Mental Health

Gazetted

30 June 2014

Task Team: A:05

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IUSS HEALTH FACILITY GUIDES

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INFORMATION

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Description: The mental healthcare infrastructure requirements for mental healthcare users are provided in five parts covering the minimum infrastructure norms and standards for inpatients and for outpatients, inclusive of hospital requirements for General Health facilities in district, regional, tertiary, central and national referral services, and the services required at designated psychiatric hospitals and designated health establishments for state patients and for prisoners who are mentally ill. The guidelines are to be read in conjunction with the norms and standards suite and covers the policy and service context (Part A), planning and design (Part B), room data (Part C), accommodation schedules (Part D), and case studies (Part E).

Reference: CSIR 59C1119 A:05 - 001
Authors: IUSS N and S task group A:05
Stakeholders: National Department of Health, Provincial Departments of Health and Public Works
Accessing of these guides

This publication is received by the National Department of Health (NDoH), IUSS Steering Committee Chairman, Dr Massoud Shaker and Acting Cluster Manager: Health Facilities and Infrastructure Management, Mr Ndinannyi Mphaphuli. Feedback is welcome.

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Application and development process

These IUSS voluntary standard/guidance documents have been prepared as national Guidelines, Norms and Standards by the National Department of Health for the benefit of all South Africans. They are for use by those involved in the procurement, design, management and commissioning of public healthcare infrastructure. It may also be useful information and reference to private sector healthcare providers.

Use of the guidance in this documentation does not dissolve professional responsibilities of the implementing parties, and it remains incumbent on the relevant authorities and professionals to ensure that these are applied with due diligence, and where appropriate, deviations processes are exercised.

The development process adopted by the IUSS team was to consolidate information from a range of sources including local and international literature, expert opinion, practice and expert group workshop/s into a first level discussion status document. This was then released for public comment through the project website, as well as national and provincial channels. Feedback and further development was consolidated into a second level development status document which again was released for comment and rigorous technical review. Further feedback was incorporated into proposal status documents and formally submitted to the National Department of Health. Once signed off, the documents have been gazetted, at which stage documents reach approved status.

At all development stages documents may go through various drafts and will be assigned a version number and date. The National Department of Health will establish a Health Infrastructure Norms Advisory Committee, which will be responsible for the periodic review and formal update of documents and tools. Documents and tools should therefore always be retrieved from the website repository www.iussonline.co.za or Department webportal (forthcoming) to ensure that the latest version is being used.

The guidelines are for public reference information and for application by Provincial Departments of Health in the planning and implementation of public sector health facilities. The approved guidelines will be applicable to the planning, design and implementation of all new public-sector building projects (including additions and alterations to existing facilities). Any deviations from the voluntary standards are to be motivated during the Infrastructure Delivery Management Systems (IDMS) gateway approval process. The guidelines should not be seen as necessitating the alteration and upgrading of any existing healthcare facilities.
Acknowledgements

This publication has been funded by the NDoH.

Information and Policy documents provided by the W. C. Dep. of Health, KZN, Gauteng, Defence Force, EC, NC and NDOH Mental Health Unit are gratefully acknowledged.

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Reviewed by:

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OVERVIEW

This document outlines the policy and service context and attempts to illustrate the desired planning principles and design considerations of mental healthcare users (see definition of "users" in Glossary).

Error! Reference source not found. outlines the national and provincial service and policy context which are the basic determinants of the planning and design principles;

PART 2 - contains planning and design guidance, design considerations, functional relationships between hospital departments with respect to adult inpatient accommodation units (inpatient units), and relationships within the unit itself;

PART 3 - develops these principles into a series of schedules of accommodation;

PART 4 - contains room data sheets and

PART 5 - includes some indicative equipment lists and case studies; and

PARTS 6, 7 and 8 are intended to demonstrate how the principles prescribed in Part 2 can be applied in worked examples. Parts 3 or 4, if used directly, are deemed to satisfy the principles developed in Part 2, but are not the only acceptable solutions.

Case studies (Part 5) provide illustrative worked solutions and should not be adopted without appropriate contextual adaptation.

While this document outlines design requirements and acceptance criteria which have an impact on clinical services, these requirements are prescribed within the framework of the entire IUSS set of guidance documents and cannot be viewed in isolation. The following documents (Table 1) should be complied with, together with this document:
## TABLE 1: IUSS – GUIDELINES NORMS AND STANDARDS (GNS) REFERENCE DOCUMENTS

<table>
<thead>
<tr>
<th>CLINICAL SERVICES</th>
<th>SUPPORT SERVICES</th>
<th>HEALTHCARE ENVIRONMENT/ CROSS-CUTTING ISSUES</th>
<th>PROCUREMENT &amp; OPERATION</th>
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<td>Administration and related services</td>
<td>Generic room requirements</td>
<td>Integrated infrastructure planning</td>
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<td>General hospital support services</td>
<td>Hospital design principles</td>
<td>Briefing manual</td>
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<td>Mental health</td>
<td>Catering services for hospitals</td>
<td>Building engineering services</td>
<td>Space guidelines</td>
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<td>Adult critical care</td>
<td>Laundry and linen department</td>
<td>Environment and sustainability</td>
<td>Cost guidelines</td>
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<td>Hospital mortuary services</td>
<td>Materials and finishes</td>
<td>Procurement</td>
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<td>Future healthcare environments</td>
<td>Commissioning health facilities</td>
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<td>Adult subacute services</td>
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<td>TB services</td>
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**Colour legend**
- Consultants
- Administrators
- Related documents
PART 1 - POLICY AND SERVICE CONTEXT

1.1. Policy context

Mental healthcare accommodation pertains to the complete infrastructure requirements for mental healthcare service in an array of settings and levels that include:

- Primary healthcare
- Community-based settings
- General hospitals
- Specialised psychiatric hospitals.

The specific interventions for mental healthcare patients include care, treatment and rehabilitation. These interventions are rendered through a multidisciplinary approach by psychiatrists or registered medical practitioners, psychiatric nurses, psychologists, social workers, occupational therapists. These spaces must effectively and economically support the care, treatment and rehabilitation of patients.

The service platform should meet the requirements for safe clinical practice, adhere to health and safety standards and meet recognised infection-control principles while upholding patients' human rights.

This document provides guidance, describing the specific mental health service spaces. The document should be read in conjunction with the full IUSS set of standards pertaining to mental health services.

1.2. Service context

The business case and the health brief will define the correct package of service and the required bed distribution per facility based on the Provincial Strategic Transformation Plan and the National Mental Health Policy Framework and Strategic Plan 2013-20.

Mental health infrastructure requirements are informed by the Acts and policies listed as Annexure 2.

Mental healthcare is rendered in line with the Mental Health Care Act No 17 of 2002 and the National Mental Health Policy Framework and Strategic Plan 2013-2020, which prescribes that mental healthcare, treatment and rehabilitation services should be available to the population equitably, efficiently and in the best interest of mental healthcare users within the limits of the available resources and integrated into the general health services environment. In this regard mental healthcare, treatment and rehabilitation services must be provided within the community primary, secondary and tertiary levels as well as psychiatric hospitals or care and rehabilitation centres designated for this purpose.

The Act also prescribes the various categories of mental healthcare users that must have access to care, treatment and rehabilitation as:

- Voluntary, assisted and involuntary mental healthcare users;
- Awaiting-trial detainees referred for forensic psychiatric assessment/observation;
- State patients; and
- Mentally ill prisoners.

The table below lists the levels of care and the associated service to be provided.
# TABLE 1: LEVEL OF MENTAL HEALTHCARE AND PLACES OF SERVICE.

<table>
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<th>TYPE OF SERVICE/ PROCEDURE OR INTERVENTION</th>
<th>PHC AND CHCS’ MENTAL HEALTH DAY CARE CENTRES</th>
<th>COMMUNITY MENTAL HEALTH RESIDENTIAL CENTRES</th>
<th>UNITS ATTACHED TO DISTRICT HOSPITALS</th>
<th>UNITS ATTACHED TO REGIONAL HOSPITALS</th>
<th>UNITS ATTACHED TO TERTIARY HOSPITALS</th>
<th>UNITS ATTACHED TO CENTRAL HOSPITALS</th>
<th>SPECIALISED PSYCHIATRIC HOSPITALS OR CARE AND REHABILITATION CENTRES</th>
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<td>X</td>
<td>X * all patients consulted or admitted</td>
<td>X * all patients consulted or admitted</td>
<td>X * all patients consulted or admitted</td>
<td>X * all patients consulted or admitted</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Electro-convulsive treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1.3. Service platform


The mental health system will include an array of health settings and levels that include primary healthcare, community-based settings, general hospitals and psychiatric hospitals.

1.3.1. Primary healthcare and community health centres

Refer to the [IUSS:GNS Primary healthcare](#).

The overall objective is to be able to detect, assess, refer and provide comprehensive primary mental healthcare treatment, rehabilitation and a wide range of psychological interventions to individual mental healthcare patients and their families.

1.3.2. Community-based mental health services

Community-based mental health services must be developed to provide care, treatment and rehabilitation to mental healthcare patients that do not require hospitalisation. The facilities should include residential (supervised and non-supervised) group homes, halfway houses and day-care centres. The following indicate the types of residential facilities that would be required:

- Halfway houses
- Residential (supervised and non-supervised) group homes, independent living units
- Day-care centres.

1.3.3. Psychiatric inpatient units in general hospitals

Psychiatric inpatient units built in general hospitals are to provide for:

- The admission of voluntary mental healthcare patients.
- Assisted care and involuntary mental healthcare patients who will be admitted in terms of the provisions and procedures prescribed in the Mental Health Care Act No 17 of 2002 as emergency admissions or for 72-hour assessment.
- Further care, treatment and rehabilitation in line with the health designation in terms of Section 5 of the Mental Health Care Act and outpatient services.
- The psychiatric inpatient bed distribution should be considered as part of the National Psychiatric Strategic Transformation Plan. (Information is pending.)

Table 3 below shows various sections in the psychiatric inpatient units that are attached to general health services. Table 4 below indicates secure unit types.

The level of security in these units will be adjusted according to the mental health status and the security needs of the mental health patients.
TABLE 2: PSYCHIATRIC INPATIENTS UNITS IN GENERAL HOSPITALS

<table>
<thead>
<tr>
<th>Type of ward</th>
<th>Level of security</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary care, treatment and rehabilitation</td>
<td>Low</td>
<td>Mental healthcare rendered to a user who submits voluntarily for care, treatment and rehabilitation</td>
</tr>
<tr>
<td>Acute unit</td>
<td>High</td>
<td>A unit to admit assisted and involuntary mental healthcare users for emergency care and 72-hour assessment</td>
</tr>
<tr>
<td>Medium to long stay</td>
<td>Medium to low</td>
<td>For further care, treatment and rehabilitation in the psychiatric unit</td>
</tr>
<tr>
<td>Outpatient services</td>
<td>Low</td>
<td>Outpatient care, treatment and rehabilitation services</td>
</tr>
</tbody>
</table>

1.3.4. Specialised psychiatric hospitals

Specialised psychiatric hospitals provide inpatient care, treatment and rehabilitation, and limited outpatient care as follows:

- Voluntary mental healthcare
- Assisted mental healthcare
- Further care, treatment and rehabilitation of involuntary admissions
- Psycho-geriatrics
- Sub-speciality child psychiatry
- Sub-speciality adolescent psychiatry
- Adult inpatient psychotherapy programmes - e.g. eating disorders
- Mental disorder and substance abuse co-morbidity
- Forensic psychiatry
- Forensic psychiatric observation
- State patient care, treatment and rehabilitation
- Care, treatment and rehabilitation of mentally ill prisoners
- Mental health research and training
- Electro-convulsive treatment
- Care, treatment and rehabilitation centres for severe to profound intellectually disabled persons.

The hospital must provide a safe and secure therapeutic environment that will embrace the human dignity of healthcare users and that will provide efficient clinical spaces appropriate to the treatment and rehabilitation of the user population.

These units are self-contained according to their level of security.

