department of Psychological Medicine*

Data below, in Table 3, shows that the monthly average length of stay at the Department of Psychological Medicine ranges from a high of 17.27 days in August 2012 to a low of 8.67 days recorded in January 2014. Typically the monthly average length of stay over the past three years is between 10 to 14 days.

[redacted]

However, towards the end of 2013 and the beginning of 2014, the month average length of stay dropped with some months recording an average length of stay below ten days.

*Table 3: Department of Psychological Medicine, Average Length of Stay, July 2011 to June 2014*

| Year | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2013-14 | 11.54 | 13.83 | 11.96 | 13.73 | 9.16 | 10.57 | 8.67 | 9.46 | 10.45 | 10.00 | 12.36 | 13.07 |
| 2012-13 | 13.83 | 17.27 | 14.06 | 13.76 | 12.96 | 12.81 | 14.74 | 13.04 | 13.48 | 12.34 | 13.41 | 11.23 |
| 2011-12 | 12.92 | 12.53 | 14.53 | 14.91 | 12.45 | 10.58 | 11.09 | 15.28 | 13.00 | 14.85 | 13.72 | 15.63 |

The graph below shows that the average monthly length of stay has remained relatively constant over the past three years despite the recent decline experienced in late 2013 and early 2014. Interestingly a similar pattern can be observed in late 2011 where the average monthly length of stay declined over a period of three months. However, this pattern did not occur in 2012.

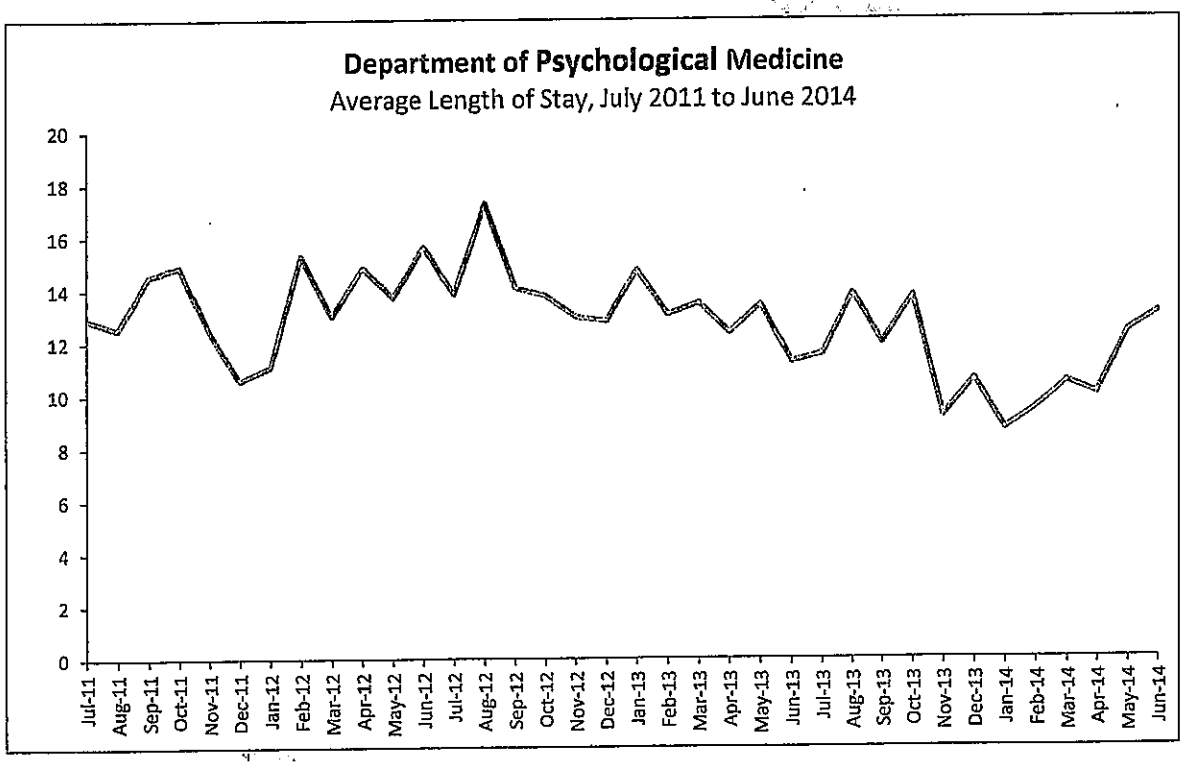



*Figure 3: Department of Psychological Medicine Average Length of Stay July 2011 - June 2014*

### *2.1.2.2 Psychiatric Intensive Care Unit (future High Dependency Unit)*

Table 4 below provides the monthly average length of stay for the Psychiatric Intensive Care Unit for the past three years. During this time there has been significant movement in the average length of stay from

[redacted]

month to month. The figures range from a low of 1.54 days recorded in December 2012 through to highs of 17.50 days and 17.63 days recorded in February 2013 and July 2013, respectively.

*Table 4 Psychiatric Intensive Care Unit, Average Length of Stay, July 2011 to June 2014*

| Year | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2013-14 | 17.63 | 11.07 | 6.75 | 13.40 | 4.63 | 8.50 | 3.64 | 2.20 | 8.50 | 1.67 | 10.93 | 3.00 |
| 2012-13 | 13.33 | 10.78 | 6.92 | 15.82 | 5.37 | 1.54 | 8.56 | 17.50 | 8.00 | 6.17 | 4.33 | 3.30 |
| 2011-12 | 6.44 | 6.65 | 5.75 | 6.10 | 5.90 | 12.50 | 5.70 | 15.13 | 5.78 | 12.11 | 3.88 | 3.71 |

Figure 4 below clearly highlights the significant changes in the average monthly length of stay which can occur from month to month. This volatility in the figures can be explained by the short term nature of care and treatment provided by the service and the small bed numbers within the service. There appears to be a trending down of the monthly average length of stay with the introduction of this current model of care.

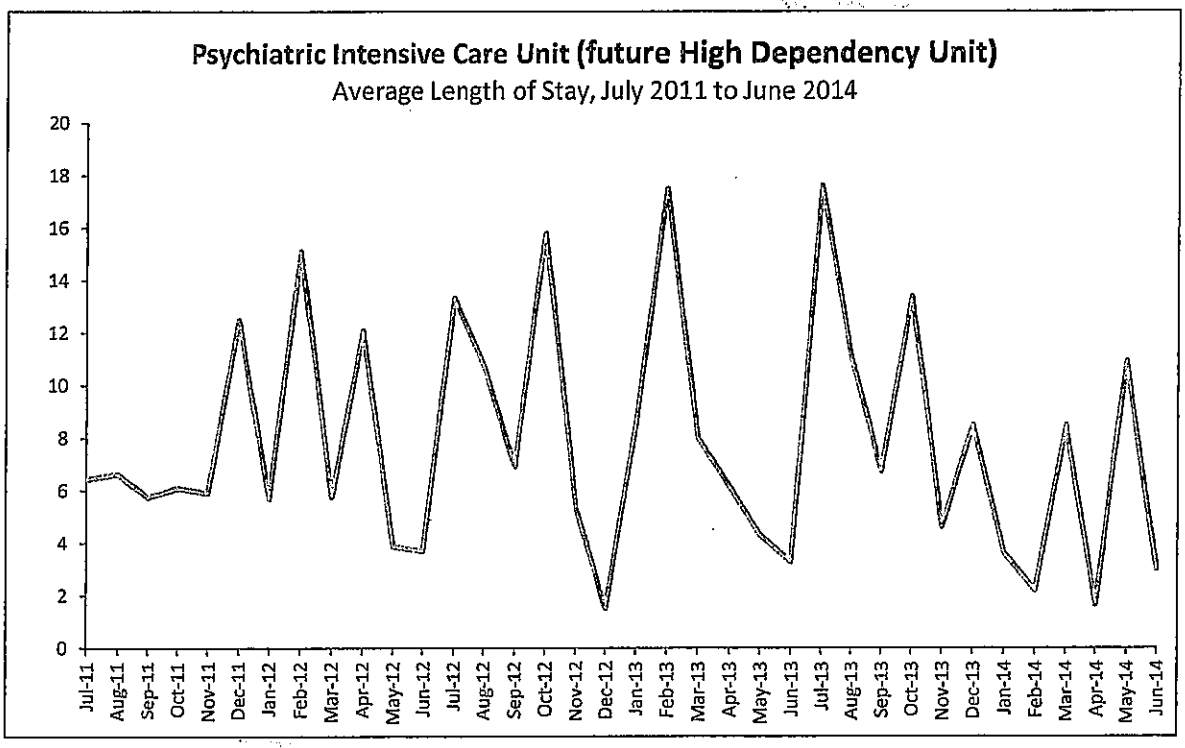



*Figure 4: Psychiatric Intensive Care Unit Average Length of Stay July 2011 - June2014*

## 2.1.3 Weighted Separations

### *2.1.3.1 Department of Psychological Medicine*

A weighted separation is an indicator of the efficiency of public acute care hospitals. It is a measure of the average recurrent expense for each admitted patient, adjusted using Australian Refined Diagnosis Related Groups cost weights for the resources expected to be used for each separation.

Table 5 below provides the weighted separations for the Department of Psychological Medicine for the past three years.

*Table 5: Department of Psychological Medicine, Weighted Separations, July 2011 to June 2014*

| Year | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2013-14 | 169.2 | 156.3 | 164.5 | 180.1 | 165.3 | 178.8 | 136.9 | 152.5 | 174.4 | 186.6 | 159.7 | 144.5 |
| 2012-13 | 179.9 | 156.1 | 177.4 | 196.8 | 143.6 | 156.6 | 205.7 | 153.2 | 149.0 | 162.4 | 162.8 | 152.2 |
| 2011-12 | 173.6 | 184.2 | 166.5 | 205.4 | 199.3 | 148.8 | 167.2 | 169.0 | 198.8 | 162.3 | 176.7 | 154.5 |

The graph below highlights that the weighted separations for the Department of Psychological Medicine have remained relatively constant between the 150 to 200 range over the past three years.

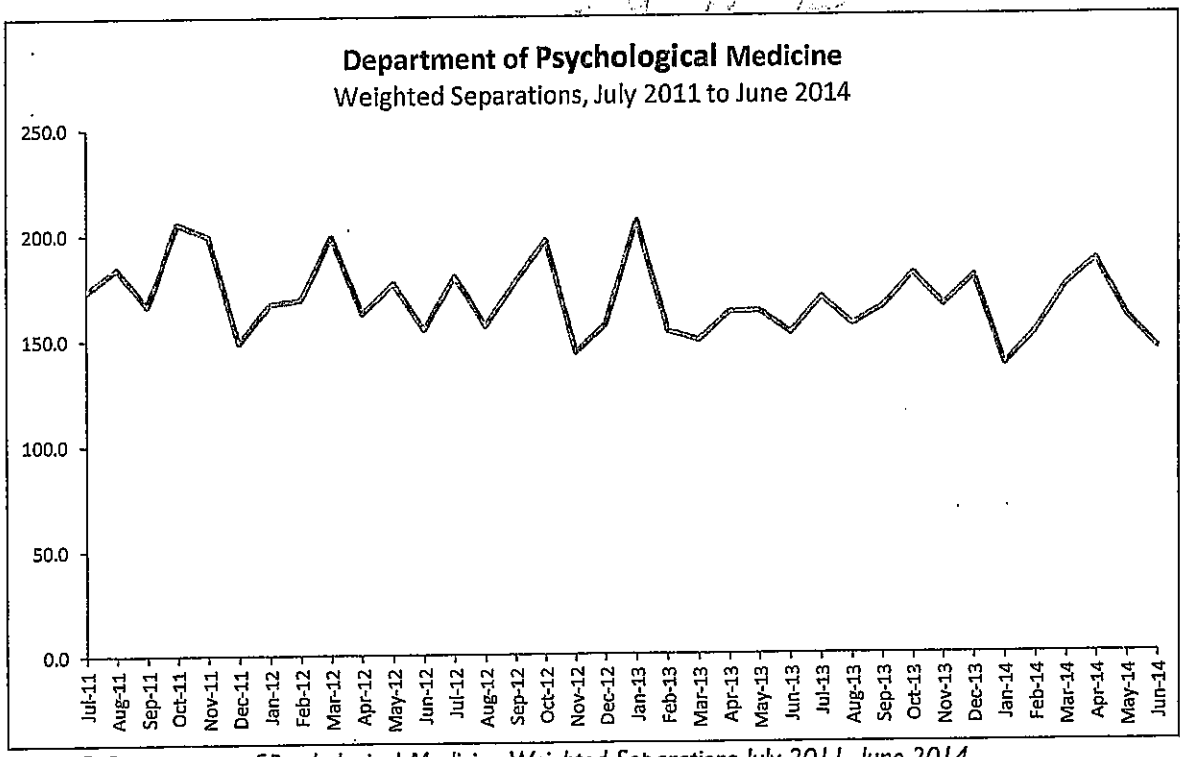



*Figure 5: Department of Psychological Medicine Weighted Separations July 2011–June 2014*

### *2.1.3.2 Psychiatric Intensive Care Unit (future High Dependency Unit)*

Table 6 below provides the weighted separations for the Department of Psychological Medicine for the past three years.

*Table 6: Psychiatric Intensive Care Unit, Weighted Separations, July 2011 to June 2014*

| Year | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2013-14 | 20.0 | 30.1 | 9.1 | 23.1 | 14.9 | 18.5 | 20.4 | 6.4 | 16.5 | 3.6 | 38.1 | 40.5 |
| 2012-13 | 35.0 | 20.8 | 23.6 | 26.5 | 32.4 | 21.8 | 17.2 | 22.7 | 18.8 | 25.4 | 27.2 | 18.9 |
| 2011-12 | 24.7 | 35.7 | 27.4 | 18.7 | 40.5 | 22.9 | 23.8 | 36.9 | 22.9 | 39.2 | 40.0 | 14.2 |

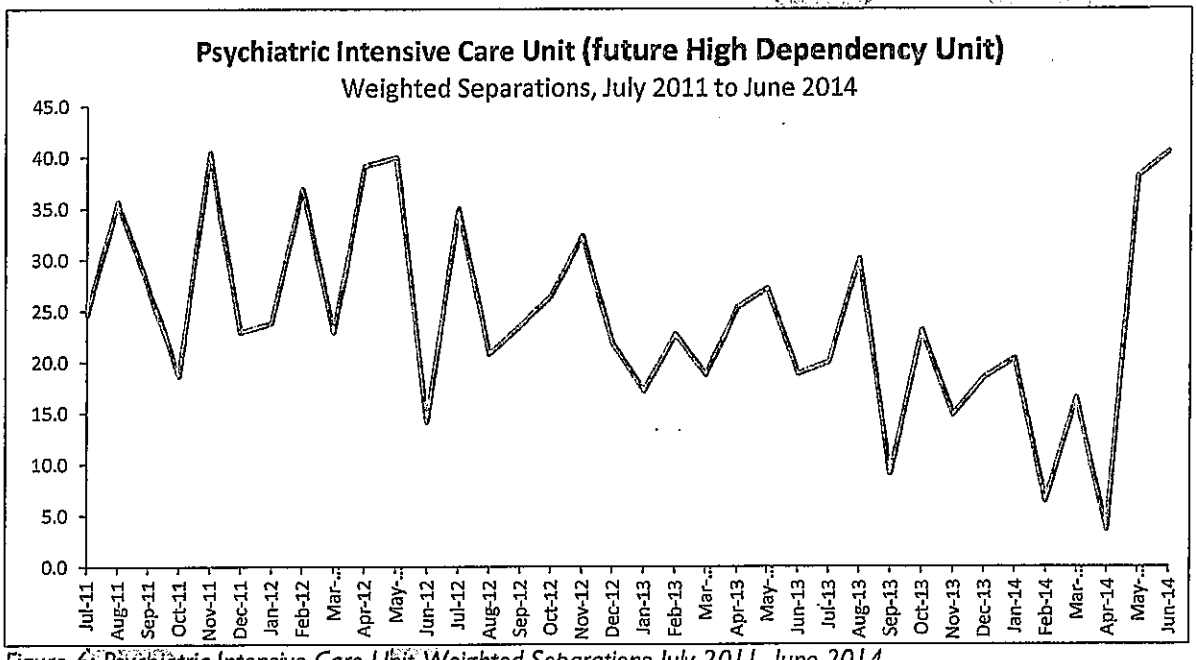



*Figure 6: Psychiatric Intensive Care Unit Weighted Separations July 2011–June 2014*

### 2.1.4 Diagnostic Related Groups for Department of Psychiatry

The following section provides an overview of top twenty-five Diagnostic Related Groups for the past three years for the Department of Psychiatry (including Department of Psychological Medicine and the Psychiatric Intensive Care Unit).

Table 7 on the next page indicates that schizophrenia disorders accounted for more than a third of all patient care days. Over the past three years 13,803 patient care days were for schizophrenia disorder, which represents 35.9% of the total bed days.

[redacted]

Major affective disorder is the second most prevalent and accounts for 19.5% of total patient care days.

For both schizophrenia disorders and major affective disorders, the average length of stay at the Department of Psychiatry is higher than the national average length of stay for those disorders.

*Table 7: Department of Psychiatry, Top Twenty-five Diagnostic Related Groups (DRG), 2011/12 to 2013/14*

| DRG V6.0x | Patient Care Days | Discharges | Average LOS | National ALOS |
|---|---|---|---|---|
| U61B - SCHIZOPHRENIA DISORDERS-MHLS | 13,803 | 749 | 18.57 | 14.85 |
| U63B - MAJOR AFFECTIVE DSRD A<70-CSCC | 7,497 | 520 | 14.58 | 13.97 |
| U67Z - PERSONLTY DSRD&ACUTE REACTIONS | 4,916 | 829 | 6.14 | 5.30 |
| U61A - SCHIZOPHRENIA DISORDERS+MHLS | 4,402 | 178 | 25.46 | 23.94 |
| U64Z - OTH AFFECT & SOMATOFORM DSRD | 2,813 | 333 | 8.73 | 7.28 |
| U63A - MJR AFFECT DSRD A>69/+CSCC | 1,119 | 64 | 18.03 | 26.96 |
| U62B - PAR&ACUTE PSYCH DSRD-CSCC-MHLS | 802 | 76 | 10.54 | 8.93 |
| V61Z - DRUG INTOXICTN & WITHDRAWAL | 647 | 84 | 7.85 | 5.77 |
| U65Z - ANXIETY DISORDERS | 431 | 65 | 6.98 | 4.39 |
| U66Z - EATING & OBSESSV-COMPULSV DSRD | 320 | 24 | 13.46 | 18.50 |
| U62A - PAR&ACUTE PSYCH DSRD+CSCC/MHLS | 259 | 18 | 14.50 | 16.31 |
| V62A - ALCOHOL USE DSRD & DEPENDENCE | 234 | 50 | 4.84 | 5.58 |
| B81B - OTHER DSRD OF NERVOUS SYS-CSCC | 188 | 14 | 10.36 | 2.92 |
| U68Z - CHILDHOOD MENTAL DISORDERS | 173 | 6 | 29.00 | 7.57 |
| V64Z - OTHER DRUG USE DISORD & DEPEND | 145 | 35 | 4.34 | 4.55 |
| Z64A - OTH FACTOR INFL HEALTH STATUS | 139 | 36 | 4.14 | 3.94 |
| V60B - ALCOHOL INTOXICATN&WITHDRWL-CC | 82 | 26 | 3.35 | 1.73 |
| X62B - POISNG/TOXC EFF DRUGS -CSCC | 72 | 18 | 4.11 | 1.97 |
| B63Z - DMNTIA&CHRNIC DISTURB CRBRL FN | 70 | 7 | 10.43 | 12.49 |
| X62A - POISNG/TOXC EFF DRUGS +CSCC | 61 | 5 | 14.80 | 5.22 |
| O61Z - POSTPARTUM & POST ABORTN-OR PR | 52 | 7 | 7.57 | 2.47 |
| V60A - ALCOHOL INTOXICATN&WITHDRWL+CC | 50 | 8 | 6.38 | 3.26 |
| B64B - DELIRIUM-CCC | 49 | 10 | 5.00 | 5.64 |
| B81A - OTHER DSRD OF NERVOUS SYS+CSCC | 38 | 1 | 37.00 | 8.94 |
| B67C - DEGNRTV NERV SYS DIS-CC | 27 | 5 | 5.40 | 1.98 |
| **Total*** | **38,460** | **3,244** | **8.80** | **10.64** |

**Note: Total figures include figures for DRGs not listed in the table (ie those outside the top 25 DRGs)*

Figure 7 below identifies the top 25 DRGs for the Department of Psychiatry over the past three years. The average length of stay for Tasmania by DRG closely mirrors what is recorded nationally.

