340 INPATIENT ACCOMMODATION UNIT

INDEX

INTRODUCTION

Preamble

340 .1.00 This Facility Planning Guideline supports the provision of optimal environments for care of patients. It accommodates requirements for assessment and treatment, and offers flexibility of space provision to respond to changing practices in health service delivery.

Inpatient settings must be flexible and optimally therapeutic to provide a setting that will enhance the individual's capacity for recovery. Providing natural light and pleasant, relaxing surroundings help to create a positive environment, which can assist the delivery of health care services.

A pleasant and high quality physical environment in which care is to be provided will indicate:

+ The patient is valued and respected;

+ The facility is able to provide the appropriate level of care;

+ Recognition of the positive contribution such environments can make in facilitating recovery and decreasing length of stay;

+ That the staff who provide care are valued, skilled and supported to achieve optimal care of the patient in a safe and rewarding working environment.

Such environments contribute to better patient outcomes and better staff conditions and satisfaction.

Patterns of care frequently change, as do the needs of the populations served. Thus it is critical that physical environments are also flexible and can adapt over time in response to changes in practice and treatment.

Introduction

340 .2.00 This Guideline outlines the specific requirements for the planning of an Inpatient Unit. It must be read in conjunction with generic requirements and Standard Components, which are described in Parts A, B, C, and D of these Guidelines. Inpatient facilities with special needs eg Maternity, Paediatrics, Rehabilitation are covered in separate Guidelines.

Policy Statement

340 .3.00 NSW HEALTH POLICIES

NSW Health's policies for the provision of healthcare services are underpinned by the following foundations:

+ Development of appropriate service models to ensure a comprehensive service network throughout the State;

+ Deployment of resources in a fair and cost effective manner to optimise the health outcomes for service delivery;

+ Development and support for enhanced information systems to monitor, plan and evaluate healthcare services.

The policy framework recognises the multiplicity of our community and the fact that special groups within that community require specific consideration to meet their needs and to enhance the effectiveness of any services provided. These groups include:

+ Aboriginal people;

+ People with physical and sensory disabilities;

+ People from culturally and linguistically diverse backgrounds;

+ The elderly;

+ Children.

Description

340 .4.00 DEFINITION OF MEDICAL/SURGICAL INPATIENT UNIT

Medical/Surgical Inpatient accommodation is for general medical and surgical patients.

In larger Health Care Facilities, this unit includes specialist medical and surgical patients, for example - cardiac, neurology/neurosurgery, infectious diseases, integrated palliative care.

In smaller hospitals - it may also accommodate paediatric, palliative care and obstetric patients.

Patients awaiting placement elsewhere may also be accommodated in this type of facility.

General

340 .5.00 FUNCTION

The Inpatient Unit is the basic nursing unit of a hospital. Its prime function is to provide suitable accommodation for the diagnosis, care and treatment of inpatients. Whilst facilitating the delivery of healthcare services to patients, the Unit must also provide facilities and conditions to meet the working needs of staff.

340 .6.00 POPULATION PROFILE

The population of an Inpatient Unit comprises of:

+ Staff including students and volunteers;

+ Patients;

+ Visitors including relatives and other carers.

There are two main groups of staff:

+ Unit-based staff who primarily provide continuous care to inpatients;

+ Visiting staff who provide periodic or specialist care to inpatients, or support services to the Unit.

The Unit patient population may range from the young to the elderly, comprise a variety of medical and surgical conditions, and come from a number of different ethnic and cultural backgrounds. The diversity of patient needs must be identified during the briefing stages, and the facility must be designed with the flexibility to meet current and future needs.

A consumer consultation process will assist in ensuring the service to be provided meets realistic consumer expectations.

Visitors are primarily carers and colleagues of inpatients.

Operational Models

340 .7.00 HOURS OF OPERATION

It is assumed that the Unit will operate 24 hours per day, 7 days per week. This may vary for individual facilities.

340 .8.00 OPERATIONAL CHANGE

The organisation, delivery and practice of bedside care is continually changing. New technologies have resulted in an inpatient population that has reduced lengths of stay, increased interventions and a higher dependence on medical services and staff.

