REVIEW OF
MENTAL HEALTH SERVICES BUNDABERG

DR MARK WATERS

JULY 2004

INTRODUCTION

This report has been commissioned by the Director-General of Health through an Instrument of Appointment dated 13 May 2004.

I wish to thank the many people who assisted by being interviewed. I wish to note the assistance provided by Mr Herb Greenwood, Team Leader, Integrated Bundaberg Mental Health (BIMHS) and Ms Auriel Robinson – Queensland Nursing Union Organiser (QNU) for arranging interviews and providing venues for interviews to take place. In particular I would like to thank Mr Bill Pepplinkhouse, Director, Princess Alexandra Mental Health Service for his expert assistance.

I accept full and sole responsibility for the content, findings and recommendations of this report.

This report is structured under the headings of Terms of Reference, Methodology, Findings and Recommendations.

TERMS OF REFERENCE

The Terms of Reference are attached (Attachment 1).

Essentially they required a review of:

a) the safety of the physical surroundings of the Mental Health Service for both patients and staff in the context of policies and practices and

b) any evidence of bullying and / or harassment of staff in management practices or organisational culture and

c) not investigate or focus upon but notify to the Director-General any instance of concern regarding individual patient care that might be uncovered during the review process.

METHODOLOGY

The report is based on interviews and a review of relevant available documentation.

Approximately fifty-eight (58) interviews were conducted at Bundaberg, Brisbane or by telephone. The interviews at Bundaberg were conducted at two (2) sites – The Bundaberg Integrated Mental Health Service (BIMHS) and the Queensland Nursing Union (QNU) Offices in Maryborough Street. The interviews were arranged at the hospital site by Mr Herb Greenwood, Team Leader, BIMS and at the QNU offices by Auriel Robinson (QNU). The interviews at the QNU offices were not arranged via the Mental Health Service, rather all contact was made through the QNU and other union organisers or representatives.

All interviewees were advised that individual's identities or individual comments would not be noted in this report, so that full and frank responses could be obtained. The list of people interviewed is therefore not provided. Interviewees were predominantly current staff, some ex-staff and a limited number of consumers and carers.

The following documents were reviewed as part of this report process:

1. Multiple written statements by staff (not identified or attached).
2. Briefing to District Manager, Bundaberg District Health Service – Dr P Brown, Dr E Leitch, Mr Laurie Isaacs June 2000 (Brown Report 2000).
3. Letter of resignation Dr M May - May 2000.
4. Letter of response Mr Martin Jarman - June 2000.
5. Investigation of November 2001 by Dr Louis Prado and Ms Lisa Fawcett into a grievance against Dr Scott Jenkins and Ms Judith McDonnell.
6. Preliminary Conference Report – Fair Treatment Appeal Nos: 5436, 5441 and 5442.
7. QNU Cursory Inspection July 2003 (sent to Bundaberg District Health Service September 2003).
8. Investigation Report by Viv Pocklington and Jean Devine July / August 2003.
9. EQUiP Organisation Wide Survey Bundaberg Health Service August 2003.
10. Operation of Psychiatric Intensive Care Unit (PICU) Dr A Waugh August 2003.
11. Report on the Health and Safety issues at Bundaberg Mental Health Unit – Megan Kreis September 2003.
12. BIMHS Response to Cursory Inspection – October 2003.
13. QNU letter to Mr P Leck 17 November 2003.

14. QNU letter to Dr S Buckland 10 December 2003.
15. QNU Response to BIMHS response to safety issues March 2004.
16. Audit and Operational Review Report March 2004.
17. Zonal Manager (D Bergin) letter to QNU of 5 April 2004.
18. Bundaberg Health Service District (BHSD) response of April 2004.
19. BIMHS Policy Manual.
20. BIMHS Adult Services Protocol Guide.
21. Information provided on staff turnover, sick leave and workers compensation claims.
22. "Tipping the Scales from Hospital to Community Service Delivery" H Greenwood, M Laurie.
23. Data on Ward Occupancy.
24. National Mental Health Standards reporting Central Zone.
25. Service Development Framework Central Zone 2002 and 2003.
26. Documents as reviewed by Mr W Pepplinkhouse