**Department of Psychiatry**
Top Twenty Diagnostic Related Groups for the Period 1 July 2011 to 30 June 2014

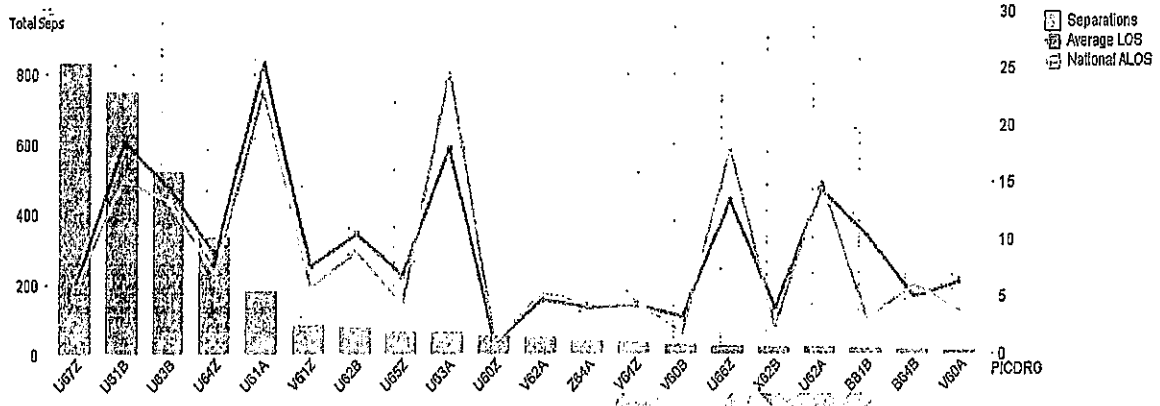



*Figure 7: Top 20 Diagnostic Related Groups for July 2011-June 2014*

## 2.2 Future Activity

The Mental Health Directorate takes the population health statistics into account when strategic plans are developed. A 5 year Strategic Plan for Mental Health Services is currently being reviewed. This Strategic Plan will outline funding arrangements.

- A new Mental Health Act (MHA) was released on 17th February 2014, bringing with it significant changes and greater system accountability which will translate into new and additional procedural requirements.
- The MHA 2013 will allow community health settings to assess and treat persons placed on Assessment Orders and Treatment Orders.
- It is envisaged that assessment and treatment in community settings will assist in reducing bed pressure in the acute hospital setting.
- Access to Tasmanian Health Organisation South (THO-South) Adult Community Mental Health Services (ACMHS) managed 'step up' beds will assist in the process of early community intervention in the illness cycle thereby limiting the potential for social dislocation caused by an acute admission.

## 2.3 Capacity

*Table 8: Department of Psychiatry Current and Future Capacity*

| | Number of rooms | Location |
|---|---|---|
| **Current Department of Psychiatry capacity** | High Dependency<br>• 8 single bed rooms<br>Higher and Lower Acuity<br>• 27 beds | Ground and Lower Ground Floor, B Block |
| **Proposed K Block capacity** | High Dependency Unit<br>• 5 single bed rooms<br>• 1 seclusion room<br>• 1 flexi bed<br>Secure Adult beds<br>• 10 single beds<br>Adult lower acuity ("open") ward<br>• 10 single bed rooms<br>• 2 double bed rooms | Levels 2 and 3 K Block |

AMA Submission to the Legislative Council Government Administration Committee 'A'

Subcommittee Inquiry into Health Services in Tasmania

Psychiatric Services/Mental Health

August 2017

APPENDIX B

Part 3

Related Documents in Chronological Order

# 3 Service Delivery

## 3.1 Current Provision of care

### 3.1.1 Admission

Unless transferred from an existing Mental Health & State-wide Services inpatient unit all admissions to Department of Psychiatry requires an initial assessment and medical examination before or within 24 hours of admission.

- For admissions to the High Dependency Unit from the Emergency Department, this medical clearance involves a face to face assessment by the Psychiatric Registrar.
- Consumers admitted to Department of Psychiatry are immediately allocated to one of the three teams and assessed by the relevant medical officer /registrar and a Department of Psychiatry team nurse. This will lead to:
    - A summary of mental health needs and initial treatment;
    - A summary of physical health needs and initial treatment;
    - Referrals to other speciality areas and pathology/imaging (including allied health and investigation requests);
    - A TAG risk assessment;
    - Nicotine replacement requirements; and
    - Leave arrangements.
- Admissions to Department of Psychiatry may include the requirement for restrictive practice interventions such as restraint and seclusion.
- All instances of seclusion and restraint is conducted in accordance with the provisions of the Mental Health Act (2013) and endorsed policy and procedure.
- Consumers treated on an involuntary basis under the Mental Health Act (2013) are provided with a copy of their Statement of Rights, Involuntary Orders, Treatment Order or Urgent Treatment Circumstances Order and will be reviewed by the MHT processes.
- Following admission all consumers are provided with, or have ready access to, a range of consumer and carer rights information which includes:
    - Rights Under the Mental Health Act;
    - Personal Information Protection;
    - How to Make A Complaint; and
    - Psychiatric Medication Management booklet.
- The Inpatient Manager (iPM) database is utilised to register admission and discharge details and to determine a known client's current legal status and community team connections. The existing Digital Medical Record (DMR) and Helpline TRIO database are utilised to obtain additional client information.

- A bio psychosocial and cultural Management Plan is formulated following the first Consultant review with the patient and the management team and will be reviewed throughout the admission.

### 3.1.2 Review

The relevant Consultant Psychiatrist and registrar/junior doctor review as required clinically the consumer's progress, assess and manage risks and the capability for leave.

- It is desirable for the consumer's allocated nurse to attend each review and provide updated nursing observations and management advice.
- The Management Plan, Medication Chart, risk assessment, alerts, clinical file, observations and leave arrangements are taken into each review and updated during or, as soon as possible, after each review. A minimum team review is expected to be twice a week.
- Psychologists, social workers or occupational therapists are available to attend reviews as requested.
- Family members, significant others, carers, community team staff and advocates may also attend reviews and provide further information with the consumer's consent.
- Specialist appointments and referrals are organised on a case-by-case basis.
- Consumers with complex needs and ongoing high-risk behaviours have a Crisis Plan formulated in collaboration with the consumer, their carer and their community based service (CAT team, GP or case manager) prior to discharge.
- The completed Crisis Plan is submitted to the cover section of the RHH Digital Medical Record (DMR) to inform ongoing continuity of treatment and care.
- The overriding principle of acute inpatient care is the provision of effective care within a minimally restrictive environment and in accordance with the Mental Health Act.
- The decision to utilise more restrictive interventions such as restraint or seclusion is based on an assessment of the person, their risk factors, mental state and physical condition, rather than service or staffing issues, although it is recognised that in extreme situations these issues may become relevant.
- There are situations where placing voluntarily admitted patients or patients admitted under the Guardianship Act in a secure environment may be appropriate and often include circumstances where impulse control is impaired.
- Voluntarily admitted patients may also request to be placed in a secure area if they feel that they cannot trust themselves to control destructive impulses in a less restrictive environment.
    - In these situations, the circumstances surrounding the decision should be documented in the notes, and patient consent to placement in the High Dependency Unit should be documented.

[redacted]

### 3.1.3 Daily Patient FLOW Meeting

During Monday to Friday week days the patient issues of concern and required flow of patients within the Department of Psychiatry are discussed at the morning Flow and Handover Meeting chaired by the Clinical Nurse Consultant (CNC).

- All Department of Psychiatry registrars and junior doctors, consultants, allied health, nurse educator and team allocated area senior nurses attend. A C&L and step down (Mistral Place) representative is also present.
- New admissions are presented and allocated to the appropriate team on a case by case basis.
- Transfers to the High Dependency Unit are presented and issues updated with the allocated Consultants and registrars.
- Any significant urgent care issues are flagged to the appropriate team.
- Impending transfers from ED and C&L are discussed.
- Patients are identified for the daily discharge or discharge dates proposed.
- Other issues around patient review or care are discussed with the group on a case by case basis.
- The On-call registrar and On-Call Consultant perform this function and weekends and public Holidays.

### 3.1.4 Continuity of Care

Continuity of care is assured by empathic engagement of the consumer and their carers by skilled Department of Psychiatry staff, regular review of progress and the ability to step up or step down to the treatment or care setting most appropriate to the current circumstances.

- Step down from Department of Psychiatry involves transfer to a community-based service, to a less restrictive inpatient service or return to the consumer's own home.
- Step up within the Department of Psychiatry could occur with transfer to the more restrictive HDU depending on assessment of the safety and security needs of the consumer and others with care continuing with the same medical staff.
- At times, step up to a more secure unit at Wilfred Lopez Centre is required using the appropriate Legislation (S65, Mental Health Act, 2013).
- Admission to inpatient services will, for many consumers, be the first point of contact with mental health services and the majority may not be 'planned' admissions.
- The process of admission and consumer progression through the inpatient system should be as efficient and effective as possible.
- At the same time, the system should respect the autonomy, dignity and individual needs of the population it serves and aim to provide an optimal experience of mental health care for each consumer.
- All MHSS community teams are encouraged to continue to actively participate in the care of, and discharge planning for, their clients throughout admissions to Department of Psychiatry.

- Each Community Team is informed of their area team patients following the flow and handover meeting by the CNC on each week day and discharges to the community requires a Department of Psychiatry medical to ACMHS medical handover and nursing transfer of care.
- Each consumer's progress is discussed on a daily basis by all members of the clinical team, with regular updates to the care plan and timely management interventions. Consumers have dedicated time with an allocated staff member and there is input from allied health professionals as required.
- Discharge planning is commenced as soon as a consumer is admitted.

### 3.1.5 Transfer of Care, Discharge & Follow Up

When safe and appropriate to do so transfers of care or discharges with appropriate follow up should occur.

- Discharge follow up includes the consumer's GP and may include a CAT team, case manager and any other relevant specialist services or private care providers.
- Prior to discharge or transfer of care from Department of Psychiatry, the Management Plan is updated in collaboration with the consumer, their family or support network and their community based treating team. The plan specifies in detail the immediate priorities and tasks required for follow up treatment and care and incorporate the person's broader health and social support needs.
- Depending on the outcome of Department of Psychiatry assessments, the degree of treatment required and stabilisation achieved, consumers are usually either:
    - Transferred to a community based mental health, alcohol and drug or forensic treatment team.
    - Transferred to another Mental Health and Statewide Services inpatient service if the consumer requires further inpatient care and treatment: for example transfer to Tolosa Street, Mistral Place or Millbrook Rise Units. At times High acuity patients, where Department of Psychiatry facilities have not been adequate to manage, require transfer to Wilfred Lopes Centre.

Or:

    - Exited from Mental Health and Statewide Services to the care of a General Practitioner, private mental health treatment service and/or Community Service Organisation with an appropriate discharge summary. All patients discharged from the Department of Psychological Medicine are contacted by the service within 7 days of discharge including the patients exited from the service at discharge from the Department of Psychological Medicine.
- People who are discharged directly to a Mental Health and Statewide Services community team receive follow-up support within two days of their discharge.
- This measure ensures the consumer is receiving adequate mental health care and sufficient support to access the health and social support services they need to maintain their mental health and reduce the chance of a further inpatient admission.

- Discharges from Department of Psychiatry to an ACMHS are determined by the consumer's home address ACMHS to provide ongoing care and treatment. The Department of Psychiatry team communicates directly with the relevant community treating team as soon as possible and provides that team with a copy of the current Management Plan to promote continuity of care and enhance client outcomes.
- On discharge from the Department of Psychiatry an electronic discharge summary is sent to each consumer's general practitioner (GP). The electronic discharge summary will also be available on the Digital Medical Records for review across the Mental Health and Statewide Services group.
- On transfer to another mental health or state-wide service, a transfer of care summary is sent to the relevant service.

### 3.1.6 Operating hours

Department of Psychiatry operates 24 hours a day, 7 days a week.

- Medical treatment at the facility will be guided by the current Therapeutic Guidelines publication and electroconvulsive therapy (ECT) is coordinated from Department of Psychiatry and performed according to ECT Guidelines in the Day Theatre at RHH.
- Three treating teams, each of which is comprised of a Consultant Psychiatrist, junior medical staff and allocated nursing staff work within the Department of Psychological Medicine.
    - The teams treat the consumer throughout the course of their admission, irrespective of their bed location in the Department of Psychological Medicine.
    - These treating teams will be aligned as much as possible with defined geographical areas in Southern Tasmania and the adult community mental health teams responsible for each of these geographical areas.
    - To optimise outcomes, patient numbers will be capped at ten per consultant lead team.
    - The Department of Psychological Medicine requires some flexibility in terms of both patient allocation capping and the interface with community based mental health services. Patients in the closed and open wards are also allocated to a treating Department of Psychological Medicine team to provide continuity of care across various acuity settings within the Department of Psychiatry.
    - Allied Health staff, such as psychologists, social workers and occupational therapists will continue to be accessed as required.
    - Out of area patients and those with no fixed abode will continue to be allocated as per the existing procedure.
- The Department of Psychological Medicine will accommodate direct admissions from community services and transfers from the Emergency Department, Consultation Liaison at the Royal Hobart Hospital and other mental health inpatient units Statewide where consumers require an acute care bed.

- A physical medical assessment will occur prior to the consumer's admission or within 24 hours of admission according to local protocols.
- A range of therapeutic interventions and programs will be available to consumers and their families to support a better understanding of:
    - the impact of mental illness;
    - ways to better manage the illness;
    - opportunities to improve coping strategies; and
    - moving towards recovery.
- While it is preferable that consumers are admitted to inpatient services voluntarily, the Department of Psychiatry is an authorised Unit where admission under the Mental Health Act, 2013 can occur. The Mental Health Act, 2013 provides for the involuntary assessment and treatment, and the protection, of persons with mental illness. All admitted upheld involuntary admission are reviewed by the Mental Health Tribunal (MHT) and have treatment authority through the MHT process.
- People on the mental health Act will be admitted to either the open or closed ward dependant on risks assessed at the time of admission.

## 3.2 Role of the High Dependency Unit (HDU)

As increased levels of intervention are sometimes necessary for the management of severely behaviourally disturbed patients, the Department of Psychiatry incorporates a High Dependency Unit (HDU).

- The HDU is currently located in a geographically separated from the other inpatient zone. In K Block this are will be incorporated into the closed ward and will have a capacity for up to 5 patients and 1 seclusion room, a de-escalation area and a flexible bedroom that can be utilised as a second seclusion room as required.
- A separate nursing station located in the HDU is responsible for the HDU area patients.
- The Unit provides access to secure, short term specialist psychiatric assessment and treatment for people experiencing an acute episode of mental illness who present a significant danger to themselves or to others and who require a safe and secure environment, with a need to be assessed further under the Mental Health Act.
- At times, voluntary patients who have capacity and ability to consent can be admitted to the HDU if they recognise the need for a more restrictive and safer environment.
- The HDU has the ability to increase staff-to-patient ratios and can facilitate a more intensive level of patient observation and intervention which may include one-on-one nursing ('specialling'), de-escalation or seclusion.
- The HDU has the potential to be utilised for the purpose of seclusion and provides a setting for a higher level of care. Seclusion is managed strictly in accordance with both the Mental Health Act 2013 and the Chief Civil and Forensic Psychiatrist or delegate.

- The HDU focusses on assessment, appropriate treatment and transfer to a less restrictive environment when the required level of care lessens. People could graduate to the open ward or to the lesser secure area within the locked ward
- At times this higher level of care setting accepts acute referrals by other Mental Health Units within Southern Tasmania and across the State of Tasmania. Clients admitted to the Department of Psychological Medicine who require a higher level of care during their admission are transferred to the HDU.
- People admitted receive care by the same medical treating team if they require transfer to the HDU.
- People admitted directly to the HDU from the Emergency Department are allocated to the appropriate catchment area medical unit at the morning flow meeting each Monday to Friday as much as possible.

## 3.3 Role of the Psychiatric Emergency Nurse

The role of the Psychiatric Emergency Nurse in ED is to:

- Provide mental health assessments with consultation, support and advice to Emergency Department staff in relation to individual patients being managed within the Emergency Department;
- Work with the Psychiatric Consultation Liaison service in relation to Emergency Department patients with mental health problems for whom admission to non-mental health wards of the hospital is planned;
- Assist in developing the skills of Emergency Department staff in identifying, assessing and managing patients with mental health problems. This may occur through the delivery of specific training programs, the development of information resources, or through less formal information sharing activities;
- Work with the Department of Psychological Medicine nursing teams, Registrars and Consultants in accordance with relevant policies and/or procedures; and
- Collaborate with other services within the community mental health service, particularly its community based triage (Helpline) and Crisis Assessment & Treatment teams, staff within the adult community, older persons and child and adolescent mental health teams, other mental health inpatient units and the Psychiatric Consultation Liaison service.

## 3.4 Role of Psychiatric Consultation Liaison Service

The Psychiatric Consultation Liaison Service provides specialist mental health liaison, assessment, treatment advice and education with the General Hospital Units and the ED as required.

- The Consultation Liaison team consists of a Consultant Psychiatrist and Registrars. People with admissions to the General Hospital have a high frequency of Mental Health Issues co-morbidity and often require care in the medical and surgical areas.
- The C&L team provides this collaborative link and can transfer people to Department of Psychological Medicine and the Psychiatric Intensive Care Unit. Allied health is accessed as required.

## 3.5 Integration

Integration with other health services is a crucial factor in improving patient flow and improving people's experience of care.

- The Department of Psychiatry works closely with ED (including PEN), Inpatient Withdrawal Unit (IPWU), other parts of the health service and community-based mental health teams, to ensure efficient and safe transitions from the community or ED to Department of Psychiatry. Consumer needs and goals are accurately assessed to enable the consumer to be treated in the safest and least restrictive setting.
- Collaboration and integration between government services is critical to assist people with mental illness to receive treatment, support recovery, and participate fully in the community. This requires effective working arrangements that are documented between police, ambulance, other human services and clinicians, within existing legislative and policy guidelines.

## 3.6 Future Changes to Provision of Care

A 5-year Strategic Plan for Mental Health Services is currently being reviewed. In late 2016 - early 2017 Department of Psychiatry: Consumer Pathway & Flow. Admissions may be referred directly to either the High Dependency Unit or other areas of the Department of Psychological Medicine depending on assessed need and risk. Figure 8 on the next page illustrates future access to inpatient mental health services.

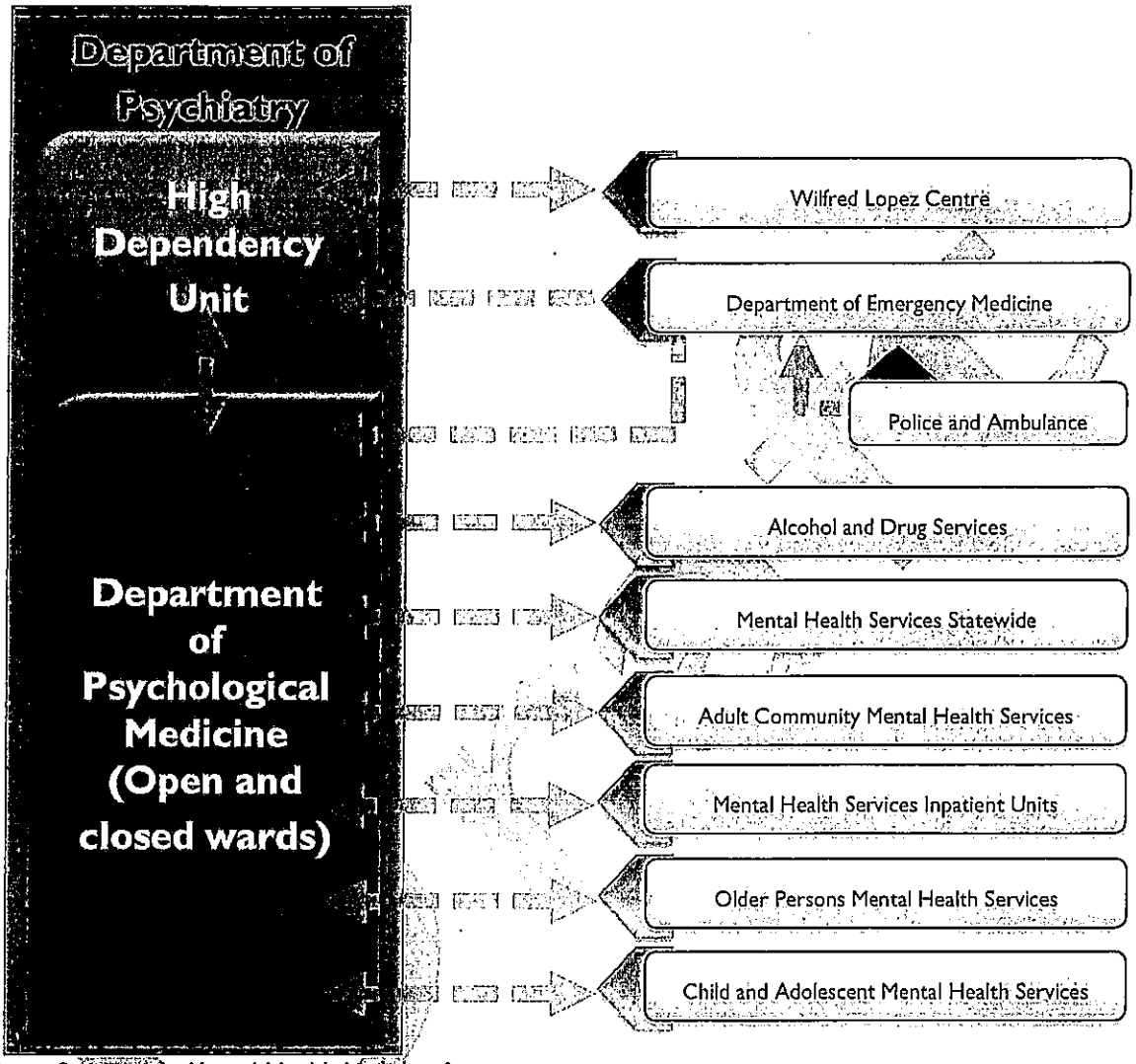



*Figure 8: Access to Mental Health Inpatient Areas*

The Department of Psychiatry (DoP) within K block will provide 24 hour acute mental health care for the adult population of Southern Tasmania. It will consist of the following:

1. A secure locked ward (no access to the public) which incorporates a high dependency unit (HDU), locked ward area and a separate de-escalation area. The locked ward will be on level 3 and is designed to allow people to be nursed and cared for according to their level of need and assessed risk;
2. A ward on level 2 that is an open ward with access to the public areas. This ward will be suitable for people with lower assessed risk and for those that graduate from the locked ward;

3. Consultation Liaison Psychiatry with personnel who work within the main General Hospital will also be located in the K block area designated for Mental Health;

- The main hospital will continue to incorporate the Psychiatric Emergency Nurses (PEN) working within the Emergency Department (ED) with other ED staff and collaborate with staff on DPM. All areas of Department of Psychiatry are designated as a smoke free environment.
- The 30 Department of Psychological Medicine's beds will be provided across three virtual ten-bed units with admission allocation determined predominately by assessed clinical need and the person's home address.
- There will be a seclusion room, 5 secure beds, a de-escalation area with a flexible additional seclusion bed, a multipurpose area and recreational space within the closed ward with a separate nursing station. This closed ward will also have 10 beds with an associated nursing station.
- The open unit will have 14 beds with a central nursing station. The unit will incorporate a two bed flexible area and small lounge where highly vulnerable or younger patients may be managed within the open ward of the unit as required. It should be noted that there are two safe rooms planned for the Adolescent Unit in K block.