An emphasis on the efficient use of resources has led to maximising utilisation of inpatient accommodation as well as diagnostic and therapeutic facilities.

Organisational change has resulted in new structures and practices such as flat management structures, multi-disciplinary teams, care groups and multi-skilling.

The use of computerised systems reduces the need for personal interaction between staff, proximity to specialised inputs and quantity of paper records.

At the same time, the public have increased expectations about the quality and delivery of services.

340 .9.00 MODELS OF CARE

Service demand and the organisation of the delivery of care are important in determining the nature and design of a facility. Different models of organising patient care continue to be developed.

Models of care and flexibility for services to be provided in the future should be defined in the process of Service Planning and the development of Operational Policies, and must be considered throughout the design process.

The physical environment should permit, not restrict the implementation of a range of models of care.

340 .10.00 LEVELS OF CARE

An Inpatient Unit may deliver the following levels of care:

+ High Dependency Nursing Care;

+ Intermediate Nursing Care;

+ Supported / Self Care.

The Unit should be flexible enough to accommodate differing patient mixes as well as different models of care.

340 .11.00 BED CONFIGURATION

Ward design should address the following bed configuration issues:

+ Enabling flexibility in bed usage and implementation of swing beds;

+ Enabling wards to be condensed during periods of low occupancy to reduce pressure on recurrent costs;

+ Clustering beds to facilitate meal relief, back-up staff assistance on routine or emergency basis and optimise patient supervision by lower numbers of staff particularly at night;

+ Incorporating identical ward design in large centres, modified only where necessary on clinical grounds;

+ Deciding how observation versus privacy and public expectations affects the choice of one, two or four bed rooms.

Operational Policies

340 .12.00 GENERAL

Operational Policies will vary from Unit to Unit depending on a wide range of factors. Users must define their own Operational Policies. Refer to Part B of these Guidelines for a general discussion on Operational Policies.

Policies that may have a significant impact on the planning of an Inpatient Unit include:

+ Admissions procedures;

+ The manner in which food, linen and supplies are ordered, supplied and stored;

+ Medical records management;

+ Staffing profile.

Staffing

340 .13.00 Staffing levels will vary for each Unit, depending on Operational Policies, specialties nursed in the Unit, availability of staff, case mix, dependency and activity levels.

Planning Models

340 .14.00 BED NUMBERS AND COMPLEMENT

Decisions regarding bed numbers, and the size and composition of units and hospitals shall be made when the individual service configuration and staffing profiles of a hospital are identified. These must be approved by NSW Health. The following discussion is offered as a guide only.

340 .15.00 The preferred maximum number of beds in an Acute Inpatient Unit in a Medical or Surgical Unit is 30. However, this will vary depending on the service needs of individual facilities.

340 .16.00 BEDROOM MIX

This Guideline assumes a standard mix of 6 One-Bed Room and 6 Four-Bed Rooms in each 30 bed unit. Two-Bed Rooms are generally only provided in specialist areas eg Maternity or where required by local service needs.

The mix of bedroom types to be provided shall be determined at Service Planning level in the planning and briefing stages.

Sanitary facilities shall be directly accessible from all bedrooms.

Bedrooms should be arranged to increase flexibility by allowing the accommodation of a range of different types of patients with regard to gender, age, condition etc.

340 .17.00 SWING BEDS

For flexibility and added options for utilisation it may be desirable to include provisions for Swing Beds. This may be a single bed, a group of beds or an entire Unit that may be quickly converted from one category of use to another eg long-stay beds that may be converted to acute beds.

Facility design for Swing Beds will often require additional corridor doors and provision for switching supervision and nurse call operation from one Staff Station to another. Security may also be an issue such as when converting General/Medical beds to Paediatric beds.

340 .18.00 ISOLATION ROOMS

All One-Bed Rooms shall be designed to accommodate patients requiring isolation. These shall be constructed as Class S rooms in accordance with Part D of these Guidelines (Infection Control).

The provision of Class N or P shall be determined by service planning analysis for the particular facility concerned.