- Protocol and Procedure – Serious Incident Review Procedure (QHEPS No 20422) (October 2001)
- Seclusion Policy October 2001/March 2003.
- Protocol for Psychiatric Intensive Care Unit – Acute Services (January 2003)
- Protocol for Acute Services – Admission (June 2003)
- Protocol for Acute Services – Duress Alarm System (June 2003)
- Protocol for Acute Services – CMH Alarm System (June 2003)
- Protocol for Acute Services – Direct Observations by Nursing Staff (June 2003)
- Protocol for Challenging Incidents (Psychiatric Emergencies/Management) (July 2003)
- Policy and Procedure – Adverse Event Management (QHEPS No 21906) (June 2004)
- Nursing Education Program (last 6 months)
- Top 20 DRG's for Mental Health
- Protocol for Work Practice Supervision (June 2004)
- Seclusion Register (last 6 months)
- Occupancy Report (last 12 months)
- Hours per Patient Day (HPPD) as per EBV requirement under Business Planning Framework.
- ACHS Audit Reporting Tool to Qld Health Central Zone.

27. Plan of the Inpatient Mental Health Unit, Bundaberg and suggested alterations (Appendix Y)

I understand that two other issues are being investigated by Audit Branch but are not yet complete.

FINDINGS

This review must commence by noting the enormous change process this health service has undergone since (at least) the report by Dr Peggy Brown et al of June 2000 (Brown Report 2000).

These changes, in terms of community focus, consumer involvement and achievement of National Mental Standards were necessary for the BIMHS to be seen both internally and externally as a contemporary mental health service. Achievement of organisational and clinical change has been noted to have been successfully achieved by reference to the stated objectives of the Brown Report 2000 and the EQUiP Organisation Wide Survey of August 2003 as well as the continuous Zonal reporting on the National Mental Health Standards.

The EQUiP Organisation Wide Survey under the auspices of the Australian Council of HealthCare Standards (ACHS) noted that the BIMHS had successfully implemented all recommendations from the previous survey and went further to commend it in a number of areas including amongst others, commendations on community and consumer participation, the integration of services and the development of outreach services.

This is in stark contrast to the situation in 1999 when an audit by the Mental Health Branch of the old Mental Health Act found it to be the most non-compliant in the State.

There is widespread support within the BIMHS for the contemporary direction the BIMHS has moved and continues to explore. Indeed it is noteworthy that staff who have concerns about the implementation of the change process, do not, significantly, dispute the direction the service is now heading or dispute the need for change (from the June 2000 situation) or dispute that significant change has been implemented.

The concerns expressed as relevant to this report, are around the implementation process of these changes and their relationship with organisational culture and management action and if these constitute harassment and bullying. The other relevant issue for this report is if, during the change process, policies have been introduced or physical changes made, which result in safety concerns for staff or patients.

I will address the issue of physical safety first. There have been many changes to the structure and function of the Mental Health Inpatient Unit over the past four years. It is timely to stop and look at the current situation in the mental health building.

SAFETY REPORT JULY 2004

SERVICE DELIVERY

The model of care provided to patients of the BIMHS was reviewed in terms of safety, work practice and whether policies/protocols/procedures were documented to support it. Only the adult component of the service was reviewed.

In general terms, the model of care is contemporary practice which is meeting the state and national standards for treating people with a mental disorder. The service provides continuity of care from the single point of contact through the continuum of community and inpatient care and vice versa. The success of this model has seen the service provide an average use of the sixteen (16) beds at 40% for 2003/2004. Policies and supporting documentation were reviewed and have been listed on Page Four (4). Documentation reviewed supported the model of care and service delivery, including the risk management of patients. There is a review process in place for all policies/protocols and procedures. Of all the documents reviewed and listed, three (3) issues need to be addressed or revisited to meet safe guidelines.