## 3.7 Patient Flow

Direct admission to Department of Psychiatry is available by transfer from:

- RHH wards via Adult Consultation Liaison Psychiatry or the CAMHS CL inpatient team;
- THO-N and THO-NW mental health inpatient units and Wilfred Lopez Centre (WLC) if higher dependency required;
- Millbrook Rise, Tolosa and Mistral extended inpatient services;
- Adult Community Mental Health Service referrals as direct admissions in business hours; and
- Alcohol & Drug Services Inpatient Withdrawal Unit (IPWU)

Admission to the Department of Psychiatry via the Royal Hobart Hospital Emergency Department (ED RHH) and Psychiatric Emergency Nurse (PEN) is available following an initial medical and mental health assessment:

- On self-presentation to Royal Hobart Hospital Emergency Department;
- On presentation by emergency services (Police and Ambulance);
- On referral from a Mental Health & State-wide Services community team after hours; and
- HDU admissions from the Emergency Department require a medical and mental health doctor review prior to admission. A plan for HDU care and treatment under the Mental Health Act 2013 is required to be discussed with the senior nurse in HDU and the responsible psychiatrist before admission.

[redacted]




*Figure 9: Department of Psychiatry Patient Flow*

## 3.8 Functional Relationships – Internal and External

### 3.8.1 Mental Health and Statewide Services Located Functional Relationships

- Older Persons Mental Health Services (OPMHS)
- Child and Adolescent mental health Services (CAMHS)
- Adult Community Mental Health Services (ACMHS) - Incorporating Crisis Assessment Teams (CAT)
- Alcohol and Drug Services (ADS) of MH&SS
- Forensic and Correctional (FHS) services of MH&SS
- MHS State-wide Helpline
- Extended inpatient Services, Mistral Place, Tolosa, MRC
- Wilfred Lopes Centre

### 3.8.2 Non Mental Health and Statewide Services Externally Located Functional Relationships

- Emergency Department
- RHH Medical and Surgical Wards
- Tasmania Police
- Tasmania Ambulance
- Community Service Organisations – Examples: Richmond Fellowship and Anglicare.
- Allied Health Department
    - Psychology
    - Occupational Therapy
    - Social Work
    - Grief Counselling
    - Dietitians
    - Physiotherapy

# 4 Enablers for the Model of Care

## 4.1 Specialised Equipment

ECT equipment

## 4.2 Current and Future Information and Communication Technology (ICT)

The current ICT functionality is very limited with a basic nurse call system, limited personal computers and no Bring Your Own Device (BYOD) policy for the Department of Health. This has been flagged as a priority in the Connected Care Strategy developed by the Office of the Chief Information Officer (OCIO). There is currently no ability to track equipment and no Internet Protocol (IP) phones with the ability to manage workflow. The following innovations are considered for the new inpatient wards which will enable clinicians to have the required flexibility in the way that day to day activities are conducted:

- The parallel use of paper-based and electronic systems and enabling the transition to electronic systems, including integrated patient monitoring, e-prescribing and an electronic medical record systems , in the medium-to-long-term.
- A patient portal ('portal') terminal that is mounted on an articulated arm, adjacent to patient beds in standards wards. Nonstandard wards such as Mental Health and Paediatric wards will require options suitable to these spaces. Each portal will be AC powered, ethernet connected and deliver a range of functions including:
    - Patient entertainment including full IPTV, movies on demand and multimedia streaming capabilities
    - Telephone services
    - Internet access/email
    - Videoconferencing
    - Nurse call
    - Room lighting control
    - Meal ordering system
    - Patient controlled electronic health record
    - Health information/education
- There will be limited use of the portal by staff, whilst interacting with the patient (such as viewing diagnostic results) and for bedside clinical data entry (such as patient observations).
- Robust nurse-call systems at the patient bedside, within ensuite bathrooms and selected public areas within RHH clinical units. Nurse-calls will have:

- IP capabilities, including voice over IP functionality between the patient bed, patient ensuite and staff handsets;
- The capacity to support advanced workflow-functions customisable for different units across the hospital, for the assignment and scheduling of tasks such as bed/room cleaning and requests for patient transport;
- Indicator lights for each room/patient area.
- Robust IP phones that support role-based allocation of messaging devices for each member of staff within each clinical unit. These phones must support wireless telephony, dynamic allocation, RTLS to room level and be capable of delivering duress functions.
- A range of clinical data-entry options including; Bring-Your-Own-Device (BYOD); handheld wireless devices and fixed data ports within the staff station.
- A virtual desktop environment, supported by single sign-on per shift (for most system software) and enabling staff to access various data entry devices through the use of 'smart' (chip)cards. Clinical terminals will enable access to a range of systems including:
    - Patient administration, digital medical record and the broad range of clinical information
    - Messaging and paging
    - Admission/discharge, bed management and patient flow
    - Food services meal ordering
    - Health information/education
    - Pathology and diagnostic results
    - Telemetry/ patient monitoring
    - RIS/PACS
    - RTLS stock and asset tracking
    - Lighting and environmental management functions
    - Email /internet
- High resolution audio-visual functions to support video conferencing in staff meeting/education and procedural areas.
- Electronic 'journey board' systems located staff-only areas, such as ward write-up room areas, that integrate with clinical information systems to provide a real-time visual display of a range of patient information, including:
    - Patient name; status and precautions; key dates, including EDD; diagnoses, procedures and referral progress; diagnostic results; as well as primary care and other key details
    - Bed allocation status.

- Digital signage to support patient and visitor, education, way-finding in a range of areas including lift lobbies and major thoroughfare/ corridor areas. Digital signage will integrate with clinical information electronic kiosk and queuing systems to assist direction finding without compromising patient confidentiality.
- Specialised location (RTLS) services will support hospital staff presence, patient tracking, asset security and stock control functions.
- A messaging platform that routes messages from various applications/ systems to communication devices such as mobile phones, tablets and desktop terminals. The messaging solution will be capable of bi-directional messaging in order to acknowledge or decline events and capable of automatic escalation of unanswered messages. This messaging will be able to be sent to:
    - Wireless VoIP phones
    - Email
    - SMS
    - Pocket pagers
- Unified communications that enable remote, real-time monitoring (including alarm/notifications) of building, environment, security, fire and emergency management systems. This will include CCTV/ Digital Video Management and smart card access systems; as well as energy management systems that monitor usage to support hospital sustainability. Clinical support systems, including those associated with pathology, radiology, pharmacy and patient monitoring will also be integrated into monitoring systems.

The ICT functionality is subject to budget availability.

## 4.3 Staffing Profile

### 4.3.1 Medical

Department of Psychiatry is a training hospital for psychiatrists and will have trainee registrars involved in clinical care supported by junior doctors who rotate from the RHH.

- Consultants, Registrars and other doctors will be rostered to work after hours and weekends.
- Each doctor will be clinically supervised by a consultant. There will be 3 consultants responsible for the 30 Department of Psychiatry beds.
- The Clinical Director Mental Health and Statewide Services or delegate is responsible for medical staffing

### 4.3.2 Nursing

The Department of Psychiatry Nursing Unit Manager (NUM) role will include the management of Department of Psychological Medicine, High Dependency Unit and PEN will be managed by a coordinated approach with ED.

- A Department of Psychiatry Clinical Nurse Consultant will co-ordinate the management of the High Dependency Unit.
- Department of Psychiatry staffing will be organised by the NUM to ensure Department of Psychiatry is adequately staffed.
- Department of Psychiatry nursing staff will be specifically trained in the areas of Basic Life Support (BLS), non-violent crisis intervention (NCI) including the de-escalation of aggression.

#### 4.3.3 **Allied Health**

A small team of Allied Health professionals will be based at Department of Psychiatry. Additional allied health resources will be sourced as required from either the RHH or the relevant adult community mental health areas.

#### 4.3.4 **Educators**

Educators across broader Mental Health and Statewide Services will provide the education to staffing across Mental Health Services.

- Department of Psychiatry staff will be provided with education and training via a combination of a dedicated Clinical Nurse Educator and Mental Health and Statewide Services specific sessions.
- Close ties between the Mental Health and Statewide Services and THO-S Safety and Quality Units and THO-S educators will be prioritised to improve patient outcomes and promote ongoing quality care.

## 4.4 Clinical and Non-Clinical Support Services

#### 4.4.1 **Pathology and Pharmacy**

Department of Psychiatry will access Royal Hobart Hospital Pathology services and Pharmacy as part of the Health Organisation.

Department of Psychiatry will maintain an imprest medication system on site. The imprest system will be managed and maintained by the allocated RHH pharmacist. Monitoring and auditing should occur on a monthly basis. Urgent medications not on imprest may be ordered from the RHH Pharmacy.

#### 4.4.2 **Electro-Convulsive Therapy (ECT)**

Department of Psychiatry patients requiring ECT will attend the ECT Unit day theatre at RHH.

- They will be transported via the most appropriate method to ensure their safety and security.
- ECT will occur within the ECT Guideline and will be under the supervision of the Director of ECT consultant psychiatrist.

[redacted]

#### 4.4.3 Mental Health Tribunal (MHT)

The Mental Health Act 2013 outlines MHT review requirements. Department of Psychiatry will include a room meeting the specifications of the MHT for review of Mental Health Act 2013 orders.

#### 4.4.4 Catering/Food Services

Department of Psychiatry has plated 'cook chill' meals delivered on site. Continental breakfasts will be prepared on site by relevant staff.

#### 4.4.5 Supply and Purchasing

A Department of Psychiatry administrative assistant will order and receive supplies.

#### 4.4.6 Medical Orderlies

Department of Psychiatry utilises MHS Ward Aides employed 24 hours to undertake the functions of medical orderlies.

- Hoists and high low beds are supplied to assist staff in lifting and manual handling.
- Education about usage of specialised equipment will be provided to all ward aides and nursing staff.

#### 4.4.7 Medical Imaging

Department of Psychiatry patients who require medical imaging will utilise RHH medical imaging services.

#### 4.4.8 Security

The management of aggression at Department of Psychiatry will be co-ordinated by the RHH Code Black team. Security is available as required.

#### 4.4.9 Referral to other specialties

Department of Psychiatry consumer requirements for cardiology, obstetrics and gynaecology, oncology and other medical/surgical services will be via appointment with RHH based services.

## 4.5 Operational Policies and Procedures

Endorsed THO policy and State-wide & Mental Health Services Protocols and Core procedures include:

- Risk Assessment & Management
- Management of Leave
- Seclusion & Restraint and patient acuity protocol
- Medication Management
- Admission, Discharge and Transfer Of Care
- Psychiatric Emergency Nurse Admission and Discharge

- Maximising Integrated Inpatient and Community care
- Deteriorating Patient and urgent medical response.
- Transport and Escort
- No Fixed Abode

Endorsed Tasmanian Health Organisation South Policy and Protocols

- Legislative Requirements:
  - Mental Health Act (2013)
  - State Service Act (2000)
  - Chief Psychiatrist Guidelines
  - Personal Information Protection (PIP) Act (2004)
  - Right to Information Act (2009)
  - Health Complaints Act (1995)
  - Health Act (1997)
  - Workplace Health and Safety Act (1995)
  - Coroners Act (1995)
  - Guardian and Administration Act (1995)
  - Firearms Act (1996)
  - Children, Young Persons and Their Families Act (1997)

## 4.6 Teaching, Training and Research

The RANZCP training program for registrars in psychiatry is assessable to registrars in training and training registrars are supervised by RANZCP supervisors according to RANZCP guidelines.

Appropriate to the RHH hospital role delineation and clinical services capability, the Department of Psychiatry contributes to the teaching of health professionals, the training of THO-South and other staff, and the conduct of clinical research.

- Much of this teaching, training and research is conducted in collaboration with UTAS and a range of interstate universities and the various college post-graduate medical training programs.
- Teaching, training and research involve all disciplines, including allied health, nursing and medicine.

# 5 Performance

## 5.1 Key Performance Indicators

The following key performance indicators are be collated and reported monthly to Department of Psychiatry team meetings and MHS Leadership Group meetings:

| Clinical Indicator | Target | Data Source |
|---|---|---|
| Occupancy rate | 85% | iPM |
| Average Length Of Stay ≤ 10 days | 100% | iPM (FYI) |
| Unplanned readmissions within 28 days | ≤ 14.7% | iPM (FYI) |
| Seclusion Rate (No. of seclusions per 1000 bed days) | ≤ 9.6 | Seclusion Register |
| Average Time In Seclusion (minutes) | < 90 | Seclusion Register |

## 5.2 Quality and Safety Benchmarks

Department of Psychiatry will operate in accordance with the Mental Health Act, 2013, National Safety & Quality in Healthcare Standards 2013, the National Mental Health Standards 2010 and the National Practice Standards for the Mental Health Workforce 2013.

- Compliance with these Standards will ensure systems and processes are in place at an organisational level to provide optimum support for people using the service and their families.
- The National Practice Standards will ensure mental health professionals' work practices demonstrate person centred approaches and reflect nationally agreed protocols and requirements.
- These standards are intended to work together to support the ongoing development and implementation of good practices and to guide continuous quality improvement in mental health services.
- In accordance with these Standards and the safety and quality benchmarks outlined below, a consumer admitted to Department of Psychiatry can expect:
    - To have a management plan, which includes identification of presenting issues, strategies to mitigate assessed significant risks and discharge planning, completed as soon as possible after admission and to participate in the formulation of that plan.
    - A physical examination before or within 24 hours of admission.
    - Timely provision of a range of consumer rights and responsibilities information.

- To be engaged by professional clinicians with expertise, empathy, understanding, compassion and who are trained in current best practice.

- Department of Psychiatry systems and processes will deliver quality outcomes and minimise the risk of harm. 'Risk of harm' covers three domains:
  - Risk of harm to self (due to suicidal ideation, acts of self-harm, significant self-neglect, non-adherence to medication, impaired judgement or impulse control, or high-risk behaviours)
  - Risk of harm to others (for example homicidal, aggressive or destructive acts or ideation, impulsivity or behaviour endangering others, and neglect of dependants)
  - Risk of harm from others (for example neglect, violence, exploitation, and physical or sexual abuse or vulnerability).
- All incidents and safety events will be communicated to the Department of Psychiatry manager and reported as soon as possible via the web based 'Safety Reporting and Learning System' (SRLS).
- All client and carer complaints will be communicated to the Department of Psychiatry manager and reported as soon as possible to the THO-S Safety & Quality Unit who will record the details on SRLS.
- All significant risks and quality improvement activities will be recorded in the Department of Psychiatry 'Risk and Improvement Plan' (RIP).

The following quality & safety benchmark indicators are be collated and reported monthly to Department of Psychiatry team meetings and MHS Leadership Group meetings

| Clinical Indicator | Target | Data Source |
|---|---|---|
| Inpatients with a complete, documented physical examination within 24 hours of admission | 100% | File Audit |
| Inpatients with a completed Management Plan | 100% | File Audit |
| Inpatients with a completed, current risk assessment (TAG) | 100% | File Audit |
| Summary of Reported Incidents by 'Specific Incident Type' | Decrease | SRLS |
| Total 'Aggression' reports with significant complications* | Decrease | SRLS |
| Total 'Falls' reports with significant complications* | Decrease | SRLS |
| Total 'Medication' reports with significant complications* | Decrease | SRLS |
| Significant Incidents (SAC 1, 2 & 3) by Incident Type | Decrease | SRLS |
| Total 'Complaint' reports | Decrease | SRLS |

| | | |
|---|---|---|
| Number of staff with a completed 'Performance Appraisal' | 100% | Proact |
| % Staff completed Mandatory Training: Occupational Health & Safety | 100% | Proact |
| % Staff completed Mandatory Training: Code Of Conduct | 100% | Proact |
| % Staff completed Mandatory Training: Fire Training | 100% | Proact |
| % Staff completed Mandatory Training: Basic Life Support | 100% | Proact |
| % Staff completed Mandatory Training: Hand Hygiene | 100% | Proact |
| % Staff completed Mandatory Training: Manual handling | 100% | Proact |
| % Staff completed Mandatory Training: Non Violent Crisis Intervention | 100% | Proact |

** Significant complications as defined by SRLS SAC Matrix indicators*

## 5.3 Service Reviews

Accreditation reviews as required by THO-S accreditation contract. The key concepts and principles outlined in the MHS Models of Care remain applicable in the new K towers but will require an update at that time.

- The K towers have been designed to ensure that the psychiatric patient's journey from initial assessment to their discharge flows seamlessly in all directions on a psychiatric needs basis.
- A patient who is admitted to one location of the ward may move to a more or less restrictive ward environment based on continuously assessed patient acuity.

# 6 Financial Impacts Statement

## 6.1 Capital costs

Capital costs for the construction of the new inpatient precinct, K Block, will enable this model of care without any additional capital costs required from the Department of Psychiatry.

## 6.2 Operational costs

No additional operational costs are required to enable this model of care.

# B. DETAILED STAFFING PROFILE

| Discipline and role description | Proposed EFT | Office needs | Comments |
|---|---|---|---|
| **Nurse Unit Manager** | 1.0 | Single Office | Preferably on the unit |
| **CNC** | 1.0 | Office | Within unit and can share, ideally with CNS or single office on each floor. |
| **CNS** | 1.0 | Office | Within unit and can share, ideally with CNC or single office on each floor. |
| **Nursing staff** | Open – 5.0<br>PICU – 3.0 | Staff Base | Open Unit requires one nurse per 5 patients, PICU requires one nurse per 2 patients. |
| **Registrars and RMO** | 3.0 and 1 RMO | 2 Offices | 2 shared per office |
| **Consultants** | 3.0 | Office | 3 single offices required preferably on the unit but could be located outside the unit within RHH in close proximity to the unit. |
| **Head of department** | 1.0 | Office | Single office required preferably on the unit but could be located outside the unit within RHH in close proximity to the unit. |
| **Nurse Educator** | 1.0 | Office | Can share office |
| **Family support and Liaison** | 1.4 | Office | Can share office |
| **Pharmacist** | 1.0 | | |
| **Psychology** | 1.5 | | Can share office |
| **Occupational Therapist** | 1.0 | Office | Can share office |

[redacted]

| | | | |
|---|---|---|---|
| **Legal Orders Co-ordinator** | 1.0 | Office | Preferably close to secure unit |
| **Administration** | 2.0 | Reception | One on each floor |
| **Visiting Personnel** | | | |
| **Dietitian** | | Hot Desk | |
| **Peer support workers** | | Hot Desk | |
| **Pastoral Care** | | | Access to multipurpose room as well as visiting the patient individual rooms. |
| **Diversional Therapist** | | Hot Desk | |

# C. DESIGN REQUIREMENTS

## 7 Design Implications for People within the Facility

The building will provide an interdisciplinary in-patient mental health service to adult people above the age of 18 who are requiring in-patient care to treat an active mental illness. Often due to this illness people are at risk to themselves or others.