340 .19.00 UNIT PLANNING OPTIONS

The planning of Inpatient Units has evolved significantly since the model developed by Florence Nightingale in the 1860s. This evolution has largely been in response to the technologies and philosophy of health care prevalent at the time.

Numerous studies have been undertaken, comparing space and operational efficiencies of alternative planning layouts. However, no one particular layout has been found to be universally superior.

Contemporary planning layouts include single corridors, double corridors (race track), a combination of the two, L, T and Y shaped units and triangular units.

A number of Inpatient Units may be grouped together to form a larger management unit that may permit greater flexibility of use.

At the other end of the scale, Single Inpatient Units may be subdivided into clusters of bedrooms with clinical care managed at the bedside.

In all cases, planning of an Inpatient Unit will be a response to the physical constraints of the site, local service needs and operational policies.

Functional Areas

340 .20.00 UNIT FUNCTIONAL ZONES

Individual functional spaces with like purposes combine to form Functional Zones:

+ Patient Areas - areas where patients are accommodated or facilities specifically serve patients;

+ Staff Areas - areas accessed by staff, including utility and storage areas;

+ Shared Areas - areas that may be shared by two or more inpatient units.

Services provided and Operational Policies may vary the zoning required.

Functional Relationships

340 .21.00 EXTERNAL

ENVIRONMENT

Inpatient Units should be in a quiet location, with a pleasant outlook and maximum environmental benefits. The location should avoid disturbing sounds, both on and off site eg traffic, mechanical plant, and disturbing views such as cemeteries and mortuaries.

340 .22.00 LOCATION

Inpatient accommodation is the core of every hospital and is supported by a wide range of services. Functional relationships should be determined that will enhance the delivery of those services.

Principal relationships with other Units include:

+ Easy access from the Main Entrance of a facility;

+ Inpatient Units must not be located so that access to one Unit is via another;

+ Ready access to diagnostic facilities such as Medical Imaging and Pathology;

+ Ready access to Emergency and Critical Care Units;

+ Surgical Units require ready access to Operating / Day Procedures Suites;

+ Ready access to staff amenities.

340 .23.00 INTERNAL

The ability to achieve optimum relationships between component spaces depends on many factors including the nominated site, available space, shape of the space available and specific operational requirements.

Optimum internal relationships include:

+ Patient occupied areas form the core of the unit;

+ The Staff Station and associated areas need direct access and observation of Patient Areas;

+ Utility and storage areas need ready access to both patient and staff work areas;

+ Public Areas should be on the outer edge of the Unit;

+ Shared Areas should be easily accessible from the Units served.

340 .24.00 OBSERVATION

Bedrooms and other areas occupied by patients should be designed and arranged give staff the greatest ability to observe patients.

At the same time, patient privacy issues must be considered.

DESIGN

General

340 .25.00 Inpatient Unit design involves a compromise between the desire to provide patients, visitors and staff with a safe, pleasant and comfortable environment and the ability to operate the Unit efficiently. For example, the patient's need for privacy must not compromise care.

340 .26.00 Refer to Part B Section 80 for general requirements.

Environmental Considerations

340 .27.00 ACOUSTICS

Refer to Part C of these Guidelines.

Noise is a constant source of complaint from patients and may be damaging to their

condition. Noise at night is of particular concern. Confidentiality of patient information must also be protected by acoustic isolation.

Noise sources may be both within and outside the Unit and include:

+ Sanitary facilities;

+ Equipment;

+ Other patients;

+ Staff activities eg meetings, cleaning;

+ Areas of public movement, lift lobbies, etc;

+ Traffic.

Solutions to be considered include:

+ Select sound absorbing materials and finishes;

+ Use sound isolating construction;

+ Plan to separate quiet areas from noisy areas;

+ Change operational management.

340 .28.00 NATURAL LIGHT

Natural lighting contributes to a sense of wellbeing, help users find their way through the building and improves service outcomes. The use of natural light should be maximised throughout the Unit.

Natural light must be available in all bedrooms.