Specialised psychiatric hospital grounds are secured by an impenetrable perimeter security fence, with a main entrance gate as the single point of entry to the facility. The main gate, hospital management, hospital administration, facility management, educational activities and the psychiatric units are positioned within this secure perimeter and will be manned by trained security staff who will censor access and search pedestrians and incoming and outgoing vehicles.
<table>
<thead>
<tr>
<th>Type of ward</th>
<th>Level of security</th>
<th>Intervention</th>
<th>Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions unit</td>
<td>High</td>
<td>Admission of awaiting-trial detainees referred by the courts for psychiatric observation/enquiry and for state patients and mentally ill prisoners</td>
<td></td>
</tr>
<tr>
<td>Observation unit</td>
<td>High</td>
<td>Forensic psychiatric enquiry referred by the courts</td>
<td>Restricted access and movement to all areas in and out of wards; hard surfaces and extremely user vandal-prone, but therapeutic</td>
</tr>
<tr>
<td>High security unit</td>
<td>High</td>
<td>Care, treatment, rehabilitation of state patients and mentally ill prisoners across all age groups and either gender</td>
<td>Restricted access into and out of ward, with open access within ward; less homely environment; user vandal-prone, yet therapeutic</td>
</tr>
<tr>
<td>Medium security unit</td>
<td>Medium</td>
<td>Care, treatment and rehabilitation of state patients and mentally ill prisoners across all age groups and either gender</td>
<td></td>
</tr>
<tr>
<td>Low security unit</td>
<td>Low</td>
<td>Care, treatment and rehabilitation across all age groups and gender</td>
<td>Open ward, soft furnishing, Homely</td>
</tr>
<tr>
<td>Co-morbid medical and psychiatric disorders unit</td>
<td>Medium to low</td>
<td>State patients and mentally ill prisoners who suffer from a medical condition will be managed in this unit for the necessary medical care and be transferred back either to the state patients’ wards or to a general hospital, based on their needs</td>
<td></td>
</tr>
<tr>
<td>Co-morbidity substance abuse and psychiatric disorders unit</td>
<td>Medium to low</td>
<td>State patients and mentally ill prisoners who suffer from both a substance-abuse and psychiatric disorder will be transferred to this unit once the psychosis has cleared and they are ready for rehabilitation from substance abuse. This is a substance-abuse rehabilitation unit for psychiatric patients, and differs from the rehabilitation centre for the general population, which is led by the Department of Social Development.</td>
<td></td>
</tr>
</tbody>
</table>
PART 2 - PLANNING AND DESIGN

2.1. Overview

This document attempts to illustrate the desired planning principles and design considerations for mental healthcare services, with applied examples to support the planning process.

Part 2 contains planning and design guidance, design considerations, functional relationships between hospital departments with respect to the mental healthcare service platform and the desired relationships between the respective units.

Workflow diagrams are provided to explain the flow of: users, mental healthcare users, clinical staff, support goods and services, maintenance and contract staff, as well as the flow of the public through the hospital. Workflow diagrams within departments are provided to assist in understanding the intradepartmental relationships in support of functional flow in the units to ensure productive service delivery.

Way-finding should support mental healthcare users, visitors and the community in understanding the hospital and the respective spaces. The inpatient units should meet the needs of both abled and differently abled people. The detailed room diagrams with accompanying norms and standards are provided to clarify understanding of the different space requirements and room-specific specifications that make up the inpatient units.

2.2. General design and planning framework

The design of the facility should meet the unique service requirements of the clinical treatment platform.

Mental healthcare users enter the facility either as psychiatric mental healthcare users or as forensic mental patients. The respective clinical units should have functional relationships with departments associated with the treatment requirements of the users.

The design of the complex should provide an environment with the least restrictive requirements in terms of the desired levels of care. The design must conform to salutogenic (health-promoting) planning principles in support of a therapeutic environment. The design should be appropriate to the inpatient’s age and desired therapeutic milieu, with consideration given to the use of colour, noise levels, natural ventilation and light, and spaces that would create a healing environment.

Landscaping designs should consider the type of inpatient units -- such as enclosed gardens for high and medium secure patient units, or the planting of trees or large scrubs that could, over time, become a safety or security risk.
Patient privacy and human rights should be considered throughout the design.

The planning of the space should consider the following:

- **Level and zones of security**: Access control at the entrance of the campus and the security requirements for the campus - both the psychiatric and forensic units.
- **Activities**: Patient treatment, clinical interventions, teaching and social or rehabilitative activities?
- **Human resources**: The resource requirements at any given time in a specific place to perform a specific task or procedure.
- **Safety and protection of staff** and the need for their rest and breakaway.
- **Equipment**: The equipment and space requirements.

### 2.2.1. General planning principles

- An ergonomically safe design that maximises patient and staff safety, human rights and reduces risk.
- A clinically safe and effective healthcare patient environment.
- Avoid large sprawling designs, which are both resource- and cost-intensive.
- Efficient workflow will support effective resource utilisation.
- Reduce noise in the unit.
- Units should be gender and age separated.
- Adopt recognised infection-control policies.
- Comply with quality assurance principles.
- Install communication and information systems that will support patient management and administration.
- Facilitate the delivery of care and services and supplies to the units.

### 2.2.2. Layout and design

- The facility layout should provide appropriate levels of security with consideration to least-restrictive designs.
- Efficient workflow will support effective resource utilisation.
- Designs should reflect therapeutic treatment spaces that are user-friendly and client community sensitive.
- Units can be grouped into “villages”, according to the different levels of care and security requirements.
- Single-storey buildings are preferred, to avoid the risk of self-harm. Single-storey buildings with a logical process flow should support clinical resources efficiency.
- Where space is a constraint, administrative offices and staff facilities could be accommodated on a second level; all patient activities must remain on ground level.
- Interior decorating should support psychiatric-specific salutogenic principles.
- Zoning of ward spaces should provide a resource-efficient layout with consideration being given to clinical care - such as placement of seclusion rooms close to the nurses’ station.
- Landscaping designs should be water wise, and should be low maintenance. Landscaping designs and the planting of trees and large scrubs should consider security and the risk requirements of medium, high and forensic units over time.
- Patient areas should have access to external and garden spaces according to the level of care.
Linked walkways are essential for users and staff to provide interconnectivity between treatment spaces - especially at night and during inclement weather conditions.

Sunlight and natural ventilation should be provided as far as possible.

User accommodation should be shielded from public activities and should provide privacy and personal space.

Design features should assist patient orientation in the facility.

Surfaces that create reflections or have patterns must be avoided.

Avoid areas where mental healthcare users may conceal themselves.

Ceilings must be sealed and vandal-resistant and out of reach by users.

Slip-resistant floors, material and finishes used in the hospital should be non-toxic and should not give off toxic gas during accidental fires. Patients’ bedroom doors must be re-enforced.

The suggested size of the door should be 450mm in height x 150mm wide, with a vertical viewing window 1.5m above floor level.

Laminated tempered glass or composite laminated glass should be provided.

Window designs should be planned according to the required level of care. In more restrictive areas windows should support the security requirements by reducing the risk of injury and escape, and promote safety.

Windows and doors should prevent escape, unwarranted entrance or opportunity for self-harm.

The type of window opening should be provided according to the level of security required. The windows types indicated below are fitted with see-through vandal-resistant mesh that is able to withstand abusive user behaviour, while providing an aesthetic visual soft touch to the rooms.

**FIGURE 1: EXAMPLES OF WINDOW OPENINGS**

**2.2.3. Furnishings and fittings**

- Avoid items or furniture that can be used as weapons.
- Panic buttons must be installed at strategic intervals, or mobile devices could be used.
- Fire-resistant mattresses should be provided to avoid user injury.
- Door knobs or handles which can be dismantled should not be used; door knobs are better than vertical or horizontal handles.
- All fixtures and fittings must be secured and firmly fitted, and tamperproof.
- Light fittings in user spaces and exit signs must be flushed counter sunk with walls and ceilings and have unbreakable covers fittings from vandalism.
2.2.4. Facility management and maintenance

Refer to the [IUSS:GNS Brief manual](#).

- All services inwards shall be controlled from outside the units.
- Maintenance must be considered when planning the building; drainage pipes should be accessible and the safety of the maintenance staff must also be considered in the design.
- Building with facebricks could encourage escape and should be discouraged.
- Provide adequate day and night-time illumination to assist user observation.
- Standby power supply should be provided (for forensic units, all passages, co-morbid units, admission unit, acute wards, treatment rooms, medicine rooms in the units, pharmacy, and mortuary).
- Electrical, plumbing and mechanical fittings must be vandal-proof.
- The position of the uninterrupted power supply (UPS) should be inaccessible for patients.
- Patient cupboards should be provided according to the level of care.
- The site preparation, construction and operation/maintenance of the building itself must be environmentally friendly and compliant with environmental legislation. Green building principles, such as energy and water efficiency and the use of solar energy should be considered in the design. ([Refer to the IUSS:GNS Environment and Sustainability document.](#))
- Washable wall paints should be used.

2.2.5. Security management

Special security considerations

Refer to the [IUSS:GNS Security](#) and SAPS Security Standards.

Psychiatric units in general hospitals and specialised hospital grounds must be secured with an impenetrable perimeter-security fence with a main entrance gate as the single point of entry to the facility. The main gate will be manned by trained security staff who will censor access and search pedestrians and incoming and outgoing vehicles. Hospital management, hospital administration, facility management, educational activities and the general psychiatric units are positioned within this secure perimeter. The forensic section of the hospital requires a dedicated entrance within the main security fence, with strict security, access control and a security fence that will contain all the forensic services within the forensic unit perimeter fence, secured with a second level of security staff.

Users admitted to the general psychiatric section will be admitted through an admission unit, from which mental healthcare users will be triaged according to diagnosis, gender and age. Mental healthcare users may be discharged from any of the units as outpatients or may be transferred or discharged to primary mental healthcare or community-based care. The design of the facility should
provide privacy for the most acute patients by placing high and medium security wards away from areas with high pedestrian and vehicular routes, or public access. Table 3 lists the types of units, the required levels of security and the clinical intervention for each unit.

Psychiatric hospital care requires different levels of containment; to this end security forms an integral part of the operational management of the hospital, with different levels and layers of security, depending on the level of care - i.e. low, medium and high security.

The forensic section requires strict security and in some units maximum levels of security. The South African Police Service (SAPS) standards for security are available in the SAPS GSR document. (Refer to GSR FS MPSS.)

- Security must be integral to the design and planning of the facility master plan. The security master plan should address security from the external perimeter inward to ensure that the security system is fully integrated.
- The level of security required will be determined by the security requirements for the specific classification of the ward and the required security zones.
- Fencing prescripts should be strictly adhered to (Annexure 4).
- Entrances to the site and buildings should be kept to a minimum.
- Staff and visitor parking should be in well-lit, safe areas, under surveillance.
- CCTV monitoring of perimeter and public spaces with monitoring devices at security offices is required in the mental healthcare policies. Refer to the IUSS:GNS Information technology and infrastructure (ICT) document.
- Vandal-resistant windows must be compliant with SANS 10400, SANS 1263, Part 2.
- All doors should have central, electrical lock-release mechanisms.
- All external inpatient unit doors should be access-controlled; Contractors, visitors, delivery and waste-removal workers are potential security risks; strict access-control management policies should be adhered to.

**FIGURE 3: PROPOSED SAPS SECURITY ZONES**
2.2.6. **Ablutions**

- Non-slip low-maintenance floor covering is required - i.e. pigmented epoxy or polyester floors in bathrooms with washable wall paint in ablution areas.
- All toilets to be low maintenance and vandal-proof (Gypsy type or similar).
- Toilets should provide patient privacy; toilet doors should swing outward and should be fitted with slip locks to prevent users from locking themselves in.
- Bathroom and shower facilities and appliances should be tamper- and vandal-resistant.

![Figure 4: Toilet Types](image1)

**FIGURE 4: TOILET TYPES**

![Figure 5: Shower Rose and Flush Button](image2)

**FIGURE 5: SHOWER ROSE AND FLUSH BUTTON**

2.2.7. **Fire-fighting, -prevention and -detection**

- Signage should indicate escape routes, which should be identified on the plan.
- The fire-detection system should comply with the regulated requirements (SANS 10400 Part T).
- Fire-fighting equipment and fire-hose fittings should be provided in all units.
- Fire equipment should not be accessible to mental healthcare users and should be according to the regulations listed below.
- All inpatient units should be provided with escape doors in cases of fire.

**FIGURE 6: EXAMPLES OF A LOCKED FIRE HOSE AND A SMOKE DETECTOR**
2.2.8. Infection control

The primary objective of hospital design is to place the patient at no risk of infection. This includes standards for hand-washing practices, cross-infection and the need for isolation with particular attention to mental healthcare users suffering from infectious diseases. These include Congo fever, malaria, tuberculosis and other infectious diseases such as measles and chickenpox, as well as immune-compromised mental healthcare users. In psychiatric hospitals the co-morbidity of mental illness and physical disease will dictate placing of the care of mental healthcare users.