- The service also involves counselling and support for their families or other carers.
- Informal social interaction begins at the entry to the building.
- The unit will operate as two interactive floors where patients may move from one area to the other dependent on need and changes in their condition throughout their hospital stay.
- There are geographical separations into operational zones associated with care type; these are
    - High Dependency Unit zone (HDU)
    - Secure Zone
    - Low Acuity Zone – "Open Ward".
- There is also fixed and flexible segregation capacity within the building to manage gender sensitivity and safety as well as safety of vulnerable patients.
- The HDU zone is a five bed secure area attached to a one bed seclusion suite with an additional flexible bed that could be used as a sixth HDU bed or a second seclusion bed when required. A de-escalation/observation room is available in this area that connects to the flexible bed area
    - It will need ready access for ED and other zone transfers.
    - The patients treated in this area have a level of acuity or have monitoring needs that is higher than patients in the secure high acuity area.
    - It is meant to be a temporary placement of the patient during a high arousal or high risk period of their admission. Patients can be placed in HDU directly on transfer from ED or other ward zones.
    - Alternatively after admission to the low and high acuity wards, they may be assessed as requiring care in the HDU for a short period of time.
    - This is a capacity for mixed gender areas and for safety of females and other vulnerable patients. There needs to be flexibility to subdivide the area and isolate groups of patients as required whilst providing for their capacity to access recreational, activities and dining areas.
    - The philosophy and practice of the unit will be to minimise the length of stay in the HDU area wherever possible.
    - Patients in the HDU will have access to recreational and sensory areas under supervision.

[redacted]

- The bedrooms should have a capacity to be lockable by the staff from the exterior door only as may be required for safety reasons. The bedroom doors must have a viewing panel so that patients can be observed by staff. This is specifically crucial in the event of a seclusion episode in the seclusion rooms.
- The associated seclusion suite needs to include one seclusion room with a patient toilet with dual access and shower room only accessible from outside the room.
- The flexible room that could be used as a second seclusion room or bed room should have an ensuite.
- A de-escalation/observation room needs to be available and connect as required to the second flexible seclusion room/bed room.
- The aim is for staff to initially bring at risk patients who cannot be managed in the broader HDU area, into the observation area where the aim is to provide a less stimulating environment with access to de-escalation to prevent the need for restraint and seclusion. Any restraint or seclusion is under authority by the MHAct/guardianship Act.
- If the patient cannot be calmed and remains at risk to themselves or others, the patient may be placed in a seclusion room where ligature risks are minimised to allow further treatment care and observation by staff. A period of seclusion may be used during a highly agitated state that cannot be managed in a less restrictive manner.
- The staff area will need to be secure, accessed by swipe and have excellent patient visibility to the recreational area
- Whilst they have access to a toileting area, staff will have capacity to restrict access to the en suite dependent on patient risk.
- The seclusion suite should have ready access to communication outside of the room and toilet as defined in the MHAct 2013. The philosophy and clinical practice of the overall unit is to minimise the use of seclusion if possible.
- Family/carers will have access to the patient via a visitor room depending on risk and supervision requirements and be given locker space as required to store any potentially dangerous items before access

- The higher acuity adult zone will have 10 single bed rooms.
  - This area will be adjacent to the HDU area and have a capacity to flexibly expand the bed numbers for HDU as required.
  - Patients in this area will still require care in a secure unit, but are less acute than those cared for in the HDU area. They will have capacity to manage their valuables in their room and dependent on risk will be able to be accessed by family/carers.
  - Visitors will be required to temporarily place any dangerous items (including cigarettes and lighter) as defined by the ward staff into individualized lockers before entering this area.
  - They will be able to control access by swipe to their bedrooms and en suites for privacy and safety that can also be accessed by staff as required.

[redacted]

- Patients will have access to recreation, dining and activity areas.
- An outdoor space is required for this patient cohort.
- A room for MHTribunal hearings will be available in this area with access to an adjacent meeting room as required by a carer/family/legal assistance and/or patient.
- There will be ease of access to the HDU area de-escalation room as required when and if nursing acuity increases.
- The nursing station area will have an open counter front to facilitate patient staff interaction whilst providing staff with the capacity to retreat to an enclosed work area for record keeping and administration and handover.

- The lower acuity/open zone will be the least restrictive area of the Unit.
  - This ward area will adopt a recovery framework in its clinical operations with its patients.
  - This will foster patient participation in care and in self-management.
  - It will assume patient capacity to care and decide for themselves.
  - It will support the active engagement and involvement of family, carers and other health workers.
  - Usually patients in a low acuity area will have free access to unit and garden areas.
  - They will have capacity to manage their valuables in their room.
  - They will be able to control by swipe access to their bedrooms and en suites.
  - In the interest of gender safety, areas will have the capacity to be subdivided on an as needs basis to segregate women or vulnerable patients from the more acute patients.
  - Patients will have access to dining recreational, activity and sensory areas.
  - For the safety of both patients and staff, the nursing station will enable easy visibility of the area and rapid response in the event of a patient emergency.
  - Visitors and patients will be required to place any dangerous items (including cigarettes and lighter) as defined by the ward staff into individualized patient lockers before entering this area with free access to lockers on leaving the ward area.
  - The open ward and recreational area is smoke free.
  - The nursing stations area will have an open counter front to facilitate patient staff interaction whilst providing staff with the capacity to retreat to an enclosed work area for record keeping and administration and handover.
  - The Unit will encourage engagement and involvement of families. There will be an area on the Unit where family consultation and meetings can be conducted with staff. There will be an area where the family including children can safely visit their ill family member. This will include child friendly garden space in the open zone.

- The building should maximise efficiency, both in terms of patient care and job satisfaction, of the interdisciplinary team, for example, short, clearly defined travel routes within the facility.
- Building fabric must allow for privacy of verbal exchange in all areas, especially in interview or quiet areas.
- Safety and security are paramount in the working environment and the design should assist staff to safely carry out their duties and supervise patients.
- Staff will be required to view patient activities and movements as appropriate.
- Approved plans will be in place for appropriate evacuation and response in emergency situations.
- In this unit staff will work both in the clinical space and in dedicated staff areas.
- Each clinical space will incorporate areas where staff on the shift can hand over and communicate with on-coming shifts.
    - They will have space with computers to enter data written clinical notes and access data.
    - There will also be the option to retreat when not needed on the clinical floor to a staff zone to undertake other administrative and non-direct care clinical work.
- For support staff there will be opportunity to bring equipment, food, linen and the like onto the Unit through staff only areas without walking through clinical areas.
- In the staff amenities zone, adjacent to the Mental Health inpatient ward on level 2, there will be change areas with showers, toilets and capacity to store personal items securely.
- There will be a rest/break area with capacity to heat food, prepare beverages, store and clean utensils.
- There will be a large education/seminar room for professional development and other meetings.
    - This area will be equipped with smart board, floor boxes for technology connectivity and video conferencing/presentation equipment.
    - It will have capacity to be used in a didactic/lecture format of a seminar/workshop/tutorial format.
    - There will be capacity to store furniture and audio visual devices in the room.
    - It will be in close proximity to the staff break area or kitchen area.
- The staff zone will have an open office area with workstations with some privacy separations, storage capacity and flexibility to accommodate multiple hot desk users.
- Throughout the unit there will be adequate computers for each work desk and nursing stations with both cabling and Wi-Fi capability. There will also be a patient computer kiosk on each floor to assist with patient access to information and communication with family and carers. This is required on secure and open wards.
- Telephony and intercom system will facilitate communication within the unit and inter-agency. The system will also include pay phones for patient access.

# 8 Design Specifics

## 8.1 Ligature/Safety

The design should facilitate the staff to safely carry out their duties and allow for the staff to allow patients either access or restrict access to areas of the unit depending upon the current mental state of the patient.

- All fixtures and fittings should be safe and durable. All fixings and plumbing should be concealed where possible. If exposed they should be tamper proof.
- All fittings such as towel rails and clothes hooks where necessary should have with an acceptable breaking strain.
- Door fixtures should be ligature proofed including single continuous hinge, detention centre type knobs and in en-suites the doors should be cut down in line with MH, D & R Division requirements. Tap and shower ware should be ligature proof.
- Fittings should not have the potential to be used as either weapons or for the purpose of self-harm.
- Mirrors should be constructed of material that is both impact resistant and shatterproof.
- In the High Dependency area and any flexible bed area that could be incorporated into the HDU movement sensors or similar devices will be installed in the ensuite with an indicator light outside of the bedroom, to clearly indicate to staff when a patient is in this area. This will allow staff monitoring of potential ligature or self-harm risks in these areas.
- The HDU area should have ligature free toilets.
- The secure area and open ward should balance safety requirements and a non-custodial atmosphere as much as possible.

## 8.2 Variety of small more intimate spaces

Whilst unobtrusive observation of patient area by staff is essential it needs to be appropriately balanced by the patient's right to privacy.

- Good sight lines from places such as the staff stations are important design features.
- Given the outdoor designs of the facility, it is important to maximise visibility across the areas to all bedrooms.
- This should not preclude the creation of small spaces where patients can use the space to either communicate with co-patients or staff members or for them to spend time alone.

## 8.3 Open staff counter for patient enquiry

An open staff counter for patient enquiry where patients' issues can be promptly and sensitively dealt with is essential in the secure and open zones. Any secure nurses station the HDU will also require prompt and sensitive access to patient enquiry

- Preferably attached to an enclosed area to facilitate staff evacuation should this be necessary.

## 8.4 Sensory Modulation Areas

Evidence suggests that the use sensory modulation approaches leads to significant reduction in subjective patient distress which in turn leads to reduction in both restraint and seclusion.

- The HDU will have access to a Sensory Modulation Room where audio-visual and information and communication technology can be accessed and utilised along with highly tactile objects and materials.
- Zones where dedicated Sensory Modulation Rooms are not available will have quiet activity spaces where patients can engage in activities such as reading and building puzzles.
- Typically, items within the sensory room will include a massage chair, bean bags, music, a variety of lighting, lollies, self-help books, stress balls, water feature, and a 'swiss ball' (large inflatable exercise ball).
- Use of the sensory room is supervised by a staff member, who helps the patient identify how the room is set up to meet their individual needs.

## 8.5 Therapeutic/ Counselling/interview spaces

These rooms should have two to facilitate egress in an emergency situation.

- At least one room on each floor should be large enough to accommodate 6 people.
- A treatment /examination room should be present in all ward zones.

## 8.6 Medication Management

With a recovery approach medication management will be very individual focused.

- The primary nurse for the patient will prepare medication for administration in the medication/drug room.
- They will administer the medication or support the patient to administer the medication in a treatment room in close proximity to the medication room.
- The proximity is important to ensure safe transport of prepared medication from the medication room to the site of administration.

## 8.7 Family involvement – area for visits to also accommodate children

Families and carers require access to a comfortable lounge for private visits with the patient.

- Location and design of the room should take into account the needs of children. The model of care's recovery and collaboration approach will call for family meetings with clinical staff; the unit will have a family room where such interviews or advocacy meetings can occur.

## 8.8 Outdoor/Garden Spaces

A carefully designed landscape can provide an environment that is sensitive, nurturing and supportive.

- Consideration needs to be given to adequate low maintenance planting and watering systems for outdoor areas.
- The outdoor spaces will provide light to the inpatient zones where possible and offer rest and recreational areas to patients and their visitors.
- They will be landscaped to allow patients to wander freely.
- They will offer garden rooms to create distinct or sub-spaces to make it conducive for reflective or conversational atmosphere.
- However with safety being and issue both within the outdoor areas and across all bedroom areas, clarity of what is happening within these areas is vital.
- There needs to be access to light and shading.
- A larger external garden where more active recreation can happen or larger group events such as barbeque should also be accessible to patients.
- These areas may be accessed either under staff supervision or by patients whom staff have deemed are of low risk and can access the space without direct supervision.
- Design should focus on achieving both a tranquil and functional outdoor space incorporating:
    - Passive areas like private courtyards and seating in a landscaped garden.
    - Active areas that encourage physical activity.
    - Separation or garden room like spaces within courtyards.
- Access to the outdoor area should be viewable from the nursing station. The design should avoid the creation of blind stops from the nursing station.
- It would be desirable to have a separate child friendly area should be available in the open zone.

## 8.9 Team offices for combined allied health and patient (peer) and carer workforce – Therapeutic team

Offices, work stations and staff amenities should be located away from in-patient areas with no patient access.

- It is important to note the access is required at all times including weekends and that staff require access to computers and photocopiers etc.

- As the Unit has a large staff establishment, a number of single and shared office spaces are required to meet the needs of consultant psychiatrist, registrars, nursing, allied health, peer workers, carer workers and education staff as much as possible. Office space if not available on the units will need to be in close proximity to the units
- The practice of seeing patients in offices should be discouraged. Sufficient consultation rooms should be provided to avoid this.

## 8.10 Discreet and quiet space for de-escalation

A low stimulus area should be located in an area of the Unit where there is less activity, noise and traffic.

- The area should be comfortably furnished to create a soothing environment.
- In the low acuity zone interview and multipurpose rooms may also be used for this purpose as required.
- However a distinct and separate observation/de-escalation room will be provided in the HDU area in close proximity to the seclusion room for this purpose.
- The room is to be used with staff presence for the purpose of de-escalation.
- Should the patient require seclusion they can then be place in the seclusion room without having to travel to another area.

## 8.11 Debrief room

Post seclusion or other incident a room will be provided in the HDU area where staff can quietly debrief and counsel the patient. This can be an interview room.

## 8.12 Smoke Free environment

The Unit is a smoke free space. Patients who are smokers will have access to nicotine replacement and other management strategies such as lockers will be utilised to support 100% compliance.

## 8.13 Disaster Planning

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

- The placement of emergency alarms, the need for emergency or uninterrupted power supply (UPS), electronic sensor taps and services such as emergency lighting, telephones, duress alarm systems, computers and the emergency evacuations of patients, many of whom will require assistance, should be considered.

## 8.14 Acoustics

The level of noise in in-patient units is a frequent source of complaint from patients and may compromise their recovery and comfort during their admission; this is more acute when noise occurs at night and has the potential to negatively impact on the patient's ability to gain a restful night's sleep.

- Acoustic integrity in interview rooms affects the willingness of patients to discuss private information.
- Thoughtful acoustic design can be used to aid hearing and ensure privacy.
- Excessive unwarranted noise is a distraction and reduces the ease of communication for all in the facility.
- External noise sources that can intrude include traffic.
- Internal noises are likely to come from mechanical and electrical equipment such as fans, air conditioners, and other people's activities such as conversation.
- Noise can be attenuated by carefully choosing and planning the site.
- Acoustic treatment should be specifically applied to these areas of the unit:
    - Day areas including patient living, dining and activities zones.
    - Patient bedrooms including high dependency and seclusion rooms.
    - Consulting/interview/sensory/tribunal/activity rooms and offices.
    - Treatment/Admission/assessment areas.
    - Seclusion and de-escalation suite.

## 8.15 Toilet Facilities

The required number of appropriately designed toilets (including a disabled toilet) must be provided within easy access from all patient areas.

- Whilst patient bedrooms will have en-suite facilities, there is a need in public and recreational areas to have access to toilet facilities for visitors and staff.

## 8.16 Signage

The signage identifying the In-patient Unit should be displayed clearly in English and other relevant languages.

- It should be designed appropriately for people with a visual impairment.
- The size will be in accordance with the relevant building code or standard.
- Universal symbols can be used instead of words.

## 8.17 Sensory Aspects

### 8.17.1 Vision

Glare can adversely affect a visually impaired person by causing distraction and disorientation.

- The impact of glare should also be taken into consideration where visual media is being used (e.g. television monitors).
- Some types of floor surfaces may cause confusion.
    - Contrast in colour where floor surfaces change can give the appearance of a step.
    - Where two surfaces tend to merge with each other, skirtings in contrasting colours can be used to clearly differentiate between walls and floor.
    - Appropriate lighting, colours and floor surfaces will facilitate visual identification.

### 8.17.2 Hearing

Too many hard wall and floor surfaces should be avoided as these could produce excessive sound reflection and increase background noise levels.

- High lighting levels (carefully avoiding glare) can assist hearing impaired people who may need to rely on visual clues to aid them.

### 8.17.3 Touch

Changing the texture of surfaces can be used to define a change of function, particularly with flooring and wall materials.

### 8.17.4 Walls

Walls should be of a durable material that can withstand frequent wear and tear.

### 8.17.5 Floors

When choosing floor coverings an institutional appearance should be avoided where possible.

- The main factors to consider when seeking floor coverings are those of safety, water resistance, ease of cleaning, resistance to retaining unpleasant odours and appropriateness within the centre.
- Non-slip vinyls are available and should be used in toilet areas.
- Vinyl floor coverings with a cushioned backing may be considered for the physiotherapy or occupational therapy treatment areas.
- Carpet may be used in the reception area, offices, multipurpose meeting/interview rooms and passageways.
- Carpets with short pile and specialised backing are practical and easy to clean. The carpet pile should be tight weave and short pile.

### 8.17.6 Doors

Doors should not be too heavy and will be of a maximum width to facilitate access for patients in wheelchairs.

- Door handles should be of a robust nature and located to allow for disabled access.
- Ligature proofing of doors including use of single continuous hinge, detention centre type knobs and door cut downs in en-suites to create space between door frame and top of door.
- Consider using automatic sliding entrance doors as they make access easier for disabled people. Sliding doors may also be appropriate for access to outside enclosed gardens or walkways.

### 8.17.7 Windows

Window design and location has to be carefully considered in relation to glare, climate control, ventilation and lighting.

- The placement of windows and the view they provide will affect the internal ambience of a space.
- Where possible the use of natural light should be optimised.
- In areas where damage to glass may occur, smaller panes of glass should be utilised due to their superior strength as opposed to larger panes.
- Either laminated or toughened glass should be installed to minimise the risk of patient injury.
- Polycarbonate is not recommended due to the likelihood of surface scratching which may limit visibility over a period of time.

### 8.17.8 Paint Finishes

Flat or low sheen washable acrylic or enamel paints should be used.

- Regard to the aesthetics should be given to ensure the colours are warm and user friendly.

### 8.17.9 Other Surfaces

Built-in joinery items, such cupboards and other furniture items, will normally have a laminate or timber veneer finish.

- Rounded corners on tables, benches and cupboards will reduce the possibility of injury.
- The placement of furniture doors in bedroom or opting for door-free shelving needs to be considered to minimise ligature risk.

### 8.17.10 Furniture

When selecting furniture the following factors must be considered:

- The furniture must be appropriate to a person's physical capability and be selected for specific rather than for multiple purposes.

- Comfort
    - Furniture that will provide maximum comfort for the specific needs of the patients should be selected.
- Safety
    - Tables and chairs must have stability and corners on tables, benches and cupboards will preferably be rounded.
    - Colours should be used that contrast with walls and floor covers.
    - Avoid glass or clear plastic furniture.
- Visibility
    - Enhanced visibility is paramount in clinical areas to assist staff in monitoring patient activity and promote the safe functioning of the unit.
    - Visibility from the staff station of bedrooms, movement in corridors and communal spaces is required; this includes capacity to look through the courtyard space to rooms beyond.
    - The use of monitoring mirrors may be an option to assist visibility where direct visibility is hampered.
- Appearance
    - The appearance of the room should be appropriate to the use of the room.
- Durability
    - Furniture should be strong and covered in fabrics that will withstand spillage and will not easily show stains.
    - This can be facilitated by the use of removable washable covers.
    - Chairs and toilet pans should be of an appropriate height for disabled access.
    - Chairs with higher seats will be required for different patient groups. They will be of a minimum seat height of 450 mm, have covered arm rests and padded seats that are not too soft.
    - Note that these chairs need to be larger than standard and will take up more space. Bariatric requirements should be considered.
    - Tables need to be stable with rounded corners.

### 8.17.11 Colours

Carefully chosen colours can help create an environment which will have a positive effect.

- Consider the use of contrasts in colour to assist in orientation.

- Specific colour schemes may be used to differentiate the various functional zones or coloured areas on a floor may be used to indicate an area such as activities of daily living (ADL) kitchen, bathroom or toilet.
- Contrasts should be used carefully, giving consideration to the needs of patients with visual impairment. As a general guide to assist in selection of appropriate colours, the following chart may be useful:

| Colour | General Psychological Response |
|---|---|
| Blue | Peaceful, comfortable, contemplative, restful |
| Black | Despondent, ominous, powerful, strong |
| White | Cool, pure, clean |
| Yellow | Cheerful, inspiring, vital |
| Purple | Dignified, mournful |
| Red | Stimulating, hot, active, happy |
| Orange | Lively, energetic, exuberant |
| Green | Calm, serene, quiet, refreshing |
| Pastels | Neutral, non-respondent, soothing |

# 9 Technology and Mechanical Services and Systems

## 9.1 Fire Prevention Services

The centre will be required to comply with the Department of Health fire guidelines and other statutory requirements.

- All hose reels or hydrants should be in cabinets or cupboards that satisfy Country Fire Authority or Metropolitan Fire Brigade requirements.
- Human safety is the first priority at all times.
- The centre must include adequate and readily accessible means of escape.
- The regulation number of exits and their required locations should be regarded as a minimum.
- The design and construction of the building and its fittings should aim to reduce any fire risks.
- Furniture and fittings should be selected on the basis that they will not contribute unduly to the production of smoke or fumes in the event of a fire. Check with the manufacturer. Floor and wall coverings are required to have certain fire index figures.