340 .29.00 OBSERVATION AND PRIVACY

A major conflict in the design of inpatient accommodation is to allow both patients and staff to be able to see each other while also ensuring patient privacy. Different styles of unit design offer varying degrees of visibility / observation.

The expected patient mix will be a prime factor in resolving the conflict between observation and privacy. For instance, the following types of patients have differing needs / desires:

+ Elderly patients;

+ Private patients;

+ High Dependency patients need almost constant observation;

+ Intermediate care patients require fairly frequent observation;

+ Supported / self-care patients require passing observation only.

Factors for consideration include:

+ Use of windows in corridor walls and/or doors;

+ Location of beds that may affect sight lines;

+ Location of bed screens to ensure privacy of patients undergoing treatment.

+ Location of sanitary facilities to provide privacy for patients while not preventing observation by staff.

Environmental Considerations

340 .30.00 INTERIOR DESIGN

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

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

Infection Control

340 .31.00 As the diagnosis or infectious status of the patients may not be known on admission, standard precautions must be used for all patients at all times.

Refer to Part D of these Guidelines for further information. Staff handwashing facilities, including disposable paper towels, must be readily available and provided in accordance with the ratio set out in Part D.

Space Standards and Components

340 .32.00 ROOM CAPACITY AND DIMENSIONS

The maximum room capacity shall be four patients.

340 .33.00 Refer to Room Layout Sheets for room dimensions. Overall bed dimensions (buffer to buffer) of 2250 mm long x 1050 mm wide are assumed. Minor encroachments including columns and hand basins (as required) that do not interfere with functions may be ignored when determining space requirements.

340 .34.00 BED SPACING / CLEARANCES

Bed dimensions become a critical consideration in determining final room sizes. The dimensions noted in these Guidelines are a recommended bed space.

340 .35.00 In multiple-bed rooms there shall be a clearance of 1200 mm available at the foot of each bed to allow easy movement of equipment and beds. It is preferable for beds on opposite sides of the room to be offset to provide greater privacy.

340 .36.00 In multiple-bed rooms, the minimum distance between bed centre lines shall be 2400 mm.

340 .37.00 Paediatric bedrooms that contain cots may have reduced bed centres, but consideration must be given to the spatial needs of visiting relatives. To allow for more flexible use of the room the 2400 mm centre line is still recommended.

340 .38.00 ERGONOMICS

Refer to Part C of these Guidelines.

340 .39.00 DISABILITY ACCESS

Refer to Part C of these Guidelines.

340 .40.00 ACCESS

Adequate access and circulation spaces must be provided for the proper use of

patient lifters and mobility aids. Particular consideration must be given to circulation around fixed structures such as baths.

Where possible, facilities should allow wheelchair dependent patients to have their normal amount of activity.

340 .41.00 DOORS

Refer to Part C of these Guidelines.

Doorways must be sufficiently wide and high to permit the manoeuvring of beds and equipment without risk of damage to the doorway or the item being moved, and without creating manual handling risks.

340 .42.00 WINDOWS

Refer to Part C of these Guidelines.

Window sill heights should be low enough to permit a view to the outside by a patient lying in bed.

340 .43.00 CORRIDORS

Refer to Part C of these Guidelines.

Finishes

340 .44.00 WALL PROTECTION

Refer to Part C of these Guidelines.

Adequate wall protection must be provided to surfaces that are subject to damage. Particular attention should be given to areas where bed or trolley movement occurs such as corridors, bed head walls, treatment areas and storage spaces.

340 .45.00 FLOOR FINISHES

Refer to Part C of these Guidelines.

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

Inpatient Units require consideration to be given to acoustic performance, slip resistance, consequences of patient falls, infection control, movement of beds and trolleys and maintenance.

340 .46.00 CEILING FINISHES

Refer to Part C of these Guidelines.

It should be remembered that patients may spend a considerable amount of time lying in bed looking at the ceiling.

Ceiling finishes shall be selected with regard to appearance, cleaning, infection control, acoustics and access to services.

Fixtures & Fittings

340 .47.00 BED SCREENS

In all bedrooms each patient shall have visual privacy. Movable curtains are recommended. The design for privacy shall not restrict patient access to the entrance, ensuite, toilet or handwashing functions (if included).