Ill mental healthcare patients will as a rule be transferred to and treated in general hospitals. If the infectious disease does not warrant admission to a general hospital but the user requires barrier nursing, the user will be internally transferred to the co-morbid clinic to prevent the spread of the infection.

Mental healthcare users admitted to a psychiatric hospital with TB and who require intensive TB treatment will be transferred to specialist TB hospitals, unless the user's mental health status dictates differently. Mental healthcare users may be admitted to the co-morbid clinic before admission to a TB facility.

Healthcare workers should comply with the healthcare standards prescribed in the National Policy document. Hand-washing facilities shall be installed in all patient-care areas, nurses’ stations and also in all areas where careful attention to hygiene is essential, such as kitchens, laundries, pharmacies and laboratories. Staff amenity areas, such as bathrooms, toilets and change rooms, shall also be equipped with hand-washing facilities. The administrative infection control measures and protocols of the hospital are to be followed and implemented in the design.

(Refer to the National Infection Prevention Control Policy)

The following aspects contribute to effective infection prevention and control and are relevant within the context of the inpatient unit:

- Provision for the isolation of infectious mental healthcare users.
- Hand-hygiene facilities.
- Ventilation and air management.
- Linen handling.
- Separation of clean, used and contaminated work flows for food, linen and waste.
- Waste management.
- Surface finishes.

2.2.9. Universal access

Refer to the [IUSS GNS Inclusive environments](#).

Consideration must be given to the wide range of clients, inclusive of those with disabilities, including:

- **Mobility impairment**: ramps required at entrances with rails, not only steps, wider door openings to allow wheelchair access, lower counter tops, and disabled ablution facilities.
- **Visual impairment**: rails required to assist in way finding, Braille signage.
- **Hearing impairment**: visual signage required, to assist in alerting users.
- **Intellectually impaired**: a controlled safe environment required with fences, and protection against injury.
2.2.10. Way finding and signage

Orientation in the buildings and on the hospital grounds, and signage in the units, must be considered from the inception of the design process. The layout of the hospital must be logical and signage must be explanatory and easy to follow to assist orientation of mental healthcare users, staff and visitors.

Each separate department and inpatient unit should be individually clearly identifiable. Appropriate signage for all the internal rooms as well as the external buildings should make use of universal signage as far as possible, taking cognisance of the specific provincial policy on signage and way-finding.

Comprehensive signposting should clearly identify staff, patient and visitor areas, and draw attention to restricted areas.

Refer to the IUSS: Signage and wayfinding document.

![FIGURE 7: UNIVERSAL ROOM FUNCTION IDENTIFICATION – MITCHELL’S PLAIN HOSPITAL SIGNAGE (PHOTO: JAKO NICE)](image)

**General**

The preferred lettering style is Helvetica Medium. Both upper and lower case is generally recommended.

**Room signs**

Non-illuminated, internal and external room function identification signs that are located on doors require the following considerations:

- The format used should allow easy replacement of the sign or sign inset when the room function changes.
- Room numbering on the inpatient unit doors should be uniform in style, starting from the entrance, with the first room on the left-hand side.
- Each bed within each unit must be numbered.
2.2.11. Telecommunication, IT and e-health systems support

The following need to be provided:

- Duress alarms in patient areas, with a central control system at security point and the nurses’ station.
- Mobile panic buttons for staff.
- Computer network connections in all management, patient-administration and information systems.
- A hospital information system (HIS)/electronic patient records.
- A patient administration system (PAS).
- A radiology information system (RIS) (Digital x-rays and picture archiving) Communication System (PACS).
- Laboratory system (NHLS link).
- Pharmacy IT system.
- All other IT systems applicable to public hospitals.

Refer to the [IUSS:GNS Information technology and infrastructure](#) (ICT) document.

2.2.12. Ventilation and air-management

- Air-conditioning in general ward areas should be discouraged.
- Natural ventilation and natural light should be provided to all areas.
- Windows should be able to open without mental healthcare users being able to harm themselves.
- Medicine rooms should be temperature-controlled to protect pharmaceuticals from excess heat.
- Appropriate air management for infectious disease.
- A dilution air-management strategy for general areas is recommended; where appropriate tempered air could be provided.

Refer to the [IUSS:GNS Building engineering services](#).

2.2.13. Day and nighttime illumination

- Natural daylight should be provided as far as possible in all user daytime spaces.
- All user beds should be provided with an individual bed light to assist night-time observation of clinical interventions.
- User beds in low-security units should be provided with a reading light. The positioning of these lights should consider patients in the supine position.
- Night lights should be provided in passages where they do not disturb the sleep of users.
- Ceiling lights in rooms should be grouped to allow illumination levels to be able to be gradually reduced (not dimmers) to support clinical and monitoring functioning, with the lowest setting providing observation of patients without disturbing their sleep.

Refer to the [IUSS:GNS Building engineering services](#).
### 2.3. Interdepartmental relationships

The master plan should demarcate the site in public, educational, inpatient, clinical, facility-management and support spaces. Acute units should be positioned in the centre of the facility with outpatients and educational spaces on the periphery. Departmental relationships between units on the site should support the clinical functional flow, reducing walking distances between departments in the interest of resource utilisation. Figure 15 illustrates the required functional relationship between the services within the periphery of the site.

![Figure 8: Relationship Diagram of Functional Relationships Between Services](image)

**FIGURE 8: RELATIONSHIP DIAGRAM OF FUNCTIONAL RELATIONSHIPS BETWEEN SERVICES**
FIGURE 9: SECURITY ZONES

2.3.1. Description of spaces

- **Security by design**: The hospital should provide appropriate levels of security, patient privacy and workflow that provide an efficient relationship flow between functional units. The facility should be zoned into logical functions. All access to and from the site should be controlled, for both vehicles and pedestrians. Refer to the [IUSS Security] and SAPS Security Standards. The required space definition on site should be aligned with both the required levels of security and the relationship of units to each other, to ensure efficient clinical and organisational functioning.

- **Public spaces**: Include public parking and access to a restaurant or kiosk, Out Patients (OPD), managerial offices and access to clinical consultants.

- **Teaching spaces** include the resource centres and lecture areas.

- **Clinical support** includes clinical management, pharmacy, rehabilitation, OPD and Inpatient areas.

- **Hotel services**: These include cleaning, linen and laundry, and food and nutritional support. Hotel services (cleaning, linen and food services), mortuary services and maintenance units should have a reasonable relationship with the inpatient units.

- **Service support**: Most of these functions are similar to those of a general hospital, the only exception being the distances that bulk store supplies, linen, food and waste would need to be transported from source to destination. Consideration should be given to access routes for delivery, maintenance and the removal of waste from the units.

- **Staff On-call facilities**: Hospitals may have a separate overnight facility for qualified staff in one or more locations. The placement of sleep-in facilities should be consulted with staff. The recommended positioning is at the co-morbid clinic.

- **Entrances**: A single security-controlled entrance to the facility is required, with secure public parking outside the inpatient zones. Staff parking should be separate from public parking, and
staff should have safe access to their places of work. The general inpatient units should be separate but not fenced off from the delivery and service access routes. Inpatient accommodation accounts for the bulk of the facility infrastructure and, as such, the orientation and placement of the inpatient units should be given priority in a hospital master plan. The forensic section should be segregated from the rest of the site, with a separate security fence provided with security checkpoints.

- **Hospital management and administration**: Hospital administration and management is responsible for the coordination and management of the site and the services. This includes the teaching and training of staff, inpatient and outpatient psychiatric services and, where indicated in the brief, **Forensic Services**. All the departments have shared facility management support. Refer [IUSS:GNS to Admin and related services](#). The general psychiatric and forensic sections will be discussed separately, to assist in understanding their unique requirements. The inpatient unit, as the greatest component of the facility, has similarities to a general inpatient unit. Descriptions of generic rooms contained in the standard inpatient IUSS document for clarity. For central hospital-patient records and archive requirements refer to the IUSS admin document.

Refer to the [IUSS:GNS Adult inpatient services](#).

### 2.4. Community-based mental health services (CBMHS)

The CBMHS refers to a range of services that provide care to people with mental illnesses in the communities where they live and work, outside of hospitals. The facilities include residential, half-way houses, group homes, independent living units and day-care centres where members of the community are able to manage their lives in the community and outside a mental institution.

#### 2.4.1. Community residential care

The infrastructure should be homely and provide for rehabilitation, recreation and care. The size of the unit may vary. Table 5 lists the spaces for a 10-bed unit.

**Requirements**

- Whenever possible, care involves group homes, independent living units and half-way houses. Health services support and utilise these facilities in preference to long-term institutional care in large institutions.
- Users and their caregivers have the opportunity to be involved in the management and evaluation of their units via their clinic committees.
- Low maintenance and facility management should be considered in the design of the space.
- CBMHS services seek to provide supported accommodation through adequate planning and intersectoral collaboration.
- Accommodation should be clean and safe, and reflect as much as possible the preferences of the users living there.
- Access to the accommodation should be non-discriminatory and determined by priority of need alone.
- Group homes should be within ordinary houses dispersed throughout the general community.
- Access to treatment and support services is delivered to persons at their residences, according to individual need.
- Users living in assisted accommodation are offered maximum opportunities to participate in decision making with regard to the degree of supervision in the facility, décor, visitors, potential residents and house rules.
• Where possible, users are accommodated as close as possible to their social and cultural support systems, and public transport.
• This type of accommodation maximises opportunities for the user to participate in the local community.
• The accommodation should maximise opportunities for users to exercise control over their personal space.
• Where possible and appropriate, cultural, language, gender and lifestyle preferences are met.
• Half-way houses are residences for mental healthcare users who have either been cared for in their communities, or formerly institutionalised, and are designed to facilitate the readjustment of individuals to community life. They need to provide gardening areas, double rooms for new admissions, protective workshops with activity rooms including tables and chairs - and are similar to group homes except for separation of double and single rooms.
• Independent living units refer to those with ongoing support in the form of individual or group supervision and instruction in the basic skills of everyday living that mental healthcare users receive within the community. They require gardening areas, double rooms for new admissions, protected workshops with activity rooms with tables and chairs, and are similar to group homes except for separation for double and single rooms.
• Group homes are homes based in the community with a staff complement providing support, with semi-independent living for adult mental health users, and assisting them to re-integrate into the community. Some of the homes offer vocational groups for individuals unable to work in an environment.

Table 5 describes a 10-resident home that must provide kitchen and laundry services to single and shared rooms with ablation facilities.  

**TABLE 4: LIST OF ACCOMMODATION GROUP HOMES / HALFWAY HOUSES**

<table>
<thead>
<tr>
<th>ROOM</th>
<th>QUANTITY</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual bedrooms with clothes cupboards</td>
<td>30% of rooms</td>
<td>The rooms should be positioned with separation of male and female residences</td>
</tr>
<tr>
<td>Double rooms</td>
<td>70% of rooms</td>
<td></td>
</tr>
<tr>
<td>Ablution areas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathrooms with showers only–</td>
<td></td>
<td>Shared bathrooms , gender separated</td>
</tr>
<tr>
<td>Toilets – no to be calculated</td>
<td></td>
<td>Gender separated</td>
</tr>
<tr>
<td>Hand basins</td>
<td></td>
<td>Numbers to be calculated</td>
</tr>
<tr>
<td>Shared laundry area</td>
<td>1</td>
<td>Heavy-duty washing machine and tumble dryer. Fully equipped with drainage and an outside wash line</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ironing area</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Linen room</td>
</tr>
<tr>
<td>Shared dining room</td>
<td>1</td>
<td>Tables, chairs</td>
</tr>
<tr>
<td>Shared kitchen</td>
<td>1</td>
<td>Fridge, stove, microwave and double sink, lockable cupboards and work tops for food preparation.</td>
</tr>
<tr>
<td>Refuse area</td>
<td></td>
<td>Lockable space for kitchen and household waste</td>
</tr>
</tbody>
</table>

*3Mental Health Service Norms: A Manual for Planning, Crick Lund and Alan J. Flisher: Department of Psychiatry and Mental Health University of Cape Town*
2.4.2. **Day-care facility**

A facility that offers daytime activities and social contact for individual mental healthcare users and groups for treatment, rehabilitation, prevention and promotion activities, as well as users with severe and profound intellectual disability.