## 9.2 Hydraulic Services

Hydraulic services include hot and cold water and sewerage waste management.

- Where hot water outlets are accessible to patients, the water must be thermostatically controlled in accordance with Department of Health guidelines.
- Toilet cisterns will preferably be of a concealed type with heavy duty cover panels and side sewerage outlets should be avoided.
- Taps that are easy to use (sensory taps) are desirable for patient hand basins.

## 9.3 Lighting and Electrical Services

Access to daylight can improve quality of life; therefore, it is important to carefully consider lighting factors that will fulfil the needs of patients and staff.

- The lighting system should conform to the recommended standards.
- All electrical circuits should include overload/emergency safety breakers.
- Carefully choose locations for general purpose outlets.
- Sufficient numbers of outlets will need to be provided to obviate the use of double adapters, power boards and cords.

## 9.4 Communication Systems

The number of required incoming and outgoing lines will be determined by the size and staffing levels of the individual area.

- Adequate telephone access and sufficient telephone points and handsets for team members are required.
- Plans need to include the installation of cabling and Wi-Fi access suitable for computers and Internet access.
- There will be public phone access for patients within each zone or clinical floor.
- Easy access to a public telephone in a recessed area (for acoustic purposes) is desirable.
- The phone will preferably be a card/coin-operated public STD phone.
- A call system that is easily accessible for disabled patients may need to be installed in some areas, for example, in toilets.
- The location of the call buttons is extremely important whichever system is installed.
- Consideration is required in regards to the capacity and age of the current switchboard system, upgrade or replacement of present system.
- Wireless Internet (with filters) controlled by password to allow for controlled access to patients on site.
- The Unit will also have a patient computer/internet kiosk for ease of information and communication with family and carers or advocates.
- Smart devices such as tablets and phones will be in use within the unit in accordance with Department of Health and Human Services policy.
- There needs to be a safe (ligature risk free) way provided to ensure that patients can charge these devices as necessary.
- This may be through a staff monitored station or through use of touch charging devices.

## 9.5 Security Systems

### 9.5.1 Duress Alarm System

A system of personal duress with location finders should operate thought the Unit in both indoor and outdoor areas.

- The system is designed to provide continuous monitoring of each handset so that in the event of a critical incident involving risk to staff or patients an immediate staff response can be affected.
- Staff are trained to immediately respond to an alarm and to ascertain an appropriate response to the incident.
- The personal duress system should incorporate both a "Person Down" function as well as a personal alarm facility.

[redacted]

- Security and safety measures are maintained for patients, families, carers and staff to minimise the risk of aggressive behaviours (family and carers) etc. This includes features such as:
    - Lockable front entrance doors with intercom system.
    - Duress buttons for staff.
    - CCTV surveillance and alarmed exits.
    - Fire exits and WIP phone.
    - Emergency call system to alert staff if needed in any of the treatment/consulting areas.
    - High priority to have a secure centre with a minimal number of controlled access points.
    - Swipe card access for all areas/rooms beyond reception and passageways.
    - Ability to lock-down centre during authorised hours.
    - WIP phones to be strategically placed in centre.
- Patients, except in the HDU zone, may gain access to their bedroom areas through swipe cards. Where bed rooms are shared, personal locked areas for personal items will be required.
- This electronic system can also be used to give or restrict patient access to garden or other spaces outside of their clinical zone.
- It will allow staff to better manage entry and egress from the unit by patients as well as facilitate patient use of specific areas without direct staff presence where their clinical condition and level of recovery allows.
- Swipe or proximity card access could potentially be used on the following doors:
    - All areas including bedrooms; the only exceptions to this are seclusion and HDU doors which will utilise a key lock.
    - Medication/drug storage areas.
    - Access will be controlled by senior nursing staff with several levels of access for different personnel:
        - Medical and nursing personnel
        - All staff
        - Management
        - Patients may have varying levels of access from bedroom-only to access to entries and exits or garden spaces. This will allow for a recovery centred encouragement for patients to participate according to their capacity in their hospital admission.

- There needs to be a back-up, override or fail safe mechanism to swipe security to ensure that there is capacity to open or lock secure spaces in the case of a system failure.
- Video surveillance cameras (CCTV) will be located at the following points:
    - Exit and entry points;
    - External garden areas; and
    - Directional viewing of path to car park.

## 9.6 Mechanical Services

### 9.6.1 Environmental Services

There will be cleaner's room/s located in centre.

- Cleaner's room should be secure providing shelving for chemical storage as per the standard layout
- The room must accommodate storage of cleaner's equipment as per the standard layout.

### 9.6.2 Waste Management

There will be disposal areas located in centre.

- These are waste receptacle storage areas which are well ventilated separate from treatment areas.
- Consideration to be given to effective recycling strategies.

# D. FUNCTIONAL RELATIONSHIPS

## 10 Zone 1:Arrival/Public Access Areas

The arrival area includes the main entry and exit points, single points of reception to the two floors.

- It is the areas where many new patients may be first met and greeted/oriented, they provide visitor access and waiting areas and provide a role in monitoring and managing entry and exit of patients.
- It is the most publicly accessible areas of the two floors.
- Planned community admissions into a vacant bed on one of the floors may occur directly with the patient arriving via the general lifts and presenting at reception with or without family/carer where they will be shown to their allocated room and orientated to the ward. Documents should be available for clerking and admission processes.
- Admission of patients involving the community team may also arrive directly via the general lift. The patient lift may need to be used if clinically indicated.
- Patients being admitted via the general lift entry will most usually be accompanied by a member of the community team or relative/carer. Staff only assisted admissions will generally go via the patient lifts and this is the preferred pathway from ED.
- The majority of admissions via ambulance or police will occur via the ED and be transferred to the HDU or secure zone by the PEN/Code team via the patient lifts.

### 10.1 Main Entry Access

- Visitors to the unit such as family/carers and other staff will need to report to the main reception areas to ensure all security measures and material checking as required can be undertaken.
- The entrances will be open on the lower acuity zone during office and visiting hours and have swipe card access after-hours.
- The entrance areas will be under video surveillance (CCTV).
- Signage and coloured waiting areas/markings will direct family/carers and patients to the Reception areas or to the appropriate meeting room.
- Access into the area for family consultations/ education or to act as a separate waiting area where necessary should be easily accessible from the front waiting area.
- Swipe card access will be situated on all public restricted areas.

### 10.2 Reception

Each floor should have a reception area located near the entrance.

[redacted]

- It should have a welcoming feel, pleasant yet secure.
- Natural light should be maximised where possible and decor should reflect the desired ambience.
- Several people may attend the reception desk at the same time and can include patients and family/carers, visitors, staff, and taxi drivers amongst others.
- It is expected that Unit clerks will travel and work in the clinical zones and undertake some duties at a dedicated workstation.
- Workstations located at reception as per the staff profile.
- The receptionist will be located at the reception desk to greet visitors to the unit and to take incoming telephone calls. They will also undertake other administrative duties as part of the clerical team.
- The Reception area on level 2 will have two distinct functions:
    - A public role - dealing with patients, family/carers and other visitors face to face and over the phone.
    - An administrative role – administration including data requirements.
- The reception area should be positioned to provide good visibility to the entrance as well as any waiting areas.
- Hours of operation are to be established. It envisaged it will be business and visiting hours Monday – Sunday.
- The reception desk should be of an appropriate height to promote communication between the receptionist and people presenting and cater for ambulant and non-ambulant (wheelchair) persons.
- Each receptionist/clerk will require a separate workstation to fulfil their allocated duties; these workstations will have access to computers and telephones.
- The function of a stand-alone area is to facilitate the separation of clerical and clinical roles.
- Receptionists will be able to direct people entering the centre to the appropriate area.
- An enclosed reception area should provide sufficient access for staff to receive and provide papers etc. however; retain the ability to maintain good communications i.e. be able to hear and see people presenting and for people to hear and see staff when conversing.
- Public toilets (including disabled toilet facilities) and telephone should be available close to the reception.
- There should be an office area located close to the reception area to provide access to computers, telephones, multifunction fax/printer/copier and confidential paper shredder.
- A secure and visually private space for computer/data entry purposes is required in close proximity.

- Natural light should be maximised where possible.

## 10.3 Waiting Area

A separate waiting area is to be provided away from the reception area but be able to be observed.

- The waiting area/s may be set out as separate sub waiting areas to provide some patient/general visitor separation and choice; however these should be visible from the reception area.
- The area will be spacious enough to allow ample provision for comfortable seating.
- Multipurpose rooms could be used when required.
- Information displays (brochures) which are of interest to the centre patients may also be situated in this area.
- There should be sufficient space for individuals in wheelchairs.
- Natural lighting should be maximised wherever possible.
- A ceiling or wall mounted television may be incorporated if possible.
- There will be a waiting area for tribunal participants on level 3; when in use this area will not require the direct supervision of reception.
- In addition to the standard reception and waiting areas around the main entry, the area also will provide access to a number of other spaces that will be accessed by visitors or patients from the public area.

## 10.4 Interview Rooms

Interview rooms can be utilised by clerical or clinical staff.

- Where a patient presents in crisis to the centre the appropriate clinician can be paged and attend to the patient in the privacy of a dedicated interview room.

## 10.5 Public Amenities

The required number of appropriately designed toilets (including a disabled toilet) must be provided within easy access from all patient areas.

- Toilets to be located within or near the arrival area.
- Cubicle size will allow for wheelchair access and staff assistance where appropriate.
- Toilet doors should open outwards or have the capacity to open out to ensure that people can be extricated should there be an emergency.
- All toilets are to have 'cistern flushers' and be mechanically ventilated with the system activated by the light switch.
- Raised toilet seats need to be available except in the HDU area.

- All toilet areas should have hand-washing facilities (accessible from both a sitting and standing position).
- For safety reasons, an electronic communication system should be installed.
- Locks on toilet doors must permit staff access in an emergency.

## 10.6 Multipurpose rooms

The multi-purpose rooms could be used for meetings and events with patients, carers and other members of the public.

- It could also act as a second tribunal room.
- It will therefore need to meet the lighting, acoustic and audio-visual requirements for a tribunal room as well as capacity for video conferencing and projection for presentations.
- Furniture needs to be movable with space for storage when not in use. The area will at times be set out in lecture style and at times with tables and chairs.
- Patients are able to meet with their personal advocate to discuss care or to prepare for tribunal hearings in the multipurpose rooms.
- The rooms need to be large enough to accommodate a patient, their family and their personal advocate.

## 10.7 Lift Access to third floor

Lift access to the second and third floor will be provided from the main hospital entry area.

- It will be supported by clear way-finding directions and will enable patients, family and other visitors, to access the second floor and the secure third floor unescorted where appropriate, including the mental health review board/tribunal room.

# 11 Zone 2: Staff Work Area

The functions of this area include:

- Staff meetings - confidential one-on-one, small and larger groups, clinical handovers.
- Teaching and training functions.
- Storage and medication management.
- Accessing medical records and recording in patient files including electronic medical records, making confidential phone calls and discussions.
- Storage of patient valuables.
- Access to workspace for visiting clinicians.
- Individual or shared staff offices where required.
- Staff need an area to congregate, when not working directly with patients, to conduct conversations, complete documentation and phone calls and meet with other staff to coordinate care.

- During shifts staff will generally circulate throughout their area of responsibility within the unit, interacting, supervising and monitoring patients.
- However, they also require spaces from which to conduct confidential one on one meetings, small and larger group staff meetings, clinical handovers at the commencement/end of each shift, more formal clinical meetings and case discussions, and capacity to conduct confidential discussions and make confidential phone calls.
- Consequently, the staff work area will provide a variety of spaces to support these functions.

## 11.1 Clinical Records

In an interdisciplinary environment, patient records are required to be accessible to all staff.

- Records storage should be secure to maintain patient confidentiality and privacy and be accessible to both the reception and clinical staff.
- It is only a requirement to retain records for current patients.
- Adequate storage facilities for medical records/files and stationary/office supplies should be available.
- Medical records will be kept in each clinical zone during patient admission and in the general staff work area where records are kept for administrative purposes.

- The record and Discharge Summary will be scanned or attached to the DMR system as per protocol and therefore follow the patient to the relevant community team where follow up post discharge will occur.

## 11.2 Staff stations/collaboration/handover rooms

For the safety of both patients and staff, the nursing station is situated to enable easy visibility of the area and rapid response in the event of a patient emergency.

- The nursing stations in the secure and open zone will have an open counter front to facilitate patient staff interaction whilst providing staff with the capacity to retreat to an enclosed work area for record keeping and administration and handover. The HDU station will also have an ability to allow staff interaction but will remain secure.
- Each zone will have a staff handover/collaboration station where staff can congregate for shift handovers, update journey boards and use as a write up/administrative workspace.
- Functions for the enclosed collaboration area and the counter area will include:
    - Workstation for ward clerk;
    - Workspace for computers, telephones, and access to printer, facsimile, copier functions;
    - Docking stations for portable phones, pagers and personal duress alarms;
    - Storage and access to procedure manuals and references and other clinical resources;
    - Sufficient space or access to a space for staff handovers and case discussions; and
    - Medical records storage (only those immediately required within the zone).
- The size of the staff station and collaboration room should be based on the number of staff who will occupy the areas, this will range from numbers who may use the staff station workspaces at any time up to the peak numbers at handover times that could be expected to use the collaboration areas.
- The number and types of offices are provided in Section B of this document.
- Offices where it may be required to meet with visitors or patients or where it is important they are directly accessible to the zones, such as NUM or shift manager's workspaces, will be located within or adjacent to the in-patient areas.
- Other staff office spaces will be located adjacent to the staff amenities area in an area not accessed by patients or their visitors or will be off the unit preferably close to the zones.
- The practice of seeing consumers in offices, unless developed for that purpose, is to be discouraged and sufficient consultation/interview rooms will be provided to avoid this.

## 11.3 Unit Manager Office

The Unit Manager's Office should be located with easy access to the different zones.

- The role of the manager is diverse and includes the requirement to have confidential conversations with staff.
- This office is lockable.
- Consideration should be made to the visual and acoustic privacy.
- The unit manager should have access to a secure and confidential filing system.
- This office needs to be large enough to allow for 3 or 4 people to meet in them.

## 11.4 Medication Rooms

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 these rooms. Room size needs to allow for this anticipated storage.
- All cupboards should be lockable. Glass fronted cupboards for medication storage may assist in inventory control.
- Storage must comply with legislative requirements and capacity for refrigeration if required.
- A hand basin is required.
- There will be one medication room in each zone.
- Preparation of medication for administration will occur in the medication/drug rooms.

## 11.5 Staff Office area

This section refers to offices and workspaces located in the staff only area of the centre, adjacent to the staff amenities.

- Offices should be based on information provided in Section B.
- Offices should be lockable.
- These spaces should contain all the requirements to allow staff to undertake routine administration work and office-based clinical tasks.
- Permanent full time staff will have either a hot desk within the staff office zone or within the clinical zone, handover/collaboration station or an individual workstation allocated.
- Permanent part time staff will have a shared workstation allocated with staff who work on alternate days.
- Rotational/visiting staff/students will have a 'hot desk' workstation allocated on a short term/daily basis.
- Workstations will be sufficient in number and size to meet current need plus additional growth.
- Each workspace will provide:

- Work desk with a PC, telephone.
- Ergonomic seating.
- Shelving for the short term storage of stationery or mobile under bench pedestal lockable units.
- Portable file storage to maximize flexibility and hot desking capabilities.

## 11.6 Large Handover Room

A large handover room will be available within the staff office area of each floor which will enable staff from the different zones to meet together to discuss patients management plans, for more general handovers and as an additional staff meeting venue for multidisciplinary meetings and educational sessions.

- As with other handover areas, needs access to smart technology and electronic whiteboards.

## 11.7 Education Room/Multipurpose room

An education room is required, primarily for staff teaching and training, that incorporates audio-visual and multimedia equipment and computer facilities to provide presentations.

- The education room will be utilised by staff from across the mental health service and may include sessions for and with other service providers or other departments of the health service.

# 12 Zone 3: Staff Amenities

Staff amenities will include staffroom, property bay and toilets.

- The primary function of this zone is to facilitate staff breaks.
- The area provided will be suitable for resting, reading, eating and drinking, storing and reheating food, access to staff toilets and secure storage of personal items while on duty.
- It will be located to provide privacy to staff whilst on breaks.
- The area should provide a quiet space for the staff to withdraw from the patient environment but should be close enough so that staff can respond if required in an emergency situation.
- Access to an outdoor space would be highly desirable for staff who are working in demanding clinical situations.
- Whilst it is important the amenities will be accessible at all times for staff use and the staffroom should not be used as a meeting room (which may prevent staff from accessing food and refreshments during their breaks).
- Patients and visitors will not be able to access the staff amenities area.

## 12.1 Staff Amenities

### 12.1.1 Staff Rooms

- Large enough to accommodate the required number of staff.
- Table and chairs.
- Refrigerator to accommodate staff.
- Microwave.
- Coffee and tea making facilities with Zip (boiling water system).

### 12.1.2 Staff Toilets

- Are to be unisex.
- All toilet areas should have hand washing facilities (accessible from both a sitting and standing position).
- Toilet doors should open outwards to ensure that people can be extricated should there be an emergency.
- All toilets are to have 'cistern flushers' and be mechanically ventilated with the system activated by the light switch.

- For safety reasons, an electronic communication system should be installed.
- Locks on toilet doors must permit staff access in an emergency.

### 12.1.3 Staff Showers/change rooms

- Staff will have access to the shared K Block staff shower, locker, change room and bike storage facilities on level 2.

### 12.1.4 Staff Property Bay

Access to a locker or lockable storage facility for personal belongings should be provided for each staff member working in the centre.

- Provision for lockers for all permanent full time staff.
- Sharing of lockers for all permanent part time and rotational staff.
- A quarter size locker will be suitable.

# 13 Zone 4: Residential /living Area

The residential / living area functional zone consists of a combination of private and more open spaces and primarily relates to the low acuity and higher acuity zones and the areas which will support the following activities:

- Sleeping, resting, personal care and hygiene
- Dining
- Activities areas - program and group activities
- Recreation and socialisation
- Quiet spaces and sensory stimulation
- Gender separation – flexible women only area as required
- Visitor access
- Access to external garden areas.

## 13.1 Low acuity zone/Open ward and secure zone

The low acuity area is the least restrictive area of the unit.

- Usually patients in this area will have free access to unit and garden areas.
- Zones will have the flexible capacity to be subdivided on an as needs basis to segregate women or vulnerable patients from the more acute patients.
- Patients will have access to dining, recreational, activity and sensory areas.
- The unit will provide for different areas where staff led and patient self-determined activities can be undertaken; these may include art, crafts, exercise, mindfulness, sensory modulation, listening to music as well as assessment and rehabilitative activities to support their activities of daily living on discharge from hospital.
- It is expected that the patients will have capacity to safely store their personal valuables in their rooms.
- They will control entry to their bedrooms and will have individualised electronic access to specific areas within the unit including garden spaces.
- They will have private ensuite hygiene facilities. Where there are double bed rooms an ensuite will be shared.
- The unit will be designed for safety; this will include minimization of ligature risk, flexibility to manage both high risk and vulnerable patients in low acuity areas and the provision of easy access to staff when required.

- Patients will generally move freely through the residential zone of the unit including being able to access the external garden areas.
- Where access to some areas within the zone may be restricted from time to time, staff will manage this through use of proximity card/bracelet access.
- The residential zone of the unit is the area where most patients will first be oriented and will spend most of their time in the unit.
- The residential zone includes private space such as the bedrooms and en-suite, small and large lounge areas, outdoor space, dining area and an area to meet visitors.
- In order to support the bedroom as a private and safe space for patients where they feel secure and have control of their personal environment, all patients will be provided with proximity bracelets to secure their bedrooms. Staff must have the capacity to override this if necessary.
- A number of bedrooms and ensuite in the residential area will have capacity to accommodate frail or elderly patients or patients with physical disability.
- Portable lifting equipment will need to be considered to address care whilst being mindful of safety and ligature risk.
- Bedrooms should be furnished to be comfortable and safe and all patients will be encouraged to manage their own personal hygiene in their own ensuite or shared ensuite. Patients will be able to store personal and valuable items such as wallets, jewellery or mobile music players in lockable safe located in the bedroom cupboard if in a shared room.
- Patients will have access to a number of shared areas where they may socialise with other patients. These areas will include capacity to watch television read books or listen to music.
- Patients will be able to have visitors on the unit and there will be capacity for safe family visits.

### 13.1.1 Bedrooms

The positioning of the bedrooms must ensure elimination of dead-end corridors where possible and provide good visual supervision by staff.