340 .48.00 CURTAINS / BLINDS

Each room shall have partial blackout facilities (blinds or lined curtains) to allow patients to sleep more easily during the daytime.

Safety and Security

340 .49.00 SAFETY

Refer to Part C of these Guidelines.

An Inpatient Unit shall provide a safe and secure environment for patients, staff and visitors while remaining a non-threatening and supportive atmosphere conducive to recovery. Patients are often unaware of their capacities or incapacities. They may be weak, unsteady, affected by medication or confused.

Whether involving patients or staff, most accidents occur in rooms containing sanitary facilities.

The facility, furniture, fittings and equipment must be designed and constructed in such a way that all users of the facility are not exposed to avoidable risks of injury.

340 .50.00 SECURITY

Refer to Part C of these Guidelines.

Security issues are important due to the increasing prevalence of violence and theft in Health Care Facilities.

The arrangement of spaces and zones shall offer a high standard of security through the grouping of like functions, control over access and egress from the Unit and the provision of optimum observation for staff.

The level of observation and visibility has security implications.

340 .51.00 Security issues to be considered in Inpatient Units are included, but not limited to, the table at the end of this section.

Building Service Requirements

340 .52.00 INFORMATION TECHNOLOGY / COMMUNICATIONS

Inpatient Unit design should address the following Information Technology/Communications issues:

+ Electronic Health Records;
+ Point of Care Clinicals;
+ Picture Archiving Communication System (PACS);
+ Patient Administration System (PAS);
+ Paging and personal telephones replacing some aspects of call systems;
+ Data entry including scripts and investigation requests;
+ Email;
+ Bar coding for supplies and X-rays / Records;
+ Personal duress claims;
+ Telephone system.

340 .53.00 NURSE CALL

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

340 .54.00 Nurse call systems must be designed and installed to comply with AS 3811 - Hard wired Patient Alarm Systems.

DURESS ALARMS

To be provided in accordance with NSW Health Policy. Refer to Part C of these Guidelines.

COMPONENTS OF THE UNIT

Introduction

340 .55.00 This section must be read in conjunction with Part B Standard Components, Room Data Sheets and Room Layout Sheets. The following text describes only specific requirements not covered by these other documents.

Standard Components

340 .56.00 Provide the Standard Components as identified in the Generic Schedule of Accommodation. Provision of Offices, Workstations and support areas will be dependant on the Operational Policy and service demand and may vary from the Schedule of Accommodation, however, room sizes should remain consistent.

Non-Standard Components

340 .57.00 Provide the Non Standard Components as described in this section, according to Operational Policy and service demand.

340 .58.00 LAUNDRY - PATIENT

DESCRIPTION AND FUNCTION

Optional provision. A Patient Laundry should generally be provided in specialist areas such as Mental Health and Rehabilitation Units, or to meet service demand.

Facilities may be provided for the washing, drying and ironing of patients' personal clothing as required. Storage for cleaning agents should also be provided.

A Patient Laundry shall be 6 m2.

LOCATION AND RELATIONSHIPS

The Patient Laundry shall be located close to patient bedrooms.

Acoustic privacy to this area should be considered.

Patient Laundries should only be provided where they are justified by service demand.

Staff Areas

340 .59.00 BAY - MEAL TROLLEY

DESCRIPTION AND FUNCTION

Similar to Standard Components for Bay - Mobile Equipment.

The requirement for a Bay - Meal Trolley will be dependent on Catering management policies and procedures.

LOCATION AND RELATIONSHIPS

Locate readily accessible to Bedroom Areas.

Schedule of Accommodation

340 .60.00 A Generic Schedule of Accommodation for a 30 Bed Unit at Levels 3, 4, 5, and 6 follows. Although categorised by level of service, this does not necessarily lead to different physical requirements.

The Schedule of Accommodation lists generic spaces that form an Inpatient Unit. Quantities and sizes of some spaces will need to be determined in response to the service needs of each unit on a case by case basis.