- Protocol for Psychiatric Intensive Care Unit (PICU) mentions staffing minimum to be one (1) staff member per two (2) patients. This is considered by the reviewer not to be a safe practice in a PICU type area.
- The Serious Incident Review process does not allow for a review by someone external to Mental Health or a process such as Root Cause Analysis.
- Protocol for work practice supervision is noted. Evidence shows that not all staff in the Adult BIMHS are receiving clinical supervision. The service plans to have all staff receiving clinical supervision by August 2004.

SUPERVISION / ORGANISATIONAL STRUCTURE

As stated in the introduction, the BIMHS has established a contemporary model of practice that would be the envy of most mainstream mental health services. This is highlighted by the low occupancy of the adult inpatient beds, allowing the service to concentrate its efforts in the community and hence keep bed occupancy low. It is also a defined catchment with very few outliers in terms of admissions from other regions. The low occupancy does however, create other issues, namely inefficiencies and currently staff skill mix concerns.

The nursing structure at present has an NO3 as the highest level nurse and this position is only involved on the inpatient unit. Following the principle that each nurse reports professionally to a senior nurse, BIMHS cannot achieve this using the Unit Manager. There are eleven (11) community nurses and seventeen (17) EN/RN's on the inpatient profile, of these seventeen (17), ten (10) do not receive clinical supervision. The highest level nurse

in the community is an NO2. There is also an OT assistant on the inpatient unit that does not receive clinical or professional supervision. At the time of this review there were three (3) of the Clinical Nurses on some type of leave and they were largely replaced by EN's. This could create issues with skill mix when rostered numbers are quite low.

The BIMHS needs to address the organisational structure to ensure adequate professional / clinical supervision.

INPATIENT UNIT STAFFING

The inpatient unit is operating at 40% occupancy, which is well below state average. The accepted hours per patient day (HPPD) for an acute unit are 5.5-6.5 HPPD and for a PICU 8-9 HPPD. Bundaberg service is averaging 8.9 HPPD for the low dependency beds. The difficulty for the unit is that the low bed day rate means inefficiencies occur in staffing levels. It is noted that a number of the NO2 level nurses are on various types of prolonged leave and are not available for rostering. EN's have filled these gaps. The effect is that the skill mix is compromised for the unit.

There is one (1) Allied Health assistant (OT) who works in isolation and appears to receive no supervision for her role. At least one (1) inpatient nurse is refusing clinical supervision and this potentially compromises patient care.

SAFETY AUDIT – ACUTE UNIT BUNDABERG IMHS ADULT UNIT (16 BEDS)

Generally, the ward design is dated and does not meet contemporary standards in Mental Health Care. These include access to privacy, four-bed rooms, no ensuites and shared toilet and shower facilities for the sixteen (16) beds. All patients need to leave their room and walk a corridor to use the bathroom.

The general ward layout is difficult in terms of observation of patients. The lounge, diningroom and activity room are located at opposite ends of the building. Seclusion and PICU (HDU) are both in the same corridor as the activities area. As these areas are often occupied by noisy and behaviourly disturbed patients, it makes the activities area a less therapeutic environment. The activities area has no windows.

The low number of patients means a low number of staff. Whilst this still equates to 8.9 HPPD, it only means two (2) staff per shift. The nurses' station is an open area and during the review, nurses were completing patient files and there were a lot of items (some confidential) on this bench. Should a nurse be in distress, the other would

respond. Between the hours of 5pm and 8am, this would mean that a staff member at the desk would need to collect and secure confidential information before responding to a colleague's distress. The extra time taken is an issue.

SPECIFIC ISSUES

1. PICU

PICU has not, so far, been used as a PICU and is part of this external review. In summary it can be stated that this area is not suitable for its intended purpose (managing aggressive and difficult behaviour). The PICU area is small, with difficult access issues and has a number of fixtures and fittings that could compromise staff and patient safety.