The day-care facility should be positioned with consideration to bus and transport access. There should be some space for gardening. The unit’s design and décor should be welcoming. The size of the facility will be described in the Health Brief. Note that some day-care centres do not require a full kitchen for food preparation as users bring their own refreshments.

**TABLE 5: LIST OF DAY-CARE ACCOMMODATION**

<table>
<thead>
<tr>
<th>ROOM</th>
<th>QUANTITY</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reception and administrative space</td>
<td>2</td>
<td>Desk, telephone and admin shelves</td>
</tr>
<tr>
<td>User toilets – Hand basins</td>
<td></td>
<td>Gender separated</td>
</tr>
<tr>
<td>Hand basins</td>
<td></td>
<td>Number to be calculated</td>
</tr>
<tr>
<td>Dining area</td>
<td>1</td>
<td>Mixed for all residents</td>
</tr>
<tr>
<td>Kitchen</td>
<td>1</td>
<td>Food preparation area</td>
</tr>
<tr>
<td>Pantry</td>
<td>1</td>
<td>Food storage area</td>
</tr>
<tr>
<td>Scullery</td>
<td>1</td>
<td>Built-in dish wash area</td>
</tr>
<tr>
<td>Recreational area</td>
<td>1</td>
<td>Shared area</td>
</tr>
</tbody>
</table>

<p>| Large household store               |          | Lockable storage for donations, furniture or extra bulk |
| Pantry                              | 1        | Lockable food storage area                        |
| Scullery                            | 1        | Built-in wash basins with drip trays, dish washing area |
| Shared lounge                       | 1        | Shared area fitted with a TV                      |
| Rehabilitation area (optional for protective workshop) | 1 | Installed plugs in the middle for equipment (drills, sewing machines, etc.) Central drainage systems for paint work |
| Store room                          | 2        | 1 installed with shelves for material             |
| Administrative office               | 1        | Office furniture, desk and lockable shelves, computer and a safe |
| Family Lounge                       | 1        | Small reception lounge                            |
| Administrative area                  |          | Meeting room, admission area                      |
| Physical activity room/gym           |          | Exercise equipment (bicycles, treadmills, etc.)   |
| Shared laundry area                  |          | Washing lines                                     |
| Rehabilitation area                  |          | Tables for carpentry                              |
| Residential care-taker (to be defined in the client Brief) | 1 | Sleeping area                                      |
|                                     |          | Ablution area                                     |</p>
<table>
<thead>
<tr>
<th>Location</th>
<th>Quantity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses’ office</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Treatment room</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Protected workshop</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Activity areas</td>
<td>3</td>
<td>Allow plugging of equipment</td>
</tr>
<tr>
<td>Store room</td>
<td>1</td>
<td>1 installed with shelves for material</td>
</tr>
<tr>
<td>Staff rest room and toilet</td>
<td>1</td>
<td>Fitted with seating, telephone and</td>
</tr>
<tr>
<td>Classrooms</td>
<td></td>
<td>Tables and chairs</td>
</tr>
<tr>
<td>Physiotherapy office</td>
<td></td>
<td>Therapy room with equipment, stimulation room (for severe and/or intellectual disability)</td>
</tr>
<tr>
<td>Administrative space</td>
<td></td>
<td>Staff room for teachers and care-givers</td>
</tr>
<tr>
<td>Rehabilitation area</td>
<td></td>
<td>Activity room with chairs and tables, kitchen for baking and cooking lessons</td>
</tr>
<tr>
<td>Clinical area</td>
<td></td>
<td>Nursing area with treatment room for visiting nurses to use</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Offices for sessional physiotherapist and occupational therapists</td>
</tr>
</tbody>
</table>

### 2.5. General psychiatric inpatient units

Inpatient accommodation and related services require priority consideration in the master planning of the site. Operationally efficient inpatient units range from 28 to 30 beds. Units where a smaller bed allocation is required and will be identified under the specific requirements for the specialist user programmes tailored per site. The specific unit’s bed configuration will be dictated by the size of the facility and the burden of disease according to in the specific brief for the project.

The beds are subdivided among units to provide efficiency in the management of levels of acuity and flexibility of use. Inpatient units should function as stand-alone single-storey buildings that will reflect the required bed separations as defined in the operational narrative for the project.

Single-, two- and four-bed units are regarded as the preferred bed combination to ensure effective inpatient management. The inpatient unit should be planned to operate at optimal occupancy, taking into consideration the model of care, staffing strategies and operational demands.

#### 2.5.1. Hours of operation

Inpatient units operate 24 hours per day, seven days per week.

#### 2.5.2. Patient visitors

The healthcare institution determines the visiting policy of the hospital. Patients’ visitors may be restricted or limited according to age, and number, and allocated visiting times.
2.5.3. Education

All healthcare facilities are responsible for teaching and training their staff. Formal tutorial spaces will be required, as well as training spaces in inpatient units.

Family and user education will predominantly be done in the inpatient therapeutic spaces.

2.5.4. Personnel

All inpatient units are managed by professional unit managers, supported by assigned nursing and housekeeping staff on a 24-hour operational cycle. Nursing staff work in shifts and provide day and night nursing supervision and support at both unit and organisational level.

Medical and clinical support staff provide medical, psychiatric or psychological clinical interventions according to the need of the individual patient. Doctors are required to provide a 24-hr service, for which sleep-in facilities is required.

Hotel services, such as food, linen, and cleaning services are scheduled to fit in with the requirements of units.

Facility management staff and maintenance are provided on a daily, weekly or other scheduled basis.

2.5.5. Operational policies

Operational policies could have an influence on the planning, design and function of an inpatient unit. The National and Provincial Departments of Health prescribe operational and clinical policies in the interest of quality care and infection control.

2.5.6. Internal zoning of a psychiatric inpatient unit

The inpatient unit forms the core of the patient’s treatment space. It is important to provide space that will assist in the treatment of mental healthcare users and their adjustment to a confined space. The levels of security and patient surveillance are defined by the category and behaviour of the patient.

The spaces should be arranged to separate day and night activities. Bed units should provide privacy to mental healthcare users and a safe and risk-free work environment for staff.

2.5.7. Zoning principles

- Therapeutic and clinical spaces will require 24-hr nursing and clinical access.
• The ward should provide clearly defined day and night spaces; mental healthcare users should not have unrestricted access to the night time areas during the day.
• The design of nurses’ stations should allow nurses the opportunity to avoid potentially threatening situations via an emergency exit into a safe space.
• The safety and security of staff should be considered in the placement of the staff restrooms and ablution facilities.
• Seclusion rooms could be in 24-hr use as a clinical observation space and user “time-out” period, according to the Department of Health policy on the use of seclusion rooms. Seclusion rooms should be positioned close to the nurses’ station, shielded from public access or other mental healthcare users. Users in seclusion should have access to ablution facilities in line with National basic Human Rights policy document.

**FIGURE 11: INTRA-UNIT SPECIAL ZONES**

The table below provides the room types in the required time availability.

**TABLE 6: ZONING OF INPATIENT WARDS SPACES**
### Patient's daytime spaces

<table>
<thead>
<tr>
<th>Patient dining room</th>
<th>Security</th>
<th>Reception</th>
<th>Sleep areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient lounges and TV</td>
<td>Nurses’ station</td>
<td>Unit manager and clerk</td>
<td>Showers and toilets</td>
</tr>
<tr>
<td>Quiet room</td>
<td>Seclusion rooms</td>
<td>Waiting areas</td>
<td>Clothes and kit rooms</td>
</tr>
<tr>
<td>Games and OT</td>
<td>Treatment room</td>
<td>Visitors’ lounge</td>
<td></td>
</tr>
<tr>
<td>Group therapy</td>
<td>Ward kitchen</td>
<td>Patient’s laundry</td>
<td></td>
</tr>
<tr>
<td>Consulting</td>
<td>Clean utility</td>
<td>Waste management</td>
<td></td>
</tr>
<tr>
<td>Counselling rooms</td>
<td>Stores (linen, general, medicine)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day ablutions</td>
<td>Staff rest room and ablutions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Garden space</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Table 3.1: Functional Flow of Day and Night Spaces

<table>
<thead>
<tr>
<th>24-hour spaces</th>
<th>General service/support space</th>
<th>Nighttime space</th>
</tr>
</thead>
<tbody>
<tr>
<td>Security</td>
<td>Reception</td>
<td>Sleep areas</td>
</tr>
<tr>
<td>Nurses’ station</td>
<td>Unit manager and clerk</td>
<td>Showers and toilets</td>
</tr>
<tr>
<td>Seclusion rooms</td>
<td>Waiting areas</td>
<td>Clothes and kit rooms</td>
</tr>
<tr>
<td>Treatment room</td>
<td>Visitors’ lounge</td>
<td></td>
</tr>
<tr>
<td>Ward kitchen</td>
<td>Patient’s laundry</td>
<td></td>
</tr>
<tr>
<td>Clean utility</td>
<td>Waste management</td>
<td></td>
</tr>
<tr>
<td>Stores (linen, general, medicine)</td>
<td>Waiting areas</td>
<td></td>
</tr>
<tr>
<td>Staff rest room and ablutions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 2.5.8. Inpatient unit activities

Inpatient units must provide for the following patient activities:

- Clinical diagnostic activities (medical, diagnostic imaging, laboratory, inpatient unit rounds, doctors’ visits, investigations or rehabilitation).
- Activities of daily living (dressing and undressing, eating, drinking, personal toilet and ablution activities).
- Social activities (relaxing, having time out, playing games or receiving visitors).

![FUNCTIONAL FLOW OF DAY AND NIGHT SPACES](image)
2.5.9. **Inpatient workflow**

A single patient entry point to the unit is preferred in order to control traffic in and out of the unit. It is important that deliveries to and from the inpatient unit are managed so as not to clash with unit security. Goods and services and refuse removal should be scheduled in line with the unit activities.
### TABLE 7: INPATIENT UNIT ACTIVITIES

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>ACTIVITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Patient must be capable of managing his or her activities of daily living.</td>
</tr>
<tr>
<td>B</td>
<td>Patient observation. Treatment procedures such as medication, etc. Patient activity, teaching. Coordination of patient care, observation, writing up of clinical notes, entering of data into computers, making and receiving of phone calls and washing hands. Patient observation and clinical group discussions. Treatment procedures such as counselling and consultations, etc. Emergency procedures - e.g. sedating mental healthcare users. Examination of mental healthcare users and washing hands. Writing reports and instructions, writing up of clinical notes, entering of data into computers. Teaching. Washing hands. Specific occupational therapeutic interventions. Patient consulting. Diagnostic procedures such as x-rays, ultrasounds, ECGs, etc. Washing hands.</td>
</tr>
<tr>
<td>C</td>
<td>Clerical/administrative Answering telephones, receiving mental healthcare users and visitors to the inpatient unit. Writing reports and collecting and entering data and statistics, ordering food and other consumables. Washing hands.</td>
</tr>
<tr>
<td>D</td>
<td>Ancillary staff (aide, patient assistant) Assist mental healthcare users in wheelchairs. Entertain mental healthcare users. Washing hands.</td>
</tr>
<tr>
<td>F</td>
<td>Maintenance Staff Maintenance – replace globes, fix fittings, resealing of floor and repair work to maintain the inpatient unit. Washing hands.</td>
</tr>
<tr>
<td>G</td>
<td>Visitors Visit mental healthcare users and socialise on the inpatient unit or day room. Washing hands.</td>
</tr>
</tbody>
</table>
**FIGURE 13: PSYCHIATIC INPATIENT FLOW DIAGRAM**

Inpatient unit layouts will vary, depending on the individual needs of a project as outlined in the health and design briefs for the specific project.

However, general principles of design will apply and the location of facilities within the inpatient unit should be a logical process, optimising the workflow and travel distances for staff, from service and storage areas to the patient’s bedside.

**Points of entry:**

- Mental healthcare users or visitors will access the unit from the main entrance of the unit through a secure entrance into a reception area, where the patient or visitors will be received by the unit’s staff, from where a new patient will be directed for admission and visitors directed to waiting areas or the visitor’s lounge. Visitors should not have access to patient spaces.
- Unit security staff are assigned to admission units and to medium-secure units. The security staff forms an integral part of the unit management system to assist in patient control and staff safety.
- Security stations should be positioned between reception and the nurses’ station, with a clear view of the nurses’ station.
- Receiving and dispatch of stores, food and laundry, and the removal of used linen and waste, will be received or collected from a secure service-access point.
- Covered walkways are required between clinical buildings in support of the night staff’s rounds, and from the service entrance door to the point of public street access.
2.5.10. Unit security

The security office is regarded as a user restricted area.