ROOM / SPACE	Standard Component					Qty x m2	Remarks
PATIENT AREAS -							* Optional
1 BED ROOM	yes					6 x 15	FPU - mix and no. depend on service demand.
1 BED ROOM - SPECIAL	yes					1 x 18	Min. 1 per facility or 1 per 60 beds, may be shared between 2 x IPUs.
1 BED ROOM - ISOLATION	yes					(15)	Class N or P + associated Anterooms; as required by service deman.
2 BED ROOM	yes					(25)	Provide only in specialist units eg Maternity, Rehab, or if required by service demand.
4 BED ROOM	yes					6 x 42	FPU - mix and no. depend on service demand.
ENSUITE - STANDARD	yes					6 x 5	Directly accessible from 1 Bed Rooms.
ENSUITE - SUPER	yes					1 x 6	Locate with 1 Bed Room - Special.
LAUNDRY - PATIENT						(6)*	Specialist areas eg Mental Health, Rehab; or where required by service demand.
LOUNGE - PATIENT	yes					1 x 20	Provided 1 per 60 beds, or shared between 2 units.
SHOWER - PATIENT	yes					6 x 4	To all 4 Bed Rooms.
TOILET - PATIENT	yes					6 x 4	To all 4 Bed Rooms. - 'full assistance'.
STAFF AREAS -							
BAY/ROOM - BEVERAGE	yes					1 x 4	Open bay. Increase area to 5m2 if enclosed in a room.
BAY - HANDWASHING	yes					4 x 1	Provisional. Qty & location to be determined for eachfacility. Refer Part D.
BAY - LINEN	yes					2 x 2	Qty & location to be determined for each facility.
BAY - MEAL TROLLEY						(4)*	Dependent on catering operational policies.
BAY - MOBILE EQUIPMENT	yes					2 x 4	Qty, size & location depends on equipment to be stored. Quiet location preferred.
BAY - PPE	yes					6 x 1	Plus as required for Unit. Refer Part D.
BAY - RESUSCITATION TROLLEY	yes					1 x 2	
CLEANER'S ROOM	yes					1 x 5	Include separate cupboard for dry goods.
CLEAN UTILITY	yes					1 x 14	Includes medication storage.
DIRTY UTILITY	yes					1 x 12	2 may be required to minimise travel distances.
DISPOSAL ROOM	yes					1 x 8	Provision depends on waste management operational policies.
MEETING ROOM - 9M2	yes					1 x 9	Interview function, small meetings.
OFFICE - CLINICAL/HANDOVER	yes					1 x 12	

OFFICE - SINGLE PERSON 9M2	yes					2 x 9	NUM office, plus for clinical personnel.
PROPERTY BAY - STAFF	yes					1 x 2	Number of lockers depends on staff complement per shift.
STAFF STATION	yes					1 x 14	Accomm'n for ward clerk dep. on operat'l policy. Size, location TBD for each facility.
STORE - EQUIPMENT	yes					1 x 20	Quiet area with access to patient areas. Size depends on eqt stored, and no. of bays.
STORE - GENERAL	yes					1 x 9	Size in accordance with service demand & operational policies.
SHARED AREAS -							
BATHROOM	yes					1 x 15	Provide one per floor, or as required by service demand.
MEETING - MEDIUM	yes					1 x 15	Tutorial. Shared by 2 units.
OFFICE - SHARED 3 PERSON	yes					1 x 15	Use by CNC, Nurse Educator, Registrars, depending on service demand & oper policy.
STAFF ROOM	yes					1 x 18	Shared by 2 units; staff resources, beverage prep.
TOILET - PUBLIC	yes					1 x 3	Shard by 2 units. Access to disabled toilet also required.
TOILET - STAFF	yes					1 x 3	Dedicated staff toilet. Shared by 2 units.
TREATMENT ROOM	yes					(14)*	May be required in specialist units, or shared by >1 unit. Depends on oper policy.
SUB TOTAL						687	Excludes optional spaces, includes shared spaces.
CIRCULATION - 32%						220	
TOTAL						907	

Functional Relationships

340 .61.00 A diagram of key functional relationships is attached.