Issues for the PICU area include:

- The space for lounge/food consumption is inadequate for four (4) people;
- The courtyard is less than 1200mm wide. This is too small and confined for aggressive patients;
- The sliding door to the courtyard can be snibbed from the inside. There is no key or way to access if a worker is locked outside;
- The courtyard external door is not marked as a fire egress. It has no key to enter from outside (i.e. no key tumbler);
- Entrance doors to PICU both operate inwardly and provide no egress. Also, these doors can be barricaded and as such, this area should not be used until this is resolved;
- The sliding door to bedroom has particle board barriers which the reviewer was able to move or demonstrate capacity to pull off;
- Bathroom has tile finish to 1800mm high. This type of finish for these patients is not ideal as tiles could be prised free;
- Folding plastic table could easily be ripped from wall and used inappropriately;
- An alternative shelf/rail needs to be considered for coat hanger space; and
- The television is installed so high that patients would need to strain their neck to watch it in the confined space.

2. SECLUSION SUITE

The seclusion policy is lengthy and not in keeping with contemporary practice for this function. The staff appear to disagree on "when is seclusion broken". This occurs due to the toilet being located inside the seclusion room. Having stated this, the reviewer noted that the seclusion register demonstrates a very low usage. The average seclusion is lower than one (1) episode per month and further analysis indicates one (1) episode of eight (8) hours or more duration in the last year.

Issues for the Seclusion area include:

- Poor observation from one door;
- Door uses only standard lock and hinges. This would not provide a safe barrier for a very aggressive person;
- Doorway to seclusion is only 820mm. Standard is 1200mm for ease of patient safe handling; and
- Cupboard inside entry to foyer contains chemicals and other objects. These cupboards should be removed or locked as appropriate.

DURESS SYSTEM

There is currently a punch button alarm and pendant system in place. The reviewer noted that no one was wearing the pendants. There is not a systems approach to a psychiatric emergency within psychiatry or with security or the hospital. This is a particular issue at night.

SAFETY REPORT RECOMMENDATIONS

Recommendation 1

Consideration be given to review the organisational structure so that appropriate professional reporting is in place. This will be further commented on in Recommendation 9 in comments on the role of the Service Director.

It is suggested that the current organisation might be improved by:

a) The NUM of the inpatient unit reporting operationally and professionally to NO4 Level nurse.

b) NO4 Level nurse (new position) report operationally to the Service Director and professionally to the Director of Nursing (DON) Bundaberg District Health Service (BDHS).

c) The existing Team Leader be responsible for the community aspects of the BIMHS and report to the Service Director.

d) One of the existing NO2 nurse levels in the community part of BIMHS be reclassified as NO3 for professional reporting for the NO2 nurses in the community. The NO3 position (upgrade of existing) would report operationally to the Team Leader and professionally to the new NO4 position.

The net effect is that clinical and professional issues can now be delegated appropriately by the Service Director.

This issue is also discussed in recommendations under organisational culture.

Recommendation 2

That the current PICU not be utilised for the management of aggressive and violent patients (this area could be readily commissioned for use as a special purpose suite, for admission of mother and baby, young adults, inpatient at risk i.e. elderly depressed). Further that egress issues be remedied prior to any occupation of this area.

Recommendation 3

The nurses station be made secure so that confidential material is not compromised when nurses need to leave the area in an emergency.

Recommendation 4

Consideration be given to changing the function of the seclusion room to that of seclusion/PICU type function (see appendix Y floor plan).

Recommendation 5

Review policies and procedures as required and commented on in this report.

Recommendation 6

The recently purchased duress system be installed and appropriate training and systems supporting psychiatric emergencies be implemented.

ORGANISATIONAL CULTURE

It is impossible to report on the present situation clearly without reviewing the past four years.

The Brown Report 2000 et al could be summarised as dealing with two issues of substance. The first was the requirement to change the processes, policies, structure and emphasis to result in the BIMHS evolving into a contemporary service which would serve the community well. The evidence of success or failure of the recommendations of this report was to be measurable and reportable against the National Mental Health Standards and the Australian Council of Healthcare Standards (ACHS) EQUiP review process. The second major thrust of recommendations referred to the need for a process to deal with the cultural issues already obvious in 2000 of staff conflict arising out of the changes already actioned.