Every ward will be supported by in-unit security staff. The security staff will form an integral part of the unit staff complement. An enclosed security station should be provided at the entrance to the unit, with a clear view of the facility’s front gate and the entrance or reception areas.

In high and medium-security units the security staff will be responsible for doing staff and visitor bag-and-body searches.

The security staff will manage access control and support the clinical staff in the event of aggressive patient behaviour and will monitor the perimeter fence of the facility and all public user spaces to maintain a conducive therapeutic environment.

2.5.11. Unit management and administration

- Unit manager
- Doctors’ office
- Clinical administration.

Refer to IUSS:GNS Adult inpatient services and IUSS:GNS Generic room requirements.

2.5.12. Nurse station

The clinical control centre/nurses’ station requires 24-hour access by the nursing and clinical staff.

The nurses’ station forms the administrative and clinical control centre of the unit. All day and night clinical functions are coordinated from the nurses’ station, with support from the ward security staff and unit management.

The nurses’ station should have direct observation of the patients’ day and night spaces. It should provide an emergency exit for staff needing to avoid confrontational situations. The control panels, nurse-call system and panic button should be provided at the nurses’ station. Inpatient ward records must be under secure lock and key.

**FIGURE 14: NURSES’ STATION –MITCHELL’S PLAIN HOSPITAL, (PHOTO: JAKO NICE)**
2.5.13. Treatment room

Treatment rooms in inpatient areas are used for clinical procedures and in some facilities for giving ECT to users. The room design should provide with clinical wall services, storage space and an emergency trolley.

Refer to [IUSS:GNS Adult inpatient services].

![Treatment Room - Mitchell's Plain Hospital](image)

**FIGURE 15: TREATMENT ROOMS –MITCHELL’S PLAIN HOSPITAL (PHOTO: JAKO NICE)**

2.5.14. Medicine room

The medicine room should be adjacent to the nurses’ station, air-regulated and fitted with a locked medicine fridge and space to accommodate the ward medicine trolley.

Refer to [IUSS:GNS Adult inpatient services].

2.5.15. Clean utility

The clean utility room should be close to the nurses’ station.

Refer to [IUSS:GNS Adult inpatient services].

2.5.16. Clinical administration

The clinical administration area is a shared workspace for doing patient administration.

Refer to [IUSS:GNS Adult inpatient services] and [IUSS:GNS Generic room requirements].

2.5.17. Consulting room

Consulting rooms in mental health facilities often double up as counselling rooms. The layout of the room should consider the positioning of the desk and chairs such that the arrangement of the furniture remains flexible.
2.5.18. Counselling room

Counselling rooms should be non-threatening spaces with furniture that supports communication. The counselling room requires a homely atmosphere and, if required for play therapy, toys and a child-friendly environment.

2.5.19. Stores: linen and general store

Refer to IUSS:GNS Adult inpatient services and IUSS:GNS generic room requirements.

2.5.20. Dirty utility

Refer to IUSS:GNS Adult inpatient services and IUSS:GNS generic room requirements.
2.5.21. Seclusion rooms

A seclusion room should be regarded as an acute clinical space. Admission to this space is regarded as a short-term emergency intervention in a restrictive environment, with the aim to reduce environmental stimulation and contain dangerous or violent behaviour that might threaten people or property, as prescribed in terms of the Mental Health Act No 17 of 2002.

(Refer to National Policy on Seclusion Rooms for position and placement.)

The positioning of the seclusion spaces should be in close proximity to the nurses’ station for purposes of observation and control. To compensate for power failures, reinforced/toughened-glass viewing panels should be installed for purposes of user observation. The size of the window panel should allow observation without impacting on patient privacy, and it should not compromise the stability of the door.

CEILINGS

- Seclusion rooms should be reinforced with concrete or tamperproof ceilings, and with recessed light fittings. Ceilings should be 3000mm above finished floor level (FFL).

**FIGURE 18: VANDAL- AND TAMPER-RESISTANT CEILING**

**TEMPERATURE AND VENTILATION**

- Suggested room temperature 18 to 26 degrees Fahrenheit.

Refer to [IUSS:GNS Building engineering services](#).

- Temperature-controlled air management is preferable. If the system cannot be provided or in cases when the system is not working, provision is to be made for natural ventilation from a window with restricted openings not more than 125mm wide.

**WALL PAINT**

- The walls of the unit require frequent washing and cleaning. The wall covering should be non-toxic.

Refer to [IUSS:GNS Materials and finishes](#).
**ILLUMINATION**

- As much natural lighting as possible should be provided. It should be noted that confused mental healthcare users have disturbed day and night rhythms and daylight assists in patient orientation to time and space.
- The light should be able to be dimmed from outside the room.
- Recessed illumination should be used and the patient should not be able to reach or break the light.

**WINDOWS**

- Windows preferably should have external views; but with little risk to mental healthcare users.
- The window design should allow for light and natural ventilation without breaching security.
- The user should not be able to break the glass and injure him/herself.
- Windows must be constructed so as to minimise windowpane breakage.
- Window frames must be able to withstand repeated attempts at dismantling.
- Windows should have heavy-duty, corrosion-resistant steel frames.
- Windows should have vandal- and corrosion-resistant finishes.
- The glass is to be manufactured with an embedded corrosion-resistant steel screen, and preferably reinforced toughened glass.
- The window opening width must be designed in such a manner as to prevent the patient escaping.

**FIGURE 19: SECLUSION-ROOM WINDOWS**

**MATTRESS/BED**

- The bed height with the mattress should not exceed 450mm.
- The built-in concrete beds should be positioned away from the wall, without providing hiding space.
- The corners of the beds should be rounded to avoid injury.
- The mattress must be fire-, waterproof- and tear-resistant, and not toxic in the event of fire.
- The room should contain no other furniture.
- The room must not have sharp corners, windowsills, hardware or protrusions which can cause injury to the occupant.
**FIGURE 20: FIXED BED WITH INFLAMMABLE MATTRESS**

**SMOKE DETECTION**
- Integrated recessed smoke detector linked to the nurse station and proposed main security control room.

**COMMUNICATION**
- Vandal-resistant intercom system linked to the nurse station.

**FLOORS**
- Floors in seclusion rooms should have floor drains casted in situ.
- Floors should be finished with 4mm self-levelling non-slip epoxy.
- Floor coverings should be seamless and reinforced.
- Skirting should not be used and corners should be coved.

**ABLUTION FACILITIES**
- Mental healthcare users to have regular and easy access to toilet facilities if these are not provided in the seclusion room.
- Design to consider how maintenance and repairs will be done, while ensuring the safety of the maintenance staff.
- If ablation facilities are to be included in the seclusion ward, the following should apply:
  - All toilets to be fitted with approved odour-extraction systems.
  - Hand-wash basins are to be encased, wall mounted ("Marley" Gyppy), and vandal-resistant.
  - All plumbing is to be chased into walls and plastered over.
  - Taps to be push-button with demand-controlled water supply.
  - No accessories should be provided.

**DOORS**
- The design of doors should be considered as internal security doors.
- Doors must be at least one metre wide and not exceed two metres. There should be enough space for the staff required to contain a patient, and for the movement of resuscitation equipment.
- A 450 x 150mm viewing panel, protected with vandal-resistant steel mesh is to be fitted into a steel frame.
- Consideration should be given to the design of the door frames, opportunity for ligature risk, and the means to barricade the door should that be necessary. Heavy-duty corrosion-resistant steel frames.
• Doors should have a vandal- and corrosion-resistant finish and an acoustic or sound-reducing capability.
• The observation panel must be fitted with vandal-resistant glazing material.
• Anti–ligature door handle and lock combination.
• Doors should have a two- or three-way dead bolt lever-locking action.
• Doors should have a continuous vertical corrosion-resistant heavy-duty hinge solution.
• Doors should be hung to open in wards on special galvanised steel frames with lugs pre-welded to the frame.
• Galvanised door frames that are hot-dipped should be built into 230mm solid brick walls. No welding should be done on site.
• Door hinges should be a heavy-duty stainless steel ball type and encased in spun casting.
• The door must be fitted with a robust lock on the outside, and preferably secured at top, middle and bottom to safeguard against repetitive patient abuse.
• The door must not have any handles on the inside.
• Doors to be fitted with externally “high strength” folding security gates - as installed by the prison authority.

**FIGURE 21: SECLUSION ROOM DOOR HINGES**

**FIGURE 22: TAMPER-PROOF HAND-WASH BASIN AND ACCESSORIES**

Refer to [IUSS:GNS:Generic room requirements](#).
2.5.22. Patient day spaces

The following room requirements are recommended for a typical 30-bed unit. The bed numbers should guide the provision of the space.

*Patient lounge*

- The patient lounge should provide a comfortable space with seating arranged to provide patient privacy. A TV set should be provided.

Refer to [IUSS-GNS Generic room requirements](#).

*Dining room*

- All meals will be served in the dining room. The room should provide a homely atmosphere with interior design that will also provide a safe space for mental healthcare users and staff.
- The room should be placed in proximity to the ward kitchen, fitted with a serving hatch between the two rooms to support food serving and the clearing of dishes. In acute and medium-acute units the legs of the tables and chairs should be bolted to the floor. Vinyl floors are preferred, and should be easy to maintain.
- The room has a dual function as a day recreation space for indoor games and social activities. A wall-mounted television should be provided, and the TV set should be protected from patient abuse.

Refer to [IUSS-GNS Generic room requirements](#).

*Quiet room*

- The quiet room should provide space for mental healthcare patients who wish to read or who want to be by themselves.

Refer to [IUSS-GNS Generic room requirements](#).

*Ablutions*

Refer to [IUSS-GNS Outpatient services](#) and [IUSS-GNS generic room requirements](#).

*Outside garden or courtyards*

- The outside garden should be fenced off with no opportunity for escape. Fixed garden furniture should be provided, as well as some overhead shading. Plants should be planted outside of the fence to support maintenance, watering and pruning by staff.

![FIGURE 23: EXAMPLES OF EXTERNAL SPACES](image_url)
2.5.23. Sleeping areas

Single- and four-bed configurations provide the highest levels of flexibility and efficiency. The bed configuration will be specified in the operational narrative for the project. Mobile panic buttons are preferred, however fixed panic buttons can be considered at strategic points.

Refer to [IUSS:GNS:Generic room requirements](#).

**FIGURE 24: EXAMPLE OF A VOLUNTARY INPATIENT ROOM WITH EN-SUITE BATHROOM**

**TABLE 8: REQUIREMENTS FOR THE DIFFERENT BEDROOM CONFIGURATIONS**

<table>
<thead>
<tr>
<th>Room types</th>
<th>Size</th>
<th>Room configuration</th>
<th>Ablution facilities</th>
<th>Windows, doors and flooring</th>
<th>Illumination</th>
<th>Wall covering</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medium to high security: Single room with toilet and basin only</td>
<td>13-15sq.</td>
<td>Bolted or built-in beds with mattress specifications.</td>
<td>Tap water must be temperature-controlled at 40°C with a metered push-button. Shower rose to be specified; Single individual urinals with push-button water flush. Toilets and basins should be break-resistant (Gypsy range). NOT pressed steel. Toilet paper holder provided</td>
<td>Glass window protection should be provided. &quot;Britplas&quot; or similar epoxy flooring in bathrooms that is slip-resistant. Vinyl floors or similar in bedrooms with integrated covered skirting.</td>
<td>All lights should be recessed, covered with laminate glass and tamper-proof</td>
<td>Epoxy painted walls. Face bricks should not be used.</td>
</tr>
</tbody>
</table>
2.5.24. **Kit room**

Mental healthcare users wear day clothes which require a patient kit room. Some mental healthcare users wear their private clothes, packing space should be provided in the bedroom. Clothes-hanging space should only be provided in the kit rooms.

Refer to [IUSS:GNS Generic room requirements](#).

2.5.25. **Patient household spaces**

Some of the unit spaces should be restricted areas for mental healthcare users. The ward kitchen is a space where mental healthcare users should not be allowed unsupervised.