Checklists

340 .62.00 A security check list is provided at the end of this section. Refer to Part C for more details designing for safety and security.

References and Further Reading

340 .63.00 The following references should be read in addition to the general references provided in these Guidelines.

+ DS16 Medical/Surgical Inpatient Unit, Health Building Guidelines, Capital Works Branch, NSW Health Department, 1993

+ DS26 Mental Health Facility Guideline, Volume 1, NSW Health Department, 2000

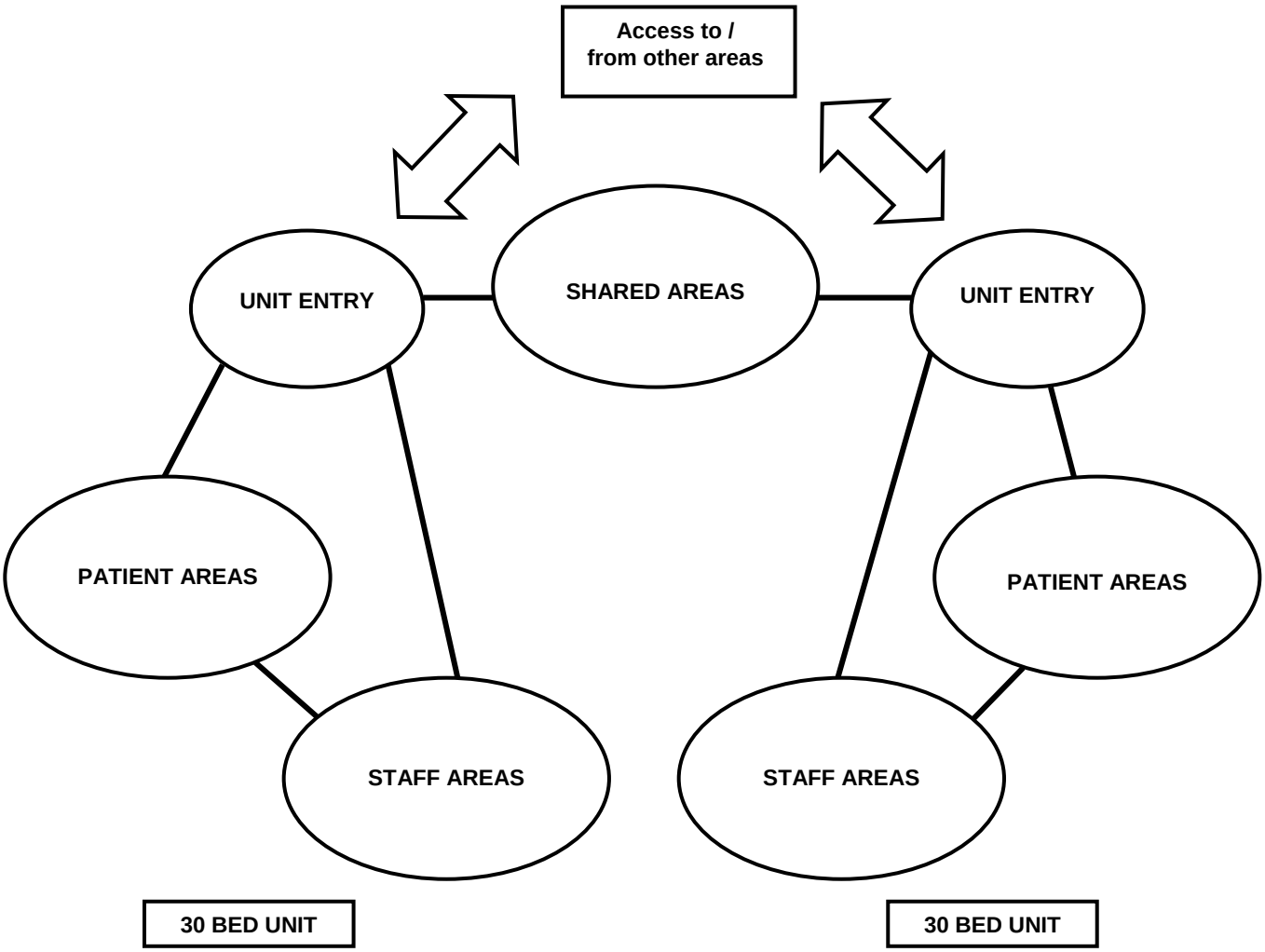
+ Capital Works Guidelines, Capital Works & Asset Management Branch, Queensland Health Department, 1998