- These rooms must provide privacy for patients while maintaining supervised care.
- Bedrooms must be lockable and controlled primarily by the patient with staff-override capacity.
- Doorways must facilitate access of beds.
- Bedrooms must have access to natural light.
- Each bedroom must have built-in joinery for storage of personal items and clothing and a small write up desk / table area which will allow patients to eat some meals (breakfast and some lunches) in their rooms if desired and capacity for a TV to be located.
- There should be IT/Wi-Fi ability from the bedroom

- Bedroom fixtures, fittings and furnishings must be anti-ligature type and minimise the risk of patient self-harm.
- Storage should be limited to open shelving and wardrobes will be built in, must be anti-ligature type and as a consequence will generally not have doors. Clothing storage may consist of plastic bins in open shelving units.
- There must be limited control of the room environment with blind/curtain control that are ligature proof, and lighting control.
- There will be low level night lighting in these areas.
- A small securely attached magnetic white board will be in each bed room for pictures and other personal material.
- Doors to the bedrooms will have the capacity to swing outwards as well as inwards to prevent a patient from barricading inside the room.
- Anti-ligature door design and hardware will be used.
- The door hinge must be continuous to prevent the hinge from being used as an anchor ligature point.
- A secure solution for keeping valuable personal effects that does not require a key must be provided such as a small combination touch-pad safe. Staff will be able to over-ride the locked safe if required.
- Staff call buttons will be provided in all bedrooms and en-suites.

### 13.1.2 Ensuites

Each bedroom room must have an adjacent ensuite.

- Ensuites must also meet the Department of Health's standards for anti-ligature while still presenting itself as a normal environment and respecting a patient's privacy and dignity.
- Ensuites will require specific services to be concealed such as drainage and exhaust fans. Fittings and fixture solutions that provide no ligature points such as showerheads, taps and cistern must be provided. Grab rails must be of an anti-ligature type.
- Mirrors must be of safety glass or other appropriate impact resistant and shatterproof construction. These must be fully glued to a backing, or alternatively, set within a sturdy frame and well secured to the wall to prevent the availability of loose fragments of broken glass.
- Space will be provided for the storage of toiletries on open shelving.
- The ensuite will need to provide:
    - Hand basin
    - Anti-ligature shower

- Toilet
- Taps (anti-ligature type with appropriate temperature restriction) over the hand basin
- Staff assist / nurse call button within easy reach
- Local temperature control (at staff base) with a thermostatic control to prevent accidental scalding

- Special attention will need to be given to patients with motor-difficulties for example using taps.
- Staff call buttons will be provided in all en-suites.

### 13.1.3 Ensuite – disabled

These ensuites will contain the above facilities but will be able to accommodate disabled.

- Grab rails must be provided and these must be of an anti-ligature type.
- In some situations an over-toilet seat may be used to provide both extra height and support for a patient.
- All toilet areas should have hand-washing facilities (accessible from both a sitting and standing position).

### 13.1.4 Shared Spaces

Although length of stay is generally from a few days to a couple of weeks, a variety of indoor and outdoor areas will be provided to support patients participating in a range of activities concurrently, such as meals, television, art, games, music, computers, exercise, meeting visitors, and telephone use.

- These areas may be used 24 hours a day, cater for a variety of activities including:
  - quiet areas for relaxation, time out or to socialise;
  - television / music with TV, multimedia players;
  - recreation area used by all patients in the zones alongside the dining area;
  - multi-function activity areas; and
  - self-care laundry.

### 13.1.5 Dining area

The unit is designed to cater for plated meals brought to the unit from the main hospital kitchen and transferred to dining areas.

- Whilst patients will eat meals communally, capacity for patients to have meals in their rooms needs some consideration.
- This area needs to have secure storage of crockery and cutlery, as these will need to be monitored by staff. Crockery will be needed for tea and coffee provisions.
- There should be a formal dining area in each zone where patients can sit in groups or alone.

- To maximise the use and flexibility of the space the dining area should be located adjacent to an open recreation / lounge space and outdoor areas where possible.
- A small beverage bay should be located in the dining room or activity/recreation area for general use by consumers and visitors outside of mealtimes.

### 13.1.6 Recreation/Lounge

The recreation/lounge areas adjacent to the dining areas are places where patients (and their visitors) can sit and relax in a communal setting.

- Due to the open nature of these areas careful attention should be paid to acoustics to prevent excessive noise.
- The areas are easily observable from the staff station.
- This area should have access to natural light with an external view into the outside area and direct access to the undercover outdoor area where possible to maximise flexibility and use of the space.
- There will be comfortable seating and other domestic style furnishings capable of accommodating 10 to 14 adults in the low acuity zone.
- There will be access to drinking water and tea coffee making in this room and television with DVD.

### 13.1.7 Activities rooms

Activity areas will be provided in the zones which are able to support a range of group and individual activities. Recreation areas will also be used for some activities.

- The activities areas will be flexible and able to be used for listening to music, watching TV, quiet reading and relaxing, art, games and other group activities and at least one should have capacity for a wet area to support art and craft activities.
- Equipment to be used in activity sessions will also need to be stored and locked storage cupboards should be provided in the activities areas to support this.
- The low acuity activities areas must comfortably accommodate 6 to 8 people (combination of clients, staff and possibly family members) at any one time.
- Apart from the more highly supervised activity room in the high acuity area, the activity areas should generally be open, flexible, light and domestic in feel to support their multiple functions.
- In addition to the staff supervised access to sensory rooms, the activity areas can also be established so that some may provide quiet/low stimulus spaces/sensory modulation to divert patients to reduce arousal.
- There will be quiet activities areas separate from high arousal areas (dining/recreation rooms) to support this function and provide access to robust sensory modulation resources located for ad hoc use /self-directed/ immediate access.

[redacted]

### 13.1.8 Outdoor spaces

Outdoor spaces will support exercising, socialising, capacity to be alone in a quiet environment, capacity to experience the outdoor environment but being sheltered from the elements.

- They will provide safe and secure external areas with access managed by staff and through proximity bracelets.
- Patients and visitors will be able to directly access outside areas from within the residential zone.
- There will be disabled access to the external areas and shade and shelter from the environment will be provided.
- Shade is especially important for mental health patients who may be receiving treatment which can make them more prone to sun burn.
- The external areas will be private and screened/fenced from public view to support privacy.
- There should be passive outdoor spaces (seating in landscaped garden area) and active outdoor spaces that encourage exercise. Some of the outdoor area should have soft surfaces.
- Lighting should be provided to outdoor areas at night.
- Access to the outdoor areas will support gender separation with women only access to one area if possible. Where this is not possible, times access control will be considered.
- Landscape features and plantings which may be climbable should be set back from the perimeter wall to avoid breaches of perimeter security.

### 13.1.9 Visitor areas and family friendly areas

Opportunities need to be provided for carers to be involved in care.

- A specific room and garden area is desirable for patients to meet with visitors, including children in private, in the public area of the open unit.
- However visitors will also access the in-patient areas of the secure and open units to visit.
- Activities and dining/recreation spaces as well as use of meeting rooms and interview rooms which are not used after hours for example will facilitate this.
- Visitors will have access to a beverage bay. Visitor toilets will be provided in each of the zones.

### 13.1.10 Laundry rooms

Laundry rooms, which will include washers and dryers, will be accessible to patients under supervision.

### 13.1.11 Separation of vulnerable patients – Gender Separation

There will be capacity to segregate/separate areas within mixed gender areas as required to better manage vulnerable patients and gender safety.

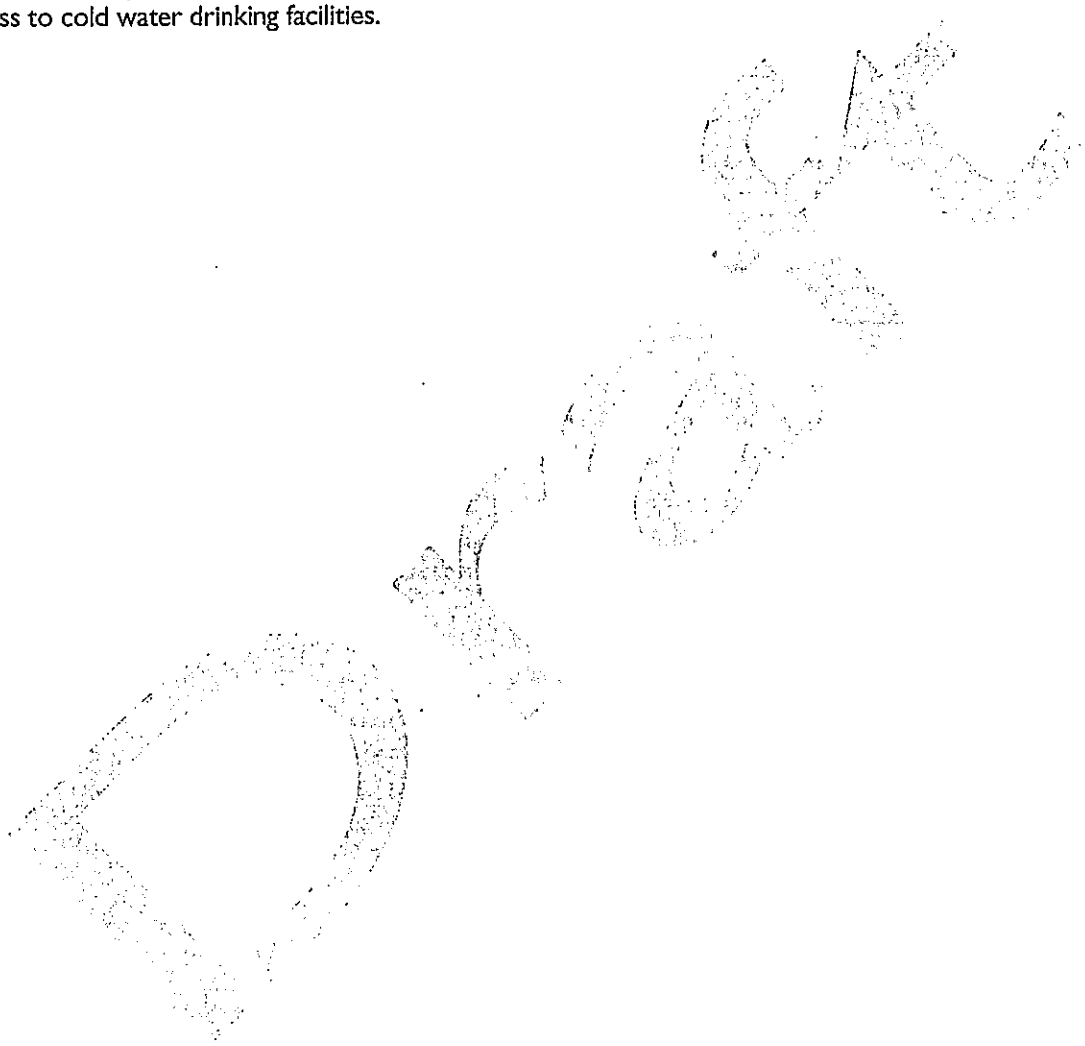
- Utilisation of activity rooms as safe places should be encouraged – possibly providing gender specific rooms/ retreats, and discreet visitor capacity.

[redacted]

- In addition vulnerable patients are supported through individual safety mechanisms such as swipe or proximity bracelet control of access to their rooms and gender or separate areas of zones, staff call buttons in all private areas and possible use of personal duress system.

### 13.1.12 Beverage Bay

Located within patient recreation/dining area to allow patients and visitors to make tea and coffee and have access to cold water drinking facilities.



# 14 Zone 5: Therapeutic/Consulting Area

The therapeutic consulting area of the centre is the area where spaces provide for more formal clinical interventions and interactions between staff and patients and times family or carers occur. Note activity rooms where group programs may take place have been included under zone 4 residential / living areas.

The therapeutic/consulting area includes:

- Interview Rooms
- Assessment and Treatment rooms
- Sensory modulation rooms
- Education/ Therapy Areas (Kitchen facilities for ADL assessment)
- Mental Health Tribunal Room

## 14.1 Interview Rooms

Interview rooms will variously cater for individual and group meetings and will generally be used for interviews, assessments and consultation with patients and families by clinical staff including visiting clinicians.

- An Interview room generally needs to be large enough to comfortably accommodate up to six people, including the consumer, clinicians and carers. This should be available in all zones.
- Consultations involving more than six participants (such as family meetings) will generally occur in a larger interview/meeting room.
- Interview rooms used for administration of medication generally only require space for up to three people however as many will serve a dual purpose a larger size allows more flexible use. These rooms should be located with direct access from or adjacent to medication rooms and staff stations within pods.
- All interview rooms will have dual entry/egress for staff safety.
- When not in use as interview spaces these rooms can be used for private patient family visitor space within zones.
- Interview rooms will generally be furnished with table or coffee table and chairs arranged to encourage informal discussion whilst not obstructing staff exit routes should the need arise.

## 14.2 Assessment /Treatment Rooms

Treatment rooms will be used for patient assessment, examination and minor procedures such as dressings and injections.

- They will require locked cupboards 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 or chair, examination light, hand basin and second exit door are required. Doors should be lockable with swipe card (with key override) or similar restricted access.
- Sound proofing and robust walls and doors are essential.
- Treatment rooms need to be of sufficient size to allow for up to four people and the following equipment and furniture:
    - Write up desk – computer and phone
    - Examination couch
    - Hand washing facilities
    - Sphygmomanometer
    - Wall mounted height measure
    - Clinical scales (bariatric)
    - Privacy screen for examinations
- A larger than standard examination couch/chair will be available at request in the treatment room given the capacity to manage bariatric patients.
- One interview /treatment room is provided in the HDU/secures area for assessment of new patients admitted via the patient lifts from ED.
- Another treatment room is provided on the open zone.

## 14.3 Mental Health Tribunal Room

This room will be the primary mental health tribunal room and will be set up to provide this function. It will need to meet the size, configuration, lighting, acoustic treatment and audio-visual requirements for a tribunal room including dual entry/egress.

- A waiting space in close proximity to the tribunal hearing room should be provided for visitors in attendance at hearings and an advocacy room where patients and families are able to meet with their personal advocate to discuss care or to prepare for tribunal hearings.
- The tribunal room will be accessible from the public area of the centre via reception and the passenger lift or stairs to level three. It will be located adjacent to the staff work area on level three which will allow an egress point into the staff only zone.
- A second back up flexible tribunal room is also available.

# 15 Zone 6: High Dependency Area

The high dependency unit includes:

- The residential, staff and treatment areas of the HDU,
- The seclusion suite and
- Secure patient entry.
- Patients can be placed in HDU directly on arrival or directly from ED via the patient lifts.
- Alternatively after admission to the lower acuity zone they may be assessed as requiring HDU for a short period of time.
- This zone requires capacity to be managed and securely separated from the secure zone, but with capacity to open it up if required.
- There should be capacity for some beds in this area to be able to be flexed between the HDU and the secure zone.
- It will include its own recreational and living spaces as well as bedrooms.
- Patients in HDU will have access to dining, recreational, activity and sensory areas under supervision.
- It will also include the seclusion area and de-escalation area.
- Patients will be managed in the HD when there is an assessed need to provide a more restrictive intervention to maintain the patient's safety or safety of others. There will be a greater emphasis on actively engaging with the patient during and after these events to minimise the time and potential trauma associated with any restrictive practice.
- The layout should facilitate controlled movement of staff and patients between zones.
- A central lounge /dining area that is readily observable by staff. Sound attenuation is important to reduce stimulus.
- The bedrooms should be lockable from the exterior door only. The bedroom doors must have a viewing panel so that patients can be observed by staff. This is specifically crucial in the event of a seclusion episode. Patients when clinically indicated may be able to have similar proxy card/bracelet control over their bedroom doors with staff override capacity as in other areas of the unit.
- Treatment in a HDU area is expected to be limited to a period where the patient cannot be managed in a less restrictive area because of their clinical condition.
- The patients treated in this area have a level of acuity or have monitoring needs that is higher than patients in the secure or open areas. Patients in this area will be under staff supervision at all times.

- They will have access to activities to support them to manage their health and arousal such as sensory modulation, psycho-social activities and access to courtyard garden space.
- The HDU area, whilst mixed gender, will provide flexibility to manage for gender safety and management of varying levels of acuity. To support this, there will be capacity to segregate areas within HDU as required to better manage vulnerable patients and gender safety including providing separate dining and recreation areas where required.
- Within the HDU area there should be quiet / low stimulus spaces/ sensory modulation to divert patients to reduce arousal and an area within HDU and close to seclusion where a patient can be taken to be de-escalated in a further attempt to avoid seclusion. A flexible room with bed room or seclusion capacity will be adjacent to the de-escalation area.
- Patients will be able to have visitors in a room on the unit and there will be capacity for safe family visits.

## 15.1 Bedrooms/Ensuites

Requirements are similar to bedrooms and en-suites in the higher and lower acuity zones. However, a greater level of staff monitoring is required which should be reflected in bedroom layout with bedroom doors supporting staff observation but maintaining privacy and consideration given to monitoring of access to en-suite facilities through electronic monitoring.

## 15.2 Dining/Recreation

Requirements are similar to the dining recreation areas in the lower and higher acuity zones, but with a greater focus on staff monitoring and separating patients to support vulnerable patients and gender separation.

- There should be a formal dining area where consumers can sit in groups or alone. An alternative dining space and recreation space will be provided to support separation of patients.

## 15.3 Secure Emergency Entry

A dedicated and discreet secure entry lobby will be required as a point of access into the high dependency zone of the Unit for safety and patient privacy.

- This lobby will provide access for patients from ED or other zones. However there is an ability to move patients from the secure zone directly to the de-escalation area as required urgently.

## 15.4 Treatment and interview rooms

This is a component of every zone and should have a second egress door.

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

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

## 15.5 Seclusion Suite

The associated seclusion suite includes one seclusion room and a flexible room which could be used as an HDU bedroom or second seclusion room when required.

- The aim is for staff to initially bring at risk patients who cannot be managed in the broader HDU zone, into the observation area where they aim to calm them and prevent the need for seclusion.
- If the patient cannot be calmed, they may be placed in a seclusion room where ligature risks are minimised and they can be observed by staff.
- Access to the toilet and shower can be restricted as required. Access to the ensuite in the flexi bed is unrestricted.
- The seclusion room can be used for highly agitated patients that cannot be managed in a less restrictive manner. The Mental Health Act 2013 protocols are required for restraint and seclusion.
- Constant observation by staff of patients in seclusion may also be required.
- Seclusion room doors allow staff to observe comprehensively into the seclusion room. The seclusion rooms must be located where they can access natural light. They should be located and acoustically treated so that they are not subject to noise from other internal or external areas and vice versa.
- There are specific guidelines and requirements for seclusion rooms that must be complied with, and consideration should be given to means of communication with a patient in seclusion and easy access to toileting.
- In the HDU area the seclusion suite will include a de-escalation space where acutely aroused patients can have a quiet space with staff to talk and work towards the prevention of seclusion. Patients will not be left unattended in the de-escalation area. This space will be in close proximity to the seclusion room should seclusion be necessary.
- The suite of rooms will be separated from the thoroughfare of the high dependency area for privacy.
- Patients who require seclusion will have access to en-suite hygiene facilities. They will be able to be monitored by staff.
- At the end of a seclusion period the patient will be provided an opportunity to debrief with staff in a private interview room.

# 16 Zone 7: Utilities Area

A utility facility is comprised of those areas that provide the non-clinical support services and utilities and includes:

- Pantry areas for delivery of meals
- Storage areas (for files, office equipment, general, and patient property)
- Dirty utility and cleaner's room
- Linen trolley bay/cupboard (securable)
- Communications room (for ITC rack/server)

## 16.1 Waste Disposal/Soiled Linen Area

This are allows for the storage of soiled linen and infectious waste materials awaiting removal from the site.

- Requirement for a floor waste outlet with a tap over it and mechanical ventilation is essential.
- There will be one room on each level.

## 16.2 Cleaner's Room

A designated cleaner's room will be available on every floor which provides adequate secure, ventilated space for storage of cleaning materials and chemicals.

- Floor level drain for emptying of buckets.
- Space to accommodate storage of cleaning trolleys.
- Utility room provides for cleaning of equipment, and safe waste disposal
- There will be one cleaner's and one dirty utility room on each level.

## 16.3 Storage rooms

Storage will not be provided in the interview rooms.

- A storage room will be provided on level 2. The store room will provide for the secure storage of general consumables and items of equipment.
- Equipment required as part of program activities will generally be stored in the storage spaces provided in the activities areas.
- Patient property deemed dangerous is not allowed on the wards will be stored in lockers outside the low acuity/open ward.

## 16.4 Linen Storage

A clean linen bay will be provided on each floor.

# BIBLIOGRAPHY


1. Adult Community Mental Health Services Model Of Care, 2013
2. Detailed Model of Care: Mental Health ACT, Adult Acute Mental Health Inpatient Unit, The Canberra Hospital, Version 2.1
3. Mercy Health. Werribee Mercy Mental Health In-patient Unit – Stage 1D. Redevelopment Werribee Mercy Hospital. June 2004.

AMA Submission to the Legislative Council Government Administration Committee 'A'

Subcommittee Inquiry into Health Services in Tasmania

Psychiatric Services/Mental Health

August 2017

APPENDIX B

Part 4

Related Documents in Chronological Order

**Australian Health Facility Guidelines VS DHHS plans for Inpatient Mental Health 2015**

Please note: The shaded areas indicate that the AHFG has not been reached.