**Ward kitchen**

- The kitchen should be fitted with a serving hatch into the dining room. Access for the food trolley should be separated from the main patient access points. Pre-plated flood systems are preferred rather than the traditional system where food is transported in bulk and dished up at the ward. A lockable cutlery and crockery store is required in addition to the normal kitchen spaces.

Refer to [IUSS:GNS Generic room requirements](#).

**Cleaners’ room**

- The cleaning station provides space for the cleaner to lock up cleaning material, cleaning machines and housekeeping items.

Refer to [IUSS:GNS Generic room requirements](#).

**Patient laundry**

- Some of the mental healthcare users may require facilities to wash and iron their clothes. For this purpose a small laundry should be provided with a washing sink, a household washing machine and ironing workspace. A clothes-drying rack or an outside washing line should be provided.

Refer to [IUSS:GNS Laundry and linen](#) and [IUSS:GNS Generic room requirements](#).

**Dirty utility and waste management**

- An 8m² space should be provided as part of the services section of the ward for temporary storage containers for dirty and used linen, household waste and, where required, clinical waste containers. Access to this space should also be restricted.

Refer to [IUSS:GNS Waste](#) and [IUSS:GNS Generic room requirements](#).

2.5.26. **Staff spaces**

**Staff rest**

Refer to [IUSS:GNS Adult inpatient services](#) and [IUSS:GNS Generic room requirements](#).

**Staff lockers and ablutions**

Refer to [IUSS:GNS Adult inpatient services](#) and [IUSS:GNS Generic room requirements](#).

**Lecture rooms**

Refer to [IUSS:GNS Training and resource services](#) and [IUSS:GNS Generic room requirements](#).
**Doctors sleep-over**

- To be placed near the admission and co-morbid unit.

Refer to [IUSS-GNS Emergency Centres](#).

---

### 2.6. Psychiatric specialist inpatient units

#### 2.6.1. Admission unit

The unit offers 24-hour acute admission to mental healthcare users. Admissions may arrive as transfers from general hospitals, the South African Police Service, community health services, with family or as self-referrals. The unit resembles an emergency unit in a general hospital, in that no inpatient beds are provided.

Below is the list of admission unit room types.

Refer to [IUSS-GNS Emergency centres](#).

**Room types:**

- Patient drop off
- Security desk
- Wheelchair/trolley park
- Admission desk/medical records
- Waiting room with ablution facilities
- Consulting rooms (two)
- Unit management, nurses’ station
- Clinical rooms: medicine room, clean utility, treatment room, stores, dirty utility
- Observation room
- Doctors’ sleep-over.

#### 2.6.2. Acute units

The acute unit receives, over 24 hours, acutely ill mental healthcare users of all ages, male and female, from the admissions unit. It is a high-secure unit and must be designed to suit the mental health and safety needs of mental healthcare users.

The design requirements for the unit should comply with the standards of a typical psychiatric inpatient unit.

#### 2.6.3. Medium and long-term care

These units manage mental healthcare users that require rehabilitation and longer-term hospitalisation.

Both the medium and long term units should be gender-specific. Both levels of care should meet the requirements of a typical psychiatric inpatient unit.
2.6.4. Specialised Psychiatric Programs

Psychotherapeutic programs

Specialised programmes include those for eating disorders, behavioural modification, and others. Most mental healthcare users admitted to the unit are voluntary patients. The unit is a low-secure unit that should meet the requirements of a typical psychiatric inpatient unit.

Co-morbidity clinic

The co-morbid clinic will provide inpatient beds, a unit for electroconvulsive therapy (ECT) and a room for an electro encephalogram (EEG).

The clinic deals with medical conditions and psychiatric disorders.

Electroconvulsive Therapy (ECT) unit.

Electro-Encephalogram (EEG) unit.

Specific Requirements

Mental healthcare users who require admission to a medical facility for medical intervention but who are not mentally stable are treated as inpatients in the co-morbid unit while awaiting transfer to a medical facility. The design requirements should meet the standards of a typical medical inpatient unit. Refer to IUSS:GNS Adult inpatient services.

The unit should provide two single-bed isolation units.

FIGURE 25: EXAMPLE OF AN ELECTROCONVULSIVE THERAPY (ECT) PROCEDURE ROOM LAYOUT
**FIGURE 26: ELECTROCONVULSIVE THERAPY (ECT) PROCEDURE ROOM ELEVATION**

**FIGURE 27: EXAMPLE OF AN ELECTRO-ENCEPHALOGRAM (EEG) ROOM LAYOUT**
**FIGURE 28: ELECTRO-ENCEPHALOGRAM (EEG) ROOM ELEVATION**

**FIGURE 29: EXAMPLE OF AN ELECTROCONVULSIVE THERAPY (ECT) PROCEDURE RECOVERY ROOM LAYOUT**
SUBSTANCE ABUSE AND PSYCHIATRIC DISORDERS

The need for a substance-abuse unit will depend on the disease profile and the requirements of the health brief. The beds assigned to the unit should be dictated by the disease profile and the facility’s bed allocation and will be attached to the co-morbid clinic.

Room types:

- Security desk
- Consulting/counselling rooms (three)
- Nurses' station
- Clinical rooms: medicine room, clean utility, treatment room, stores, sluice (for urine testing only), dirty utility
- Group room (one)
- Patient lounge
- Dining room
- Kitchen
- Single bedrooms with en-suite bathroom
- Outside enclosed garden with some shaded spaces.

Electroconvulsive therapy (ECT) is administered only in exceptional cases under general anaesthetic by an anaesthetist. There should be rooms for ECT and for recovery post-ECT, which should provide emergency life support, oxygen and suction facilities.

The infrastructure requirements for ECT should be provided according to the requirements specified in the national policy guideline on ECT for mental healthcare users. (Refer to the National policy on ECT.)

**TABLE 9: ELECTRO-ENCEPHALOGRAM**

<table>
<thead>
<tr>
<th>Reception</th>
<th>Waiting area with a toilet</th>
<th>Consulting room</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seating for four people</td>
<td>Refer: IUSS OPD</td>
<td></td>
</tr>
</tbody>
</table>
PSYCHO-GERIATRICS: 20 BEDS

The unit provides for mental conditions associated with the elderly. Due to the nature of the unit, it is regarded as a secure area. Special consideration should be given to accessibility for the mobility-impaired. Assistive devices should be provided, such as hand rails, as well as ablation facilities and showers for the disabled.

2.6.5. Child and adolescent unit

Child and adolescent mental healthcare users are admitted to separate sections of the mental healthcare facility only if they cannot be managed as inpatients in other healthcare facilities or as outpatients. Mental healthcare facilities should be the last resort for admitting children.

The space design of the unit should be flexible and age-appropriate. The unit should resemble a domestic environment while providing a highly secure, robust environment that will be able to withstand acting-out behaviour and support severely withdrawn behaviour. To this end the suggested size of the unit should be smaller than the standard adult inpatient unit. The bed configuration will be dependent on the burden of disease and the province’s strategic plan.

The design should provide single-bed units which are gender-separated. The interior design should be client-appropriate. The unit should have a smaller segregated unit for children under the age of 12 years. Linked to the child unit there should be accommodation for parents.

The unit should be regarded as a high-security area. CCTV monitoring of the peripheral fence should be monitored by the in-unit assigned security staff.

Video conferencing of play areas, counselling and consulting spaces should be linked to the clinical discussion room for clinical observation of users.

**TABLE 10: ADOLESCENT UNIT AND CHILD UNIT**

<table>
<thead>
<tr>
<th>Adolescent spaces and beds</th>
<th>Shared spaces</th>
<th>Child spaces and beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male beds</td>
<td>Female beds</td>
<td>Adolescent observation or seclusion.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Time-out/quiet room.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Games/play room.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ablution facilities.</td>
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</tr>
</tbody>
</table>

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**INFRASTRUCTURE UNIT SUPPORT SYSTEMS (IUSS) PROJECT**

Health Facility Guides: 11 June 2014
Mental Health [PROPOSAL V.2]
2.7. Clinical support

The inpatient units are supported by a diverse clinical support network that includes the rehabilitative sciences of occupational therapy, psychology and dietetics. These professionals form an integral part of the treatment and rehabilitation of mental healthcare users.

2.7.1. Rehabilitative sciences

The service refers to the services by social workers and occupational therapists and psychologists.

Psychological services

The psychologists will consult with mental healthcare users on an individual and group basis. All inpatient units will provide therapeutic space for both requirements. Office space for psychologists will be provided as part of the clinical management unit.

Social work: service and functions

The social work sub-division is responsible for service delivery in designated psychiatric hospitals. Social-worker services include an assessment of cases and services to the family, care-givers or support systems, augmented by community resource networking (ensuring appropriate resource access/services in the community). Social work includes case work, group therapy/group work and community work.

Occupational therapy: service

Occupational therapy aims to prepare the mental healthcare user for discharge, assists the patient in skills development and cognitive rehabilitation. All stable mental healthcare users are expected to participate in occupational therapy (OT) on a daily basis.

Refer to the IUSS Rehabilitation document for physical rehabilitation. The IUSS rehabilitation document is specifically directed at physical rehabilitation, and not mental healthcare rehabilitation.

The type of services offered in the OT department are largely group-based with a strong emphasis on active patient involvement. Activities range from the creative (art, pottery, woodwork) and include activities aimed at addressing occupational needs (employment, self-care, community survival). The following aspects need to be considered:

- A security access-control system should be provided that will allow visual access to the front door.
- Installation of an alarm system is essential. All rooms should be lockable and the locking system should be able to withstand constant use.
- The building should be designed in such a way that concealment, both inside and outside is minimised.
- The staff areas should be in a section of the building that is access-controlled. Mental healthcare users should not have access to the staff areas.
- A public address system should be installed which can be controlled from the reception office.
- The building should be able to withstand volumes of people constantly moving about.
- External doors should be limited.
- The patient flow should be between the front door and the various patient areas.
- The unit should be easy to clean – floors should be able to withstand spillage of a variety of substances (water, paint, glue, etc.).
- The unit should be well lit and well ventilated and provision should be made for heating during the winter months.
- All treatment areas, including the work-rehabilitation area, should have hand-wash basins with lockable cupboard space.
• All areas should have appropriate electricity plugs, evenly dispersed around the rooms.
• A central courtyard is desirable.
• The passages in the building should overlook the courtyard to provide light and access to the garden space. Access to the courtyard should be via patio doors that have robust locks with a partially shaded area.
• A greater focus on group treatment sessions is appropriate for mental health.
• A smaller number of individual session rooms are required, except for psychologists.
• A smaller number of individual spaces is required for physiotherapy and occupational therapy rooms.
• The gym space is a group non-institutionalised set-up, with a preferred focus on circuit training rather than individual exercises.
• The central gym space should double up as the group therapy and treatment area, run by a counsellor, psychologist, occupational therapist or physiotherapist as and when required.
• The individual rooms should not openly face the gym area, but have discreet access and both visual and auditory privacy.
• Inter-disciplinary elements of adult physical rehabilitation need to be maintained where possible, but considering patient confidentiality and privacy.
• Consideration for family support or counselling areas needs to be included.

** Please note the suggested room sizes in Table 12 should be appropriate to the overall bed numbers and user population.