+ Inpatient Accommodation: Options for Choice, Health Building Note 04, NHS Estates, HMSO, UK, 1997

+ Design and Care in Hospital Planning, Alan Dilani, Karolinska Institut, Stockholm, 1999

FUNCTIONAL RELATIONSHIP DIAGRAM – INPATIENT UNIT

The following diagram sets out the functional relationships between areas in an Inpatient Unit:



SECURITY ISSUES TO BE CONSIDERED IN INPATIENT ACCOMMODATION

GENERIC SAFETY AND/OR SECURITY RISKS	POTENTIAL SOLUTIONS
1. Entry by all relevant personnel visiting or working within the Hospital.	1. Minimise entry and exit doors. 2. CCTV monitoring of Ward entry and exit doorways. 3. After hours remote switch and intercom on entry doors. 4. Use of reed switches on all external doors and swipe card entries.

SPECIFIC SAFETY AND/OR SECURITY RISKS	POTENTIAL SOLUTIONS
1. Relatives / Visitors	1. Good visibility from staff station to Ward. 2. Manage relatives/visitors admittance in the area by restricting visiting hours and/or number of visitors.
2. Patient files	1. Personnel working on these files must return the files to secure area after use or return them to Medical Records Department. 2. If any electronic files are produced, save them in restricted area of hard drive.
3. Furniture fittings and equipment including Computers, Office and Medical Equipment	1. Non-removable 'Asset No.' on all equipment above a predetermined value. 2. Keep equipment in lockable area.
4. Hospital personnel safety	1. Staff working in this area to have knowledge of where the fixed duress system is located and/or use a mobile duress pendant. 2. Design shape of interview rooms and location of desks, etc, in such a way that minimises risk to health personnel. 3. Provide storage and store for items not in constant use that could be used as weapons. (Operational Policy). 4. Minimise furniture that can be used as a weapon, ie, picked up and thrown.
4. Staff and patient personal effects	1. Provision for lockers in staff areas and lockable desk drawer to keep small personal effects. 2. Provision of lockable patient bedside lockers or storage facilities for patient effects. 3. Minimising personal effects kept by patients in the facility
5. Drugs storage	1. Drugs safe to be located in area that can be monitored by staff eg Clean Utility area.

SECURITY CHECKLIST – INPATIENT UNIT

FACILITY:	DEPARTMENT: Inpatient Unit
RISK ISSUE	**DESIGN RESPONSE**
1. Has a CCTV System been considered to monitor the waiting area and/or access to the public access points in the Waiting Area?	
2. How is 'after hours' access provided for patients and how is this access point monitored?	
3. Has a secure "barrier" been installed between staff and the waiting area to: (a) monitor the waiting area; and (b) provide staff contact with patients.	
4. Do staff have access to both fixed and mobile duress systems?	
5. Is access to patient records restricted to staff entitled to that access?	
6. Is a system implemented to prevent theft of equipment, files, personal possessions, etc?	
7. Are drug safes installed in accordance with current regulations?	
8. Is the waiting area furniture incapable of being utilised as a "weapon"?	
9. How is after hours access provided for staff?	
10. How is this area secured during and after hours?	
11. How is the security of patient's valuables managed?	
12. Are there lockable storage areas available for specialised equipment?	
13. Is lockable furniture provided for storage of staff personal effects?	
14. Are interview rooms appropriately designed with specific reference to staff egress, furniture selection, furniture location, provision for storage of equipment, etc.	

DESIGN COMMENTARY/NOTES	DESIGN SIGN OFF
	Name: …… Position: …… Signature: …… Date: ……..
	Name: …… Position: …… Signature: …… Date: ……..
	Name: …… Position: …… Signature: …… Date: ……..