Open Unit (14 beds - @ 85% occupancy, this would be 11.9 beds used)

| AHFG room type and size | Prefab plans (Jan 2015) | Prefab plans (Feb 2015) | K Block plans (Jan 2015) | K Block plans (Feb 2015) |
|---|---|---|---|---|
| 1 bed room (14m2) | 16.5-17.5m2 | 16.5-17m2 | 18m2 | 9 rooms @ 18m2<br>1 room @ 29m2 (inc own lounge) |
| 2 bed room (28m2) | 25m2 | 25m2 | 26m2 | 27m2 |
| Ensuite (5m2) | 5-5.5m2 | 5-5.5m2 | 5.5m2 | 5.5-6.5m2 |
| *Dining (Combined 105m2 based on 14 pts)* | 19.5m2 | 19.5m2 | 50m2 | 50m2 |
| *Lounge (Combined 105m2 based on 14 pts)* | 9.5m2 | 0 | 31m2 | 31m2 |
| *Activity (Combined 105m2 based on 14 pts)* | 25m2 (combined total 54m2) | 25m2 (combined total 44.5m2) | 30m2 (combined total 111m2) | 30m2 (combined total 111m2) |
| Kitchen (10m2) | 11.5m2 | 11.5m2 | 0 | 0 |
| Laundry (8m2) | 4.5m2 | 4.5m2 | 6m2 | 6m2 |
| Treatment (16m2) | 13.5m2 | 13.5m2 | 14m2 | 14m2 |
| Meeting/tribunal (20m2) | 17m2 | 17m2 | 21m2 | 21m2 |
| Store/linen (3m2) | 0 | 0 | 10m2 | 10m2 (non specific stores) |
| Pt property (6m2) | 0 | 0 | 0 | 0 |
| Staff station (14m2) | 13.5m2 | 13.5m2 | 15m2 | 15m2 |
| Office (15m2) | 17m2 | 17m2 (may be consulting room) | 14.5m2 | 14.5m2 |
| Staffroom (15m2) | 14m2 | 14m2 | 20m2 | 20m2 |
| Consulting rooms (14m2 @ 1 per 5 pts – 2.8 rooms) | 0 | ? 1 x 17m2. Not enough | 10m2 and 14.5m2 (2 rooms) | 10m2 and 14.5m2 (2 rooms) |
| Outdoor area (105m2 based on 14 pts) | 32m2 | 32m2 | 81.25m2 | 81.25m2 |

Secure Unit (10 beds @ 85% occupancy would be 8.5 beds used)

| AHFG room type and size | Prefab plans (Jan 2015) | Prefab plans (Feb 2015) | K Block plans (Jan 2015) | K Block plans (Feb 2015) |
|---|---|---|---|---|
| 1 bed room (14m2) | 17.5m2 | 8 rooms 17.5m2<br>2 rooms 25.5m2 (inc own lounge) | 16.5-17.5m2 | 16.5-17.5m2 |
| Ensuite (5m2) | 5.5m2 | 5.5m2 | 6.25-7.5m2 | 6.25-7.5m2 |
| *Lounge/dining (combined total 100m2, based on 10 pts)* | 80.5m2 | 80.5m2 | 60m2 | 60m2 |
| *Recreation (combined total 100m2, based on 10 pts)* | 37.5m2 (combined total 118m2) | 37.5m2 (combined total 118m2) | 29.5m2 although appears not 24/7 (combined total 89.5m2) | 29.5m2 although appears not 24/7 (combined total 89.5m2) |
| Treatment room (16m2) | 17m2 | 17m2 | 16m2 | 16m2 |
| Tribunal/meeting (20m2) | 10m2 (presumably to share PICU 25.5m2) | 10m2 (presumably to share PICU 25.5m2) | 26.75m2 (shared with PICU) | 26.75m2 (shared with PICU) |
| Therapy (? Is this a consulting room, if so 14m2 and 2 required) | 17m2 - 1 room | 17m2 | 12.5m2 - 1 room | 12.5m2 interview room |
| Assessment room (15m2) [can be room type above] | 0 | 0 | 0 | 0 |
| Staff station (18m2) | 17m2 | 17m2 | 15.5m2 | 15.5m2 |
| Store/linen (3m2) | Size not stated | Size not stated | 0 | Not shown |
| Pt property (6m2) | 0 | 0 | 0 | 0 |
| Kitchen (10m2) | 0 | 0 | 0 | 0 |
| Laundry (8m2) | 5.5m2 | 5.5m2 | 6.25m2 | 6.25m2 |
| Courtyard (100m2 based on 10 pts) | 42.5m2 | 42.5m2 | 43.75m2 | 43.75m2 |
| | | | | |

PICU (5 bed unit, @ 85% occupancy, 4.25 beds used)

| AHFG room type and size | Prefab plans (Jan 2015) | Prefab plans (Feb 2015) | K Block plans (Jan 2015) | K Block plans (Feb 2015) |
|---|---|---|---|---|
| 1 bed room 14m2 | 17-17.5m2 | 17-17.5m2 | 15m2 | 15m2 |
| Ensuite 5m2 | 5-5.5m2 | 5-5.5m2 | 5.5m2 | 5.5-7m2 |
| *Lounge/dining (combined total 50m2 based on 5 pts)* | 63m2 | 63m2 | 50m2 | 50m2 |
| *Activities/breakout (combined total 50m2 based on 5 pts)* | 25m2 (combined total 88m2) | 25m2 (combined total 88m2) | 15m2 (Combined total 65m2) | 15m2 (Combined total 65m2) |
| Seclusion (15m2) | 32.5m2 | 32.5m2 | 20m2 | 20m2 |
| Staff station (18m2) | 17m2 | 17m2 | 16m2 | 16m2 |
| Assessment room (15m2) | 17m2 – 1 interview room | 25m2 interview room | 16m2 – 1 interview room | 16m2 "multipurpose room" |
| Consult room (14m2) | 1 interview room as above | As above | 1 interview room as above | see above |
| Meeting/tribunal room (20m2) | 25.5m2, presumably to share with secure unit | 25.5m2 shared with secure unit | 26.75m2 (shared with secure unit) | 26.75m2 (shared with secure unit) |
| Treatment room (16m2) | 17m2 | 17m2 | 13.75m2 | 13.75m2 |
| Store/linen (3m2) | 8.5m2 (for all stores), no linen specific | 6.8m2 (for all stores), no linen specific | Unstated size | Unstated size |
| Pt property (6m2) | 0 | 0 | 0 | 0 |
| Kitchen (10m2) | 0 | 0 | 0 | "Tea point" bench in rec/dining room |
| Laundry (8m2) | 0 | 0 | 0 | 0 |
| Courtyard (50m2 based on 5 pts) | 0 | 0 | 0 | 0 |

Please note, the Prefab plans include a "workstation area" (in addition to staff areas and offices) of 34m2. Explanation as to what this is required.

MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

# Record of Investigation into Death (Without Inquest)

*Coroners Act 1995*
*Coroners Rules 2006*
*Rule 11*

**(These findings have been de-identified in relation to the name of the deceased, family, friends and others by direction of the Coroner)**

I, Simon Cooper, Coroner, having investigated the death of Mr S

**Find, pursuant to section 28(1) of the *Coroners Act* 1995, that:**

(a) The identity of the deceased is Mr S;

(b) Mr S died as a result of an action taken by him alone, with the intention of ending his own life;

(c) The cause of Mr S's death was asphyxia;

(d) Mr S died in bushland in Southern Tasmania;

(e) Mr S was born on mainland Australia and was aged 58 years at the time of his death; he was in a *de facto* relationship and recently retired.

In making these findings, I have had regard to the material provided to me as a consequence of the comprehensive investigation in relation to Mr S's death. That material included a police subject report, the police report of death to coroner, affidavits dealing with identification and the declaration of life extinct, an affidavit from the forensic pathologist who conducted the autopsy, the results of toxicological analysis carried out at the laboratory of Forensic Science Service Tasmania on samples taken from Mr S's body at autopsy, medical records from both the Royal Hobart Hospital and Mr S's general practitioner, and affidavits and photographs from investigating police. Perhaps most importantly I have had regard to the affidavits of those close to Mr S.

It is clear, and I find, that Mr S was suffering depression in the lead up to, and at the time of, his death. He consulted with his general practitioner and a diagnosis of depression was made, and medications to assist with that condition (and sleep) were prescribed to him. Advice was given to Mr S with respect to actions he needed to take in the event that he was actively suicidal. At the time he consulted with his general practitioner, Mr S indicated he had no suicide plan and was not actively suicidal, although he was experiencing occasional suicidal thoughts.

The next day Mr S was taken to the Royal Hobart Hospital by his partner at his own request. In the Department of Emergency Medicine he was triaged and assessed by a medical practitioner. The notes of that medical practitioner indicate that there was sufficient evidence for there to be real concerns about Mr S's safety. He was admitted to the Royal Hobart Hospital, but due to a shortage of beds in the mental health unit of the hospital, he was required to spend the evening in the Department of Emergency Medicine. In addition to the medications prescribed by his general practitioner, diazepam was provided to Mr S.

The next day at about 9.30am, Mr S was assessed by a psychiatrist. It was noted that he was a moderate suicide risk, and that he was to be admitted properly to the Royal Hobart Hospital. The psychiatrist, after discussion between Mr S and his partner, allowed Mr S to return home with his partner so he could shower and prepare some clothes, then return to the hospital by 4.00pm that day. The request came from Mr S and his partner, and was agreed to by the psychiatrist. A consideration was, it would appear, that the Department of Emergency Medicine is an inappropriate environment for a depressed or anxious patient (such as Mr S). Arrangements were made for the psychiatrist to review Mr S the following day.

After Mr S and his partner returned home, the evidence is that while his partner was in the shower Mr S walked away from their home and made his way to nearby bushland. There, very sadly, he took his own life. His body was located the next day by police using a scent dog. It was clear that he was deceased, and no efforts of first aid were carried out. The lividity described as being present on the lower parts of Mr S's body together with the fact that his body was cold and exhibiting signs of *rigor mortis* all indicate that he had been deceased for an extended period of time.

All of these factors lead me to conclude that Mr S took his own life shortly after he walked away from his home the previous morning.

The results of the autopsy and toxicological analysis showed no signs of alcohol or drugs being present in Mr S's body at the time of his death. The forensic pathologist who conducted the autopsy, Dr Donald McGillivray Ritchey, expressed the opinion that the cause of Mr S's death was asphyxia. I accept this opinion.

It is clear that Mr S was suffering from mental illness at the time of his death. Had sufficient beds been available in the mental health ward of the Royal Hobart Hospital then doubtless he would have been admitted and it is likely that he would not have taken his life. Self-evidently the Department of Emergency Medicine at the Royal Hobart Hospital is no place for anyone suffering from depression, anxiety, suicidal ideation and indeed any mental health issue.

**Comments and Recommendations**

I comment that it is a matter of real concern that, at the time of Mr S's death, insufficient beds were available in the mental health ward at the Royal Hobart Hospital.

I convey my sincere condolences to Mr S's family and loved ones on their very sad loss.

**Dated** 21 November 2016 at Hobart in the State of Tasmania.

**Simon Cooper**
**Coroner**

# Strategies to Improve Bed Flow across Mental Health Services

| Strategy | Description | Responsible | Timeframe | Desired Outcomes |
|---|---|---|---|---|
| Strategy 1<br>Direct Admissions to the Department of Psychiatry | Increase the number of direct admissions to the Department of Psychiatry (DoP). This will include broadening the scope of the existing procedure to incorporate all consumers who do not require the specific interventions of the ED | Deb Solomon<br>Len Lambeth<br>Barry Nicholson | 30/05/2017 | *Increasing direct admissions swill reduce the need for patients to be admitted to DoP via the Emergency Department (ED). This strategy will reduce the numbers of mental health presentations to ED.* |
| Strategy 2<br>Renew formal Memorandum of Understanding (MoU) with The Hobart Clinic | Renew previous MoU with The Hobart Clinic (THC) to support office hours and after hours' transfer of appropriate clients from DoP to THC as / when required. Important that the medical / consultant support of former DoP clients at THC is clarified as part of this process. | Marni Lucas<br>Chris Fox | ASAP | *Re-establishing the MoU with The Hobart Clinic will provide another option for clients on discharge from the DoP. This should help to improve patient flow through DoP (subject to available beds at The Hobart Clinic).* |
| Strategy 3<br>Improve client transfers between the three specialist acute inpatient mental health services. | Revamp relevant procedures to support timely transfer of DoP clients to Northside and the Spencer Clinic when required. (This may be incorporated into the MHSS Consumer Transfer of Care Procedure). | Kathy Gregory | ASAP | *Improved transfer procedures will improve the timely discharge of clients from DoP to Northside or Spencer Clinic (when clinically appropriate).* |

| Strategy | Description | Responsible | Timeframe | Desired Outcomes |
|---|---|---|---|---|
| Strategy 4<br>Mistral Place to become a step-down facility. | Mistral Place to become a step-down facility with all 10 beds filled via clients transferring in from DoP (this to be implemented in conjunction with strategy 5 below).<br>Consultant and Registrar support to be provided via DoP who will assume overall clinical governance.<br>Operational management to continue via CMHADS until the new statewide structure is in place<br>Funding for an additional Registrar position to cover Mistral<br>Place and Tolosa Street will be included in business case | Len Lambeth<br>Barry Nicholson<br>Peter Baker<br>Chris Fox | ASAP | *Increased number of step down beds in close proximity to DoP will improve patient flow and provide greater flexibility in managing beds across DoP and Mistral Place.* |
| Strategy 5<br>Tolosa Street respite beds to be converted to step-up beds. | Existing community step-up beds at Mistral Place to transfer to Tolosa Street Respite facility (increasing number of available beds to six (this to be implemented in conjunction with strategy 4 above).<br>Consultant and Registrar support for this facility to also transfer from Mistral to Tolosa Street.<br>Additional staffing and resource implications to be quantified and sourced (to be included in business case). | Len Lambeth<br>Chris Fox<br>Peter Baker | ASAP | *This strategy essentially increases the number of step-up beds from five (currently in Mistral; Place) to six. One of the main objectives for a step-up model of service is to avoid admission to an inpatient mental health facility. Additional step-up beds will reduce the pressure on DoP.* |

| Strategy | Description | Responsible | Timeframe | Desired Outcomes |
|---|---|---|---|---|
| Strategy 6<br>Collect and analyze respite utilization data. | Data set specific to existing Tolosa Street Respite facility to be produced and analyzed to determine usage patterns and ongoing need.<br>Outcomes of this analysis will inform discussions with relevant community sector organisations if there is an ongoing need for specific respite service provision. | Peter Baker<br>Mark Frohmader<br>Chris Fox<br>Directorate | ASAP | *This data will inform any decisions in relation to the future provision of respite services.* |
| Strategy 7<br>Commencement of registrar for Millbrook Rise and Tolosa Street sites. | Residential rehabilitation registrar to commence operation across Millbrook Rise and Tolosa Street Residential Rehabilitation facility sites, with overall clinical governance and supervision via Dr Milford McArthur. | Milf McArthur<br>Peter Baker<br>Tom O'Brien<br>Barry Nicholson<br>Chris Fox | August 2017 | *Increase medical support for clients across residential services.* |
| Strategy 8<br>Review medical requirements across Mental Health Services South | Review of ongoing adult mental health services medical resource requirements across Mental Health Services South, with a particular focus on DoP, Mistral Place, Millbrook Rise Centre and Tolosa Street. | Statewide Clinical Director<br>Statewide Specialty Clinical Director, Adult Mental Health Services | By 31 Dec 2017 | *A review will ensure that medical resources are utilised efficiently and effectively across services.* |

| Strategy | Description | Responsible | Timeframe | Desired Outcomes |
|---|---|---|---|---|
| Strategy 9<br>Mental Health Homeless Forum | Schedule a meeting of all relevant providers of accommodation services or homeless services for people with a mental illness in the South. The forum will aim to discuss and review current processes and identify potential improvements that might improve access for individuals with serious mental illness | Mark Frohmader<br>Marni Lucas | ASAP | *The Forum will provide an opportunity to discuss the current issues for mental health clients accessing accommodation services. Will also allow for some discussion around potential solutions which may assist in improving access for clients.* |
| Strategy 10<br>Establish a protocol to manage the discharge of clients who have no fixed abode. | Develop a protocol to support discharge of clients from DoP without a clearly identified ongoing accommodation option. Discharge will be to short term accommodation options. This will need to include significant communication and consultation as it represents a significant change in service philosophy | Len Lambeth<br>Barry Nicholson | ASAP | *Change in protocol will allow patients who have no fixed abode to be discharged from DoP to short term accommodation options when options for longer term accommodation options have been explored with the patient and exhausted.* |
| Strategy 11<br>Utilisation of Patient Flow Manager across Mental Health Services. | Arrange for relevant Managers to have access to Patient Flow Manager to monitor mental health patients (in DoP and ED).<br>Extend Patient Flow Manager to incorporate Mistral Place, Tolosa and Millbrook Rise. | Adie Gibbons<br>Barry Nicholson<br>Chris Fox | 30/05/2017 | *Access to real time information in relation to bed utilization across services will improve patient flow.* |

| Strategy | Description | Responsible | Timeframe | Desired Outcomes |
|---|---|---|---|---|
| Strategy 12<br>Draft a business case to fund an additional 5-8 mental health beds in the South. | Business care to be developed to increase mental health beds in the South. This will build on initial work that was undertaken early in 2017 to provide an additional 8 beds. | Mark Frohmader<br>Barry Nicholson<br>Chris Fox | By June 2017 | *Securing funding for additional beds in the South will provide increase flexibility for clients and will improve patient flow through DoP.* |
| Strategy 13<br>Ensure the timely transfer of clients between individual Mental Health Services. | The transfer of clients (particularly from and to acute inpatient mental health services) should occur in a timely manner. All MH Inpatient units will accept transfers from other MH Inpatient units 24 hours 7 days. Admission Policies to be updated to reflect | Chris Fox | 30/05/2017 | *All inpatient units will admit transferred patients 24 hors 7 days which will increase ability to transfer out of DoP* |

Statewide Mental Health Services

# Mental Health Services

## A Plan to Deliver Improved Patient Flow

2017-2019

# Contents

# Introduction

The current service configuration and clinical governance arrangements across all Adult Inpatient Mental Health Units have been in place for the past ten years.

During this period there have been a number of changes and reforms to individual services, including the introduction of community step-up capacity to Mistral Place, a reduction in the number of available acute inpatient beds within the Royal Hobart Hospital (RHH), the transition of the acute inpatient service to a new temporary facility and the addition of a Psychiatric Registrar resource to the Millbrook Rise Centre site.

Based on analysis of available data, there has also been a continuing increase in both the demand for service and client complexity over this time.

This is reflected in a number of ways including:

- An increase in the occurrence of bed-block both within the RHH and across the broader system;
- A growing number of clients in all units with extended lengths of stay; and
- A recent significant increase in the number of presentations of clients who are homeless.

These issues have been compounded by:

- Inequitable medical resource allocation across services;
- Separate clinical governance and operational management structures across Adult Mental Health Services; and
- Issues with patient flow between individual services, particularly after hours.

This plan identifies a number of strategies (short term, medium term and long term) which will improve patient flow across the statewide mental health service system.

# Short Term Strategies

The following section identifies strategies which can improve care for clients and ensure a more effective and efficient use of current resources within Mental Health Services. The majority of these strategies have little resource implications and can be implemented relatively quickly (over the next three months).

***Strategy 1:*** ***Improve communication across the Emergency Department, Department of Psychiatry and other Mental Health Services.***

*Strategy 1.1* *Ensure relevant stakeholders have the Mental Health Services on-call mobile phone number to ensure options for client transfers can be considered and enacted where appropriate.*

*Strategy 1.2* *Establish a formal email which can be sent from the Department of Psychiatry to relevant stakeholders when the service is operating at full capacity with no opportunity to manage additional patients.*

*Strategy 1.3* *The Department of Psychiatry are now included on Patient Flow Manager. Ensure that an estimated discharge date is documented*

*for all patients. Ensure that relevant managers across Statewide Mental Health Service have access to that information.*

*Strategy 1.4* *Include other Mental Health Services on Patient Flow Manager (including Mistral, Tolosa, Millbrook Rise and Roy Fagan).*

In recent times there have been there have been a significant number of patients with a mental health issue who wait for extended periods in the Emergency Department for a bed to become available within the Department of Psychiatry. In recent months it has not been uncommon for three or more patients to wait in the Emergency Department in excess of 12hrs until a bed becomes available. This pressure typically occurs outside of business hours (eg overnight and during the weekends).