Refer to [IUSS:GNS Adult physical rehabilitation services](#) and [IUSS:GNS Generic room requirements](#).
### TABLE 11: ROOM NUMBERS FOR PROFESSIONAL SERVICES ALLIED TO MEDICINE

<table>
<thead>
<tr>
<th>Offices, therapists and support staff</th>
<th>Office to accommodate at least 3-4 people, and storage space. Telephone and computer points.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shared offices (6)</td>
<td>Workspace for 6 staff, computer points and telephones.</td>
</tr>
<tr>
<td>Staff rest/tearoom</td>
<td>Ref: IUSS standard.</td>
</tr>
<tr>
<td>Staff ablutions</td>
<td>Ref: IUSS standard.</td>
</tr>
<tr>
<td>Computer room</td>
<td>Computers (4) are to be installed to teach mental healthcare users IT skills.</td>
</tr>
<tr>
<td>Work rehabilitation</td>
<td>To seat about 12 people at 3 tables.</td>
</tr>
<tr>
<td>Activities of daily living unit for mental healthcare users</td>
<td>The purpose of this facility is to train mental healthcare users in life skills are appropriate for both rural and urban clients. This would require cooking devices appropriate to the specific client’s needs. Provide a four-plate stove with an oven, fridge, microwave, and hydro boil, with work surfaces/tables, lockable storage and floor space that will allow 4 people to work in the area.</td>
</tr>
<tr>
<td>Handicrafts</td>
<td>Two four-seater tables with chairs, lockable storage space, worktops.</td>
</tr>
<tr>
<td>Art and pottery room</td>
<td>Space for kiln and at least one pottery wheel. Water supply with stainless steel basin/sink. Open shelving. Lockable storage cupboards. Should be well ventilated.</td>
</tr>
<tr>
<td>Group rooms (2)</td>
<td>To accommodate at least 10 people seated in a circle. At least one of the rooms should have observation facilities, either a one-way observation facility or a teleconference system linked to a staff group room. One of the group rooms should be larger to accommodate quiet sessions - e.g. relaxation and yoga. This room should be carpeted, airy and spacious with wall-mounted heaters.</td>
</tr>
<tr>
<td>Patient lounge</td>
<td>To accommodate about 15 people seated.</td>
</tr>
<tr>
<td>Gymnasiun and multipurpose recreation hall</td>
<td>An area that can accommodate 10-15 mental healthcare users and exercise gear. Activities include table tennis, snooker, indoor soccer, dances, talent shows, ceremonies, drumming sessions, screening of movies, etc.</td>
</tr>
<tr>
<td>Patient ablutions</td>
<td>Male/female and a disabled toilet that would have to provide for about (100 patients per day).</td>
</tr>
<tr>
<td>Outdoor area</td>
<td>There should be a large space, grass-covered, which can be used when playing soccer, volley ball or doing athletics.</td>
</tr>
<tr>
<td>Library</td>
<td>To accommodate at least three large shelving units, with a separate space for a quiet reading corner, furnished with approximately four easy chairs and a small coffee table. Space for a desk and chair for the library assistant. Good lighting and well ventilated.</td>
</tr>
<tr>
<td>Hairdressing / self-care</td>
<td>At least 2 basins (suitable for hair washing), with hand-held tap shower. The electricity points should be close to this wall. A waiting area and storage area should be adjacent to the hairdressing section.</td>
</tr>
<tr>
<td>Store rooms</td>
<td>Storage rooms should be attached to the work-rehabilitation area, art room, pottery area, handicrafts area, general store. Each should have floor-to-ceiling shelves.</td>
</tr>
<tr>
<td>Tuck shop</td>
<td>This is a small shop with seating for about 12 people. Separate from the OT building.</td>
</tr>
</tbody>
</table>

#### 2.7.2. Radiology

Mental healthcare users who require radiology services will be treated at general hospitals’ radiology departments.

#### 2.7.3. Laboratory services

All laboratory specimens will be taken to the main hospital laboratory by messenger service.
2.7.4. CSSD

A small CSSD will be required to meet the needs of the facility. Refer to IUSS:GNS Facilities for surgical procedures and IUSS:GNS Central sterile service department.

2.7.5. Mortuary services - body store

A mortuary that will provide body storage will be required.

2.7.6. Outpatient care

Mental healthcare users discharge as an inpatient will be followed up at an outpatient facility. The follow-up visits could be scheduled to form part of a designated psychiatric hospital or a mental healthcare user might be referred to a general hospital outpatient service. Refer to IUSS:GNS Outpatient services document.

**TABLE 12: ACCOMMODATION SCHEDULE: FORENSIC OUTPATIENT DEPARTMENT (OPD)**

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>NO OF ROOMS</th>
<th>FUNCTION</th>
<th>NO OF PERSONS</th>
<th>REMARKS/NARRATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GENERAL</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secured drop-off point for patients</td>
<td>1</td>
<td></td>
<td></td>
<td>Outside main entrance to OPD</td>
</tr>
<tr>
<td>Security point at entrance</td>
<td>1</td>
<td>Security control</td>
<td>2</td>
<td>See specific requirements</td>
</tr>
<tr>
<td>Reception area</td>
<td>1</td>
<td>Patients received &amp; directed to applicable admission point</td>
<td>7</td>
<td>See specific requirements</td>
</tr>
</tbody>
</table>

**SECURE OPD AREA for short courses (OPD1) and outreach (OPD2)**

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>NO OF ROOMS</th>
<th>FUNCTION</th>
<th>NO OF PERSONS</th>
<th>REMARKS/NARRATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office for administration</td>
<td>1</td>
<td>For use by admission clerk</td>
<td>1</td>
<td>See specific requirements</td>
</tr>
<tr>
<td>Waiting room (secure)</td>
<td>1</td>
<td>Waiting facilities</td>
<td>12</td>
<td>See specific requirements</td>
</tr>
<tr>
<td>Toilets (disabled-friendly) Inside waiting room</td>
<td>2</td>
<td>Toilet for use by SAPS and staff + Awaiting-trial detainee</td>
<td></td>
<td>See general specifications</td>
</tr>
<tr>
<td>Consultation room</td>
<td>3</td>
<td>MDT</td>
<td></td>
<td>See general specifications</td>
</tr>
<tr>
<td>Treatment/examination room</td>
<td>1</td>
<td></td>
<td></td>
<td>See general specifications</td>
</tr>
</tbody>
</table>

**GENERAL ADMISSION AREA for state patients (OPD 3) and Primary Healthcare (OPD 4)**

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>NO OF ROOMS</th>
<th>FUNCTION</th>
<th>NO OF PERSONS</th>
<th>REMARKS/NARRATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting area</td>
<td>1</td>
<td>Waiting facilities</td>
<td>20</td>
<td>See specific requirements</td>
</tr>
<tr>
<td>Visitors’ toilet (male)</td>
<td>1</td>
<td>Toilet for use by visitors/patients</td>
<td>1</td>
<td>See general specifications</td>
</tr>
<tr>
<td>Visitors’ toilet (female)</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visitors’ toilet (disabled)</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reception</td>
<td>1</td>
<td>For use by admission clerk</td>
<td>1</td>
<td>See specific requirements</td>
</tr>
<tr>
<td>Nurses’ duty room</td>
<td>1</td>
<td>For nursing hand-over</td>
<td>10</td>
<td>See specific requirements</td>
</tr>
<tr>
<td>General store</td>
<td>1</td>
<td>Storage of supplies</td>
<td>1</td>
<td>See general specifications</td>
</tr>
<tr>
<td>Staff room with</td>
<td>1</td>
<td>For tea / dining / relaxing</td>
<td>10</td>
<td>See general specifications</td>
</tr>
</tbody>
</table>
### Table: Infrastructure Unit Support Systems (IUSS) Project

**DESCRIPTION** | **NO OF ROOMS** | **FUNCTION** | **NO OF PERSONS** | **REMARKS/NARRATIVE**
--- | --- | --- | --- | ---
Kitchenette | | | | 
Staff toilet (male) |  | Toilet for use by staff | | See general specifications
Staff toilet (female) |  | | | 
Staff toilet (disabled) |  | | | 
Cleaner’s room | 1 | For use by cleaner | 1 | See general specifications
Treatment / examination / medication room | 1 | Combined for clinical procedures & examination of patients | | See specific requirements under OPD
Consultation room | 5 | MDT | | See general specifications
Counselling room | 2 | | | See general specifications
Meeting room | 1 | For group activities with patients. | 11 | See general specifications
Pharmacy medicine room | 1 | For use by pharmacy to dispense medication to forensic outpatients | 1 | Situated near entrance

**Table 13: Accommodation Schedule: Child & Adolescent Outpatient Department**

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>NO OF ROOMS</th>
<th>FUNCTION</th>
<th>NO OF PERSONS</th>
<th>REMARKS/NARRATIVE</th>
</tr>
</thead>
</table>
| Waiting area | 1 | Waiting facilities | 20 | See specific requirements under OPD
| Visitor toilet (male) | 1 | Toilet for use by visitors / patients | 1 | See general specifications
Visitor toilet (female) | 1 | | | 
Visitor toilet (disabled) | 1 | | | 
Assistant Manager Nursing office | 1 | Office for assistant nursing manager | 1 | Office norms
Administrative office | 1 | Office for CAC | 1 | Office norms
Communication and photocopy room | 1 | Service counter | | 
Nursing Operational Manager office | 1 | Nursing - operational duties | 1 | Office norms
Nurses’ duty room | 1 | For nursing duties | 10 | See specific requirements under OPD
General store | 1 | Storage of supplies | 1 | See general specifications
Staff room with kitchenette | 1 | For tea / dining / relaxing | 10 | See general specifications
Staff toilet (male) |  | Toilet for use by staff | | See general specifications
Staff toilet (female) |  | | | 
Staff toilet (disabled) |  | | | 
Cleaners’ room | 1 | For use by cleaner | 1 | See general specifications
Kitchen / dining area | 1 | Supply point for children | 25 | Norms
Play area | 1 | | | 
Therapeutic play room | 4 | | | 
Therapy room | 1 | Interview with family | 8 | Round table to accommodate 8 people. Electronic observation and recording.
The design of an outpatient unit at a psychiatric hospital should include the following design principles:

- A therapeutic and safe environment that is welcoming.
- Security support.
- Unobtrusive clinical observation of waiting areas.
- Include flexibility in the use of the spaces.
- An environment and design that supports user privacy and dignity.
- Signage should support way-finding and understanding of the unit layout.
- Acoustic control of therapeutic spaces is required to reduce noise and sound.
- Outside spaces.
- Tamper proof fixtures.
- Clinical spaces for medical interventions (taking of lab specimens and giving of injections).
- Counselling, consulting and larger spaces for group rooms.
- Children space.
2.7.7. Pharmacy

The pharmacy will address the specific needs of the general psychiatric units for both inpatient and outpatients and for the forensic services for in- and outpatients on an eight-hour basis. The pharmacy should be positioned close to the OPD with one-way traffic to the delivery and exit routes and there should be convenient access to the inpatient wards.

Refer to [IUSS:GNS Pharmacy] and [IUSS:GNS Generic room requirements].
2.8. Forensic inpatient units

2.8.1. Forensic mental health service

The forensic mental health service (FMHS) provides a multidisciplinary approach for the assessment of detainees referred to the unit by the courts, and the treatment and rehabilitation of forensic state patients and mentally ill prisoners. Integral to this service are teaching, training and academic research activities.

The design of the facility should provide privacy to the most acute patients by placing high and medium-secure wards away from areas with high pedestrian and vehicular routes, and away from public access.

Forensic psychiatry provides forensic psychiatric observation of detainees, as well as care treatment and rehabilitation for state patients and mentally ill prisoners. The forensic inpatient units should be designed according to the required level of security that will protect mental healthcare users, staff and the community. Forensic patients must be separated by gender and age.

Awaiting-trial detainees admitted from the courts to specialised psychiatric hospitals for forensic enquiries in terms of the Criminal Procedures Act are accommodated in highly secure observation units, until the justice system declares him/her fit for trial or they are returned to the hospital for readmission as a state patient for an indeterminate period of time. State patients and mentally ill prisoners are admitted to a forensic admission unit for care, treatment and rehabilitation. Patients are managed in terms of the required level of security, which might include maximum (high), medium, long-term or low-security care.
2.8.2. General design principles

The design and construction of the forensic section should reduce the possibility or opportunity of escape:

- **Interaction with other healthcare facilities**: The forensic unit has integral links with community clinics, prisons, places of safety, child and adolescent services, the courts, and learning disability services. It should not be regarded as a stand-alone facility.

- **Human Rights Issues**: The design of the facility must adhere to the human rights principles contained in the Mental Health Care Act, 17 of 2002.

- **Accessibility**: The facility should provide for universal access to disabled persons.

- The forensic section is made up of an observation unit and inpatient units for state patients and mentally ill prisoners.

The levels of security for the inpatient units should dictate the types of windows, doors and fittings. Units with maximum security would be fitted with almost prison-type security, while low-security units will be similar to low-security units in the general psychiatric section.

Services and water pipes should be protected against being used as means of escape.

The design features listed for inpatient care should be complied with state patients and mentally ill prisoners require the same clinical treatment and personal consideration as other mental healthcare users.

- CCTV systems are used to enhance observation. The system should comply with the Human Rights Act (1998) and Data Protection Act (1998). The use of the system should be in accordance with the provincial procedures. The system should not replace the function of clinical observation or interaction with a user.

- Landscaping should consider the planting of trees near fences to avoid escape.

- Security fences should be built with foundations that will discourage tunnelling.

**FIGURE 33: MEASURES TO SUPPORT SECURITY**

The wall and the roof in the picture above are protected against possible escape, but the tree could over time provide opportunity. The covered walkway allows for sunshine and external views, but prevents escape over the roof.
2.8.3. Clinical process flow

- Detainees are transported to the forensic observation unit of a designated psychiatric hospital in a secure police vehicle under police escort.
- On arrival at the hospital the police vehicle will pass through the hospital main security gate and the security gate of the forensic section en route to the observation unit.
- The vehicle will reverse-park into an enclosed parking space at the observation unit. The parking space should be secured with a sliding gate, which has to be locked behind the police vehicle prior to the detainee being taken out of the vehicle and into the observation unit.
- The same security procedures are to be followed for the departure of detainees back to the prison, or for detainees requiring referral to other facilities for clinical investigations not provided in the unit.
- Security at the entrance to the unit is manned by the police, with strict access control fitted with metal detectors, x-ray screening and CCTV cameras. (See Annexure E.)
- All visitors, contractors and staff working in the unit are required to enter the observation unit through this very strict security checkpoint.
- The police escort will hand the detainee over to the ward police and the admission unit nursing staff.
- The police will conduct a full body search for possible hidden weapons. All valuables or weapons will be removed for safe keeping and will be kept in the police duty room in each ward.
- Detainees are escorted to a shower and will then change into hospital clothes.
- This is followed by admission to the unit by a unit clerk.
- The detainee is escorted to the consulting room for a full physical examination, after which the person is escorted by the police for admission to the observation unit.
- The admission unit should be attached to the observation unit. The design of the facility should provide a secure environment that will assist in the secure containment of detainees.

Scenario 1: Admission for observation & return to court.

Scenario 2: Found mentally ill, return from court & admit to HC unit.

Scenario 3: Admit mentally ill prisoners, transfer directly into HC unit.
The patient flow in Figure 34 illustrates the desired relationships between units to ensure that very ill patients are protected from public view and low-security areas, and outpatients will enjoy relative freedom.

### 2.8.4. Forensic admission unit

The observation unit is a maximum-security unit for admission of awaiting-trial detainees referred by the courts for forensic enquiries in terms of the Criminal Procedures Act, as well as state patients and mentally ill prisoners. The detainees are under the responsibility of the SAPS for the period of observation and during their transportation. The security standards for detaining awaiting trial detainees must comply with the minimum security standards of the SAP. (Annexure E.)

They may be sent by the courts for panel or single-psychiatrist investigation.

After the investigative report has been concluded, detainees are returned to the detention centre by the police. Detainees found to be unfit due to mental illness are declared state patients for committal to a psychiatric hospital until they are granted leave of absence, discharged or reclassified by the court.

Others will be reassigned from being state patients to involuntary mental healthcare units and will be admitted in any psychiatric hospital for general psychiatric care, not in the forensic units.

Access of pedestrians and vehicles into the forensic section is strictly controlled. Admissions, visitors, staff and contractors working in the unit are all required to pass through the security gates.

**Visitors and contractors:** Visitors and contractors to the unit are received through the security check point and are directed to the relevant space.

**Staff:** Access control for staff working in the observation unit should be positioned near the security checkpoint.

**Room types and features:**

- Enclosed vehicle parking bay secured with a lockable sliding gate, approximately 3m high x 2.4m wide, as the size of transfer vehicles may differ.
- Security access gates into the unit.
• Search facility.
• Police workstation fitted with a safe for keeping weapons or valuables.
• Patient shower and ablution.
• Staff toilet and rest room.
• Clothes store.
• Admission desk and lockable file and fire-proof records room.
• One consulting room (the room must be able to accommodate at least 5 people at a time).
• Clean utility.
• Two store rooms (consumables and equipment).
• Dirty utility.

2.8.5. Observation unit

Awaiting-trial detainees are transported, admitted and supervised under police protection in the observation unit. If the person is found fit to stand trial, the person is returned to the prison to serve a sentence. Detainees not found fit to stand trial by the courts are committed to the hospital as state patients. The state patients will be admitted through the admission unit to the high-security units, through to the medium and then low-security units in terms of their mental health status. State patients comprise male and female adults and adolescents. All the inpatient units must be separated by gender and age.
2.8.6. Observation inpatient unit (20 beds)

The same configuration as for an acute ward should be provided. The unit must provide for both genders, and age groups should be separated. Single beds with en-suite ablutions should be provided to allow flexibility to manage gender ratios.

Room types:

- Provide the standard inpatient unit with the following additional spaces.
- One consulting rooms.
- Three counselling rooms.
- Ward-rounds room for staff.
- All patient rooms should be single rooms with built-in beds and lockable doors.
- Ablution areas should provide showers fitted with slatted plastic curtains, toilets and basins.
- The services area and goods entrance should have security access control and should be a restricted area for detainees.

2.8.7. High-security wards

The same configuration as for an acute ward for state patients should be provided. Provide all beds with single beds with en-suite ablutions. Mental healthcare users will require additional clinical observation.

2.8.8. Medium secure

The same configuration as for an acute ward should be provided.

2.8.9. Low-security

The same configuration as for an acute ward should be provided.

2.8.10. Co-morbid clinic

The same configuration as for an inpatient ward should be provided.

2.8.11. OPD with medicine room

The same as for the general section.

2.8.12. Occupational therapy

Provide the same requirements as for the general OT section. The therapeutic rooms should be provided with emphasis on skills training as part of rehabilitation.

2.8.13. Medical records

Patient files should be kept for the natural life of the mental healthcare user.

2.8.14. Recreational services

Tuck shop, shared sports fields, shared multipurpose recreational hall.
2.8.15. Operational management

The operational management of the forensic section forms part of the operational management of the hospital. Operational services should be is decentralised from the general section. It should be positioned to provide secure and easy access to the respective clinical areas in close proximity to the forensic section.
### LIST OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>CBMS</td>
<td>Community-based mental health services</td>
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<tr>
<td>MH</td>
<td>Mental health</td>
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<td>MHCU</td>
<td>Mental healthcare user</td>
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<td>OPD</td>
<td>Outpatient department</td>
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<td>PHC</td>
<td>Primary healthcare</td>
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<td>SAPS</td>
<td>South African Police Service</td>
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GLOSSARY

Assisted care, treatment and rehabilitation: The provision of health interventions to people incapable of making informed decisions due to their mental health status and who do not refuse the health interventions.

Assisted mental healthcare user: A “mental healthcare user” is defined as follows in the Mental Health Care Act No 17 of 2002:

“Mental healthcare user” means a person receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental health status of a user, state patient and mentally ill prisoner and where the person concerned is below the age of 18 years or is incapable of taking decisions, and in certain circumstances may include:

(i) a prospective user;
(ii) the person's next of kin;
(iii) a person authorised by any other law or court order to act on that persons behalf;
(iv) an administrator appointed in terms of this Act; and
(v) an executor of that deceased person's estate

“User” has a corresponding meaning.

Care and rehabilitation centres: Health establishments for the care, treatment and rehabilitation of people with intellectual disabilities.

Community-based care: Care that is provided outside of institutional and hospital settings, as near as possible to the places where people live, work and study.

Community health worker: Any lay worker whose primary function is to promote basic health or the delivery of basic health services within the home or primary healthcare facility.


Correctional centre: A centre as defined in Section 1 of the Correctional Services Act (Act No 111 of 1998).


Court: A court of law.

Health: A state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity.

Healthcare: Outpatient and inpatient care, medical care, dental care, mental healthcare, and acute and chronic care provided by registered healthcare professionals.

Healthcare professionals: These are individuals registered with the various health-related statutory bodies who render health and any related care to improve and maintain the health status of all healthcare users within the purview of the Department of Health (as stipulated in the National Health Act No 61 of 2003).

Health establishments: The whole or part of a public or private institution, facility, building or place, whether for profit or not, that is operated or designed to provide inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventive or other health services. This includes facilities such as community health and rehabilitation centres, clinics, hospitals and psychiatric hospitals.
Involuntary care, treatment and rehabilitation: The provision of intervention to people incapable of making decisions due to their mental health status and who refuse health intervention but require such services for their own protection or for the protection of others.

Involuntary mental healthcare user: A person receiving involuntary care, treatment and rehabilitation.

Medical practitioner: A person registered as such in terms of the Health Professions Act, 1974 (Act No 56 of 1974) as amended.

Mental healthcare practitioner: A psychiatrist or registered medical practitioner or a nurse, occupational therapist, psychologist or social worker who has been trained to provide prescribed mental healthcare, treatment and rehabilitation services.

Mental healthcare provider: A person providing mental healthcare services to mental healthcare users and includes mental healthcare practitioners.

Mental healthcare user: A person receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing his or her mental health status. This includes a user, state patient and mentally ill offender. And where the person concerned is below the age of 18 years or is incapable of taking decisions, in certain circumstances may include:

- A prospective user;
- The person's next of kin;
- A person authorised by any other law or court order to act on that person's behalf;
- An administrator appointed in terms of the Mental Health Care Act, 2002 (Act No 17 of 2002); and
- An executor of that deceased person's estate.

Mental health status: The level of mental well-being of an individual, as affected by physical, social and psychological factors and which may result in a psychiatric diagnosis.

Mental illness: A positive diagnosis of a mental health-related illness in terms of diagnostic criteria made by a mental healthcare practitioner authorised to make such diagnosis.

Mentally ill offender/prisoner: An offender as defined in Section 1 of the Correctional Services Act, in respect of whom an order has been issued in terms of Section 52(3) (a) of the Mental Health Care Act to enable the provision of care, treatment and rehabilitation services at a health establishment designated in terms of Section 49 of the Mental Health Care Act. Prisoners who become mentally ill during their time of incarceration are referred to a psychiatric hospital for care, treatment and rehabilitation.

Primary healthcare: Essential healthcare made accessible at a cost a country and community can afford, with methods that are practical, scientifically sound and socially acceptable (Alma Ata Declaration, 1978). This approach is organised to reduce exclusion and social disparities in health, is people-centred, inter-sectoral, collaborative, and promotes the participation of all stakeholders.

Primary-level services: The first level of contact for individuals seeking healthcare.

Psychiatric hospital: A health establishment that provides care, treatment and rehabilitation services only for users with mental illness.

Psychiatric assessments: Awaiting-trial detainees referred by the courts for forensic psychiatric evaluation.

Panel psychiatric assessments: Awaiting-trial detainees referred by the court for 30-day observation conducted in an inpatient unit by a panel of clinical experts.
**Psychiatrist:** A person registered as such in terms of the Health Professions Act.

**Psychologist:** A person registered as such in terms of the Health Professions Act.

**Psychosocial rehabilitation:** Mental health services that bring together approaches from the rehabilitation and mental-health fields, which combine pharmacological treatment, skills training, and psychological and social support to clients and families in order to improve their lives and functional capacities.

**Recovery model:** An approach to mental healthcare and rehabilitation which holds that hope and restoration of a meaningful life is possible, despite someone's serious mental illness. Instead of focusing primarily on symptom relief, as the medical model dictates, recovery casts a much wider spotlight on restoration of self-esteem and identity and on attaining a meaningful role in society.

**Secondary care:** Specialist care that is typically rendered in a hospital setting following a referral from a primary or community health facility.

**Tertiary care:** Specialist care that is rendered at central hospitals.

**Single psychiatrist evaluation:** Awaiting-trial detainees referred by the courts for an evaluation by a single psychiatrist, which could be conducted either at an outpatient department or at a detention centre. Only complicated cases will be admitted for shorter periods of up to a week.

**State patients:** Awaiting-trial detainees who allegedly committed certain criminal offence(s) and who have been declared by the court to be state patients for detention in a psychiatric hospital until they are fully rehabilitated for re-integration back into society, which is normally after long periods of admission in the hospital.
REFERENCES


StdsAust 2003a, AS 1428.1-4: Design for Access and Mobility, SAI Global.
ANNEXURE 1. LEGISLATIVE REQUIREMENTS

National Health Act 61/2003 and Regulations:

- The Mental Health Care Act, 2002 (Act No 17 of 2002)
- The Criminal Procedures Act, 1977 (Act No 51 of 1977)
- The Child Justice Act, 2008 (Act No 75 of 2008)

The Criminal Law (Sexual Offences and Related Matters)

- Government Notice - R.185, 2nd March 2012
- Government Gazette, Categories of hospitals: No 35101

National Mental Health Policy Framework and Strategic Plan 2013 – 20120, NDoH
## ANNEXURE 2. ROOM REQUIREMENT SCHEDULE

<table>
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<tr>
<th>No</th>
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