On some of these occasions, there have been available beds within other public Mental Health Services which could have been utilised to make a bed(s) available at the Department of Psychiatry. Improvements in communication across the Emergency Department, Department of Psychiatry and other public Mental Health Services will help to ensure that all possible options to transfer clients is explored (especially when the issue arises outside of normal business hours).

| | |
|---|---|
| Responsible: | Chris Fox, Barry Nicholson, Relevant Service Managers |
| Timeframe: | ASAP |
| Resource Implications: | Nil |
| Desired Outcome: | *Improving communication and access to up to date information will assist clinicians to identify possible options to alleviate pressure on the Department of Psychiatry (and the Emergency Department).* |
| Progress: | Mental Health on-call contact details provided to relevant staff.<br>Email developed to use when the Department of Psychiatry is approaching or has reached bed block.<br>Department of Psychiatry included on Patient Flow Manager. |

## *Strategy 2: Direct admissions to the Department of Psychiatry, Northside and Spencer Clinic*

Currently many admissions to the mental health inpatient units are made via the Emergency Department of the local Hospital. Unless there is an obvious medical problem or a specific reason for requiring ED care (e.g. post overdose, post self harm requiring medical attention) clients should be directly admitted to the mental health inpatient unit, thus avoiding the need for an Emergency Department admission.

This strategy would increase the number of direct admissions to the mental health inpatient units. This will need to include broadening the scope of the existing procedure.

| | |
|---|---|
| Responsible: | Chris Fox, Len Lambeth, Barry Nicholson, Deb Solomon, Franco Giarraputo, Chris Wareing, Susan Crave, Andrew Adam, Jan Dorman, Jean Burrows |
| Timeframe: | ASAP |
| Resource Implications: | Nil |
| Desired Outcome: | *Increasing direct admissions should reduce the need for patients to be admitted to the Department of Psychiatry (DoP), Northside or Spencer Clinic via the respective Emergency Departments (ED). This strategy will reduce the numbers of mental health presentations to ED who require admission to a mental health acuter inpatient service.* |
| Progress: | Initial meeting to discuss with Senior Managers occurred on 8 May – further meeting with medical staff and other key staff to be held on 24 May 2017.<br><br>New process advised to all staff. Some concerns have been raised in relation to direct admissions for unknown clients – this will require further discussions with staff to address concerns – email sent from Chris Fox on 22 June 2017 to address the issues raised. |

## *Strategy 3: Reconfiguration of existing services.*

*Strategy 3.1* *Reconfigure Tolosa Street respite beds to become step-up beds (providing a total of 6 rehabilitation beds and 6 step-up beds).*

*Strategy 3.2* *Reconfigure Mistral Place to become a sub-acute step-down facility (providing a total of 10 step-down beds).*

This strategy will provide an opportunity to reconfigure the models of care at both Tolosa Street and Mistral Place.

The existing community step-up beds at Mistral Place will be transferred to the Tolosa Street facility (increasing the number of available step –up beds from 5 to six – providing a total of 6 step-up beds and 6 rehabilitation beds at the facility). Consultant and Registrar support for this facility to also transfer from Mistral to Tolosa Street.

This will allow for Mistral Place to become a sub-acute step-down facility with all 10 beds filled via clients transferring in from the Department of Psychiatry. Consultant and Registrar support to be provided via the Department of Psychiatry who will assume overall clinical governance.

This strategy will require extensive consultation and revised models of care for Mistral Place and Tolosa Street services.

| | |
|---|---|
| Responsible: | Len Lambeth, Barry Nicholson, Chris Fox, Peter Baker |
| Timeframe: | 3 months |
| Resource Implications: | There will be additional staffing and resource implications associated with this strategy. |
| Desired Outcome: | *Mistral Place established as a 10 bed sub-acute step-down facility and Tolosa Street to be established as 6 bed step-up and 6 bed rehabilitation facility.* |
| Progress: | Funding to progress this initiative was provided in the 2017/18 State Budget.<br>Change proposal has been drafted and will be circulated for consultation (around the week of 26 June 2017). |

## *Strategy 4: Increase the capacity to manage demand*

*Strategy 4.1* *Allocate one-off unspent Rethink Mental Health funding to increase the number of packages of care provided by the community sector.*

*Strategy 4.2* *Allocate one-off unspent Rethink Mental Health funding to provide community based 24/7 respite beds.*

| | |
|---|---|
| Responsible: | Mental Health and Alcohol and Drug Directorate |
| Timeframe: | 3 months |
| Resource Implications: | The delays in implementing some strategies associated with the Rethink Mental Health Plan have resulted in some unspent funding. A request will be made to utilise this funding (on a one-off basis) to provide additional packages of care and to fund respite beds in the community sector. |
| Desired Outcome: | *This will provide greater flexibility for patient flow across the service system. Establishing respite beds in the community sector will support the reconfiguration of the Tolosa Street site.* |
| Progress: | Initial meeting with the Directorate has discussed options in relation to this strategy.<br>Advice received from the Directorate on 20 June 2017 that one off funding is available to use for this purpose |

## *Strategy 5: Renew Memorandum of Understanding with The Hobart Clinic*

In previous years, Mental Health Services has had a formal memorandum of understanding (MoU) with The Hobart Clinic. The MoU provided an opportunity for Mental Health Services to purchase beds from The Hobart Clinic at an agreed daily cost as required (and when beds were available).

This strategy will see a renewed MoU with The Hobart Clinic (THC) to support office hours and after hours' transfer of appropriate clients from the Department of Psychiatry to The Hobart Clinic as and when required. It will be important that the medical/consultant support of former Department of Psychiatry clients at The Hobart Clinic is clarified as part of this process.

| | |
|---|---|
| Responsible: | Chris Fox, Marni Lucas, Priscilla Kelly |
| Timeframe: | ASAP |
| Resource Implications: | Costs will be negotiated as part of the MoU. |
| Desired Outcome: | *Re-establishing the MoU with The Hobart Clinic will provide an alternative option for clients referred to or discharged from the Department of Psychiatry. This should help to improve patient flow through the Department of Psychiatry (subject to available beds at The Hobart Clinic).* |
| Progress: | Initial discussions with The Hobart Clinic have occurred who have indicated a desire to renew the MoU.<br><br>Draft contract has been developed and is being considered by The Hobart Clinic.<br><br>Contact has also been made with St Helens Hospital who have also indicated that they would be prepared to enter a similar arrangement – a draft MoU has been forwarded to St Helens for their consideration. |

## *Strategy 6: Improve client transfers between specialist Mental Health Services.*

*Strategy 6.1* *Client transfers between specialist acute inpatient Mental Health Services*

*Strategy 6.2* *Ensure the timely transfer of clients between individual Mental Health Services can occur at any time.*

This strategy aims to improve client transfers between specialist mental health services across the State. This includes transfer of clients between the three acute inpatient services of the Department of Psychiatry, Northside and Spencer Clinic. The strategy also aims to ensure that client transfers can occur at any time of the day, seven days per week.

This strategy will require amendments to relevant procedures to support the timely transfer of patients between the Department of Psychiatry, Northside and the Spencer Clinic when required. (This may be incorporated into the MHSS Consumer Transfer of Care Procedure).

| | |
|---|---|
| Responsible: | Kathy Gregory, Clinical Practice and Performance Committee, Relevant Clinical Specialty Groups |
| Timeframe: | ASAP |
| Resource Implications: | Nil |
| Desired Outcome: | *Improved transfer procedures will improve the timely transfer of clients between the Department of Psychiatry, Northside and Spencer Clinic.* |
| Progress: | Work has commenced on draft procedures for transfer of clients. The process of transferring clients between the three specialist acute mental health inpatient units already occurs in practice.<br><br>A quick reference guide has been developed for transferring clients between ED, Acute Inpatient Mental Health Services and other services. This is currently being finalized before it is distributed more broadly. |

## *Strategy 7: Commencement of registrar for Millbrook Rise and Tolosa Street sites.*

This strategy will see the commencement of a residential rehabilitation registrar to operate across Millbrook Rise and Tolosa Street sites, with overall clinical governance and supervision via Dr Milford McArthur.

| | |
|---|---|
| Responsible: | Milf McArthur, Peter Baker, Tom O'Brien, Barry Nicholson, Chris Fox |
| Timeframe: | By end of August 2017 |
| Resource Implications: | Nil (position already funded) |
| Desired Outcome: | *Increase medical support for clients across residential services.* |
| Progress: | Registrar is due to commence on 1 August 2017. |

## *Strategy 8: Managing patients who are homeless.*

*Strategy 8.1* *Conduct a homeless forum with relevant stakeholders.*

*Strategy 8.2* *Develop a protocol to manage the discharge of clients who have no fixed abode.*

In recent times there has been a significant number of clients presenting to Mental Health Services who have no fixed abode. As many as six homeless clients have been patients of the Department of Psychiatry at any one time. This is similar in Mistral Place where up to half the beds have been occupied by patients who have no fixed abode and are therefore not discharged from the service.

These strategies aim to identify what barriers currently exist for clients when they try to access an accommodation service. The forum will provide an opportunity to identify and resolve issues for our client group.

The establishment of a specific protocol to manage the discharge of clients who have no fixed abode will help to provide some clarity for clinicians and allow for the discharge of clients who would normally remain with the service when an agreed accommodation option is secured.

| | |
|---|---|
| Responsible: | Mark Frohmader, Marni Lucas, Barry Nicholson, Chris Fox, Len Lambeth |
| Timeframe: | By end of August 2017 |
| Resource Implications: | Nil |
| Desired Outcome: | *The Forum will provide an opportunity to discuss the current issues for mental health clients accessing accommodation services. Will also allow for some discussion around potential solutions which may assist in improving access for clients.*<br><br>*Change in protocol may allow patients who have no fixed abode to be discharged from the Department of Psychiatry to short term accommodation options when options for longer term accommodation options have been explored with the patient and exhausted.* |
| Progress: | Work has commenced on identifying stakeholders and gathering relevant statistical data which will help inform any discussions.<br><br>An initial forum was established but was postponed until some decisions were made in relation to the availability of additional resources. Forum will be undertaken during July/August. |

## *Strategy 9: Improved integration with Alcohol and Drug Services to improve outcomes for clients with comorbidities.*

Recent advice from the Department of Psychiatry indicates that there is a cohort of patients who have co-existing alcohol and drug issues. There is no specialist alcohol and drug support offered to patients whilst they are in the Department of Psychiatry. These AoD issues can impact on a patient's mental health which may result in an extended length of stay within the Department of Psychiatry.

This strategy will increase the capacity of the Alcohol and Drug Service to provide support to patients in the Department of Psychiatry by building on the current consultation liaison service which is located at the Royal Hobart Hospital. It is suggested that the current service would need to be bolstered with additional specialist nursing and allied health resources, with specialist medical input coming from the existing medical specialists within the Alcohol and Drug Service.

| | |
|---|---|
| Responsible: | Chris Fox, Adrian Reynolds |
| Timeframe: | 3-6 months |
| Resource Implications: | To fully implement an effective strategy there will be a requirement for additional resources to support this strategy (nursing and allied health). These are yet to be quantified. |
| Desired Outcome: | *Improved outcomes for patients with alcohol and drug issues. Reduced lengths of stay within the Department of Psychiatry.* |
| Progress: | A ADS planning day occurred on 16 June 2017 where a range of service initiatives were discussed and prioritised. The need for increased consultation liaison services is a high priority. |

# Medium Term Strategies

The following section identifies strategies which will provide increased capacity of the service system to support additional clients. These strategies will have resource implications and will require more detailed financial analysis if they are supported. It is anticipated that these strategies could be implemented over the next 6-12 month.

## *Strategy 1: Introduction of a Consultation Liaison Registered Nurse at Launceston General Hospital.*

There is currently no Psychiatric Emergency Nurse (PEN) service at Launceston General Hospital (LGH). The Crisis Assessment Team in the North currently provides assessments for patients admitted to ED with a mental health issue. It is proposed that a new role be established, the Consultation Liaison Registered Nurse, which in addition to providing the PEN role will also provide support, training and education to general wards within LGH, in relation to mental health, as part of the current Consultation Liaison Team.

The CLRN role will also provide assistance to the Patient Flow Coordinators to improve patient flow into Northside.

| | |
|---|---|
| Responsible: | Susan Crave, Jan Dorman, LGH ED NUM |
| Timeframe: | 6 months |
| Resource Implications: | A business case will need to identify the resource implications for this strategy. |
| Desired Outcome: | *Introduction of the CLRN role will facilitate more timely assessment of patients admitted to ED with mental health issues, and will improve the timely transfer of clients between the Emergency Department and Northside.* |
| Progress: | Work has commenced on draft Statement of Duties. Meetings with CATT staff, ED staff and Unions are occurring. |

## *Strategy 2: Introduce a process that allows admission to Northside by Specialist Emergency Physicians.*

In order to allow direct admissions to Northside, Medical Officers within the ED will be trained to become Authorised Medical Practitioners under the Mental Health Act 2013, allowing them to utilise "Urgent Circumstances" to admit patients to Northside. The CLRN role will support the ED MO in the assessment of mental health issues.

| | |
|---|---|
| Responsible: | Susan Crave, Medical Director ED |
| Timeframe: | 6 months |
| Resource Implications: | Nil |
| Desired Outcome: | *Direct admissions by the ED MO will reduce the time from decision to admit to admission*<br>*ED Registrars will have effective training in mental health triage and the Mental Health Act* |
| Progress: | Initial meeting with Medical Director ED has occurred. |

## *Strategy 3: Provision of Respite Services.*

*Strategy 3.1 Collect and analyse respite utilization data.*

*Strategy 3.2 Establish permanent respite capacity within the community sector.*

Currently respite services (both emergency and planned) are provided by the public Mental health Service at its facility at Tolosa Street. The facility currently has six beds allocated for the purposes of providing respite. The provision of respite services may be better provided by the community sector as there can be greater flexibility in the delivery of services.

To inform the discussion there is a need to collect and analyse respite utilization data for the existing Tolosa Street Respite facility. This will help to determine usage patterns and will provide an indication for the ongoing need for respite services (both planned and emergency). Outcomes of this analysis will help inform discussions with relevant community sector organisations for the need and level of specific respite service provision.

The provision of respite services can be efficiently and effectively managed by the community sector. Essentially this strategy would see the future provision of respite services provided by the community sector (at a level to be determined). This would allow the Tolosa Street beds to be utilised as step-up beds.

| | |
|---|---|
| Responsible: | Peter Baker, Len Lambeth, Chris Fox, Mark Frohmader |
| Timeframe: | 6-12 months |
| Resource Implications: | It is anticipated that the need for respite services (planned and emergency) could be managed by funding two or four beds within a community sector organisation. . A business case will need to identify the resource implications for this strategy. |
| Desired Outcome: | *Establish a two or four bed mental health respite service in the community sector.* |
| Progress: | Change proposal has been drafted in relation to the change in service for Tolosa Street. |

## *Strategy 4: Establishment of a Mental Health Hospital in the Home Team.*

This strategy will provide a Mental Health Hospital in the Home Team in the South to care for patients in their home either as a hospital avoidance program or after discharge from the acute inpatient service.

The patients supported by the team would include those who would normally be admitted to the acute inpatient services but are assessed as well enough to go home but not well enough to use the ordinary support services available in the community. Patients of the acute inpatient service who require a level of support in their own homes to be discharged would also be clients of this team.

| | |
|---|---|
| Responsible: | Len Lambeth, Chris Fox |
| Timeframe: | 6 months |
| Resource Implications: | There will be significant resource implications associated with this strategy. |
| Desired Outcome: | *Greater numbers of clients supported in the community and less reliance on acute inpatient services.* . A business case will need to identify the resource implications for this strategy. |
| Progress: | Work has commenced on developing a business case to secure funding for this initiative. If successful there will be significant consultation with relevant stakeholders to assist in establishing a model of care prior to establishing the service. |

## *Strategy 5: Review of Medical Requirements.*

This strategy will see a review of ongoing adult mental health services medical resource requirements across Mental Health Services South, with a particular focus on DoP, Mistral Place, Millbrook Rise Centre and Tolosa Street (this may be incorporated into the broader Statewide Medical Workforce Review undertaken by the Executive Director of the Medical Profession).

| | |
|---|---|
| Responsible: | Statewide Clinical Director |
| Timeframe: | 6 months |
| Resource Implications: | Unknown |
| Desired Outcome: | *Improved access to medical support and more effective and efficient usage of medical resources across Mental Health Services.* |
| Progress: | Statewide Medical Workforce Review has been announced. Initial meeting with the Executive Director of Medical Profession, THS has been held. SMHS is pulling together a range of information to support the review. |

## *Strategy 6: Establish a General Practice Consultation Liaison Support Service.*

The establishment of this service would allow for regular consultative activities between general practitioners and specialist mental health workers. The specialist mental health workers may provide some direct clinical services with the main aim of providing guidance to the general practitioner.

This strategy would see designated positions established to assist general practitioners with communication and access to mental health services for their patients, as well as advice and support on clinical matters. Support would also be available for general practitioners when clients are being referred from specialist mental health services back to a general practitioner.

It is suggested that a team be established to support general practitioners in the South of the State and another team to support general practitioners across the North and North West of the State. Each team would consist of five specialist mental health nurses with additional support from 0.5 medical specialist.

| | |
|---|---|
| Responsible: | Len Lambeth, Chris Fox, Vicki Polanowski, Directorate |
| Timeframe: | 6-12 months |
| Resource Implications: | This strategy will require additional resources to establish a team in the South and a team for the North and North West. A business case will need to identify the resource implications for this strategy. |
| Desired Outcome: | *Improved support for general practitioners to maintain their patients who have a mental illness in their own community. Reduced pressure on specialist mental health services (including residential and acute inpatient services).* |
| Progress: | Not yet commenced.<br>A business case will be required to seek additional resources to progress this strategy. |

## *Strategy 7: Establishment of a 4 bed Observation Unit within the Emergency Department for Patients with a Mental Health Illness.*

Currently more than 80% of admissions to the Department of Psychiatry are made via the Emergency Department of the Royal Hobart Hospital. When there are no available beds within the Department of Psychiatry, patients can remain in the Emergency Department for extended periods of time. In some cases, when these patients are reviewed, they are discharged from the Emergency Department without the need for admission to the acute inpatient mental health facility. Additionally, it is clear that patients in a psychiatric crisis have worsened outcomes with increased stays within an Emergency Department.

The establishment of a 4 bed observation unit within the Emergency Department (or within close proximity) will improve outcomes for patients and help to alleviate the current "bed block" within the Emergency Department. The observation unit will provide psychiatric patients a quiet environment separate from the chaotic environment of the Emergency Department. The Unit will be staffed by Mental Health Professionals, allowing for ongoing assessment of each patient with regard for need for admission or referral to CSO/Community MHS for intensive support.

| | |
|---|---|
| Responsible: | Len Lambeth, Barry Nicholson, Chris Fox |
| Timeframe: | 6-12 months |
| Resource Implications: | This strategy will require additional specialist mental health staffing to monitor patients who utilise the observation unit. This could be achieved by increasing the capacity of the PEN service (costs yet to be determined) with additional nursing and medical support. A business case will need to identify the resource implications for this strategy. |
| Desired Outcome: | *Improved clinical outcomes for patients.*<br>*Reduced bed block on the Emergency Department.* |
| Progress: | Initial discussions have taken place – the major issue will be identifying an appropriate space.<br>Given the pressures on RHH ED, a business case has already been developed and forwarded to the COO and CFO for consideration.<br>If approved, consultation will take place with relevant stakeholders to develop a model of care and establish the service. |

## *Strategy 3: Review the Model of Care for Adult Community Mental Health Services and the Crisis Assessment Treatment Teams.*

One of the reform directions under the Rethink Plan is to re orientate the mental health system are contemporary mental health practice to increase community support and reduce reliance on hospital based mental health services. In order to achieve this a full review of current community mental health services is required to review models of care, activity, focus of care and staffing resources to better address current needs.

The Rethink Plan also includes an action to review the role of the Mental Health Helpline. The Mental Health Drug and Alcohol Directorate are in the process of instigating an external review of the Helpline, this review will also investigate the current model of care and function of the Crisis and Assessment Teams, to ensure the model of care meets consumer and community need.

| | |
|---|---|
| Responsible: | Mental Health And Alcohol and Drug Directorate, External review team, representative Senior staff and Dr's |
| Timeframe: | 6-12 months |
| Resource Implications: | TBA |
| Desired Outcome: | *A community mental health service model of care that prioritising hospital avoidance and that is resourced to provide intensive community support*<br>*A Helpline that meets the needs of all community users* |
| Progress: | Not yet commenced |

# Long Term Strategies

The following section identifies strategies which will improve the effectiveness and efficiency of the service system across the State. These strategies will have significant reform implications for the government and the community sectors. It is anticipated that these strategies could be implemented over the next 12-36 month.

## *Strategy 1: Increased bed numbers at the Tolosa Street facility.*

This strategy is aimed at increasing the number of rehabilitation beds at the Tolosa Street site which will provide improved access to accommodation services for clients and enable greater flexibility for patient flow. The strategy will see the construction of additional eight beds on the Tolosa Street site. This strategy will have resource implications in relation to capital costs and staffing costs.

| | |
|---|---|
| Responsible: | Chris Fox |
| Timeframe: | 18-36 months |
| Resource Implications: | The resource implications associated with this strategy would be significant. A business case will need to identify the resource implications for this strategy. |
| Desired Outcome: | *Additional eight beds across the service system.* |
| Progress: | Not yet commenced. |