The Brown Report 2000 identified ten significant issues:

1. **Lack of stability in key management positions**
   Unfortunately, for a variety of reasons this has not, over the past four years, been able to be addressed. It is noted that the initial appointment of the Service Director was a twelve-month secondment, not a permanent appointment. The position of Team Leader and Nurse Unit Manager (NUM) have recently taken a prolonged period to fill permanently (approximately twelve months). The NUM process is still underway. Whilst there may be valid reasons for these prolonged gaps in permanent appointment, the result on team building and conflict resolution is still a problem.

2. **Lack of definition and recognition of roles, responsibilities and duties of key positions**
   The daily actions of the Service Director (A08) engender some ambiguity amongst staff.
   It is apparent that the Service Director (an administrative, non-clinical role) does become involved in clinical matters because of the significant clinical expertise of the incumbent. This practice, for example attending clinical hand overs or commenting on the clinical competence of staff, continues to blur the roles and accountabilities of key positions. It obviously effects the clinical and professional roles of the Clinical Director and nursing professional leaders within the service.

3. **Management processes and organisational structure**
   This issue has been significantly addressed however the current clinical and professional roles assumed by the current Service Director require resolution and are referred to in Recommendations 1 and 9.

4. **Strategic service direction and development**

This issue seems to have been significantly addressed.

5. **Contemporary practice**

Enormous positive changes have occurred in this area.

6. **Consumer and carer focus**

This issue seems to have been embraced.

7. **Service Quality**

There is demonstrated achievement in this area.

8. **Staff Skills**

Significant training and skills development has occurred.

9. **Identification within the wider District**

This seems to have been addressed.

10. **Change Management**

Unfortunately the requirement for specific training in change management does not seem to have occurred. Suggestions for external facilitation of the change also seems not to have been taken up.

The current review is significantly about the change process, the appropriateness of the methods used, the scope of change and time frames and the affect of this process on the staff involved.

The BIMHS has gone through great change and is now a service of which the Bundaberg District Health Service can be proud. It is demonstrably a benchmark service in contemporary mental health delivery. External review by the ACHS praises the current service.

Unfortunately, given that a major emphasis of the Brown Report 2000 recommends dealing with the already existing conflict resulting from the change process at that time, an acceleration of the change process in the absence of training, resources and support for a difficult change project perhaps inevitably led to the current situation. That the service change achieved occurred in this environment is an extraordinary testament to the people involved.

The unfortunate side affect is that there now exists a legacy of intra-organisational conflict which has escalated to being highly personal. Indeed, many people readily identified the protagonists and referred to how personalised the current situation was.

Simply put, some inpatient staff, whilst accepting that change is in the right direction, believe that the implementation has occurred inappropriately. Specifically that there has been management harassment and bullying.

The conflict is now reported to largely be between staff in the inpatient unit and the management of the service.

This bullying is alleged to take the form of withholding information, being derisive of staff in the inpatient unit and "splitting" staff between "good staff – bad staff". It should be noted that most of the changes over the past four years have increased the emphasis on community management and the opening of an inpatient unit at Maryborough, which effectively halved the population catchment of the service, further reduces inpatient needs. As previously noted, the inpatient unit now averages 40% occupancy (of 16 beds) – leaving a small average number of inpatients to be managed in a stand alone unit.

As importantly as the reduction in the actual size of the unit is a perception by staff in the inpatient unit that they are not as important, as skilled, as worthwhile, as staff in the community arm of the service. The fulltime equivalent inpatient staff members number approximately eleven (11) out of a total of approximately fifty (50) staff in the whole service.

Recently, Bundaberg has been accepted as a pilot site for a "Recovery" model of care which is suggested to lead to a further reduction in the future for the requirement of inpatient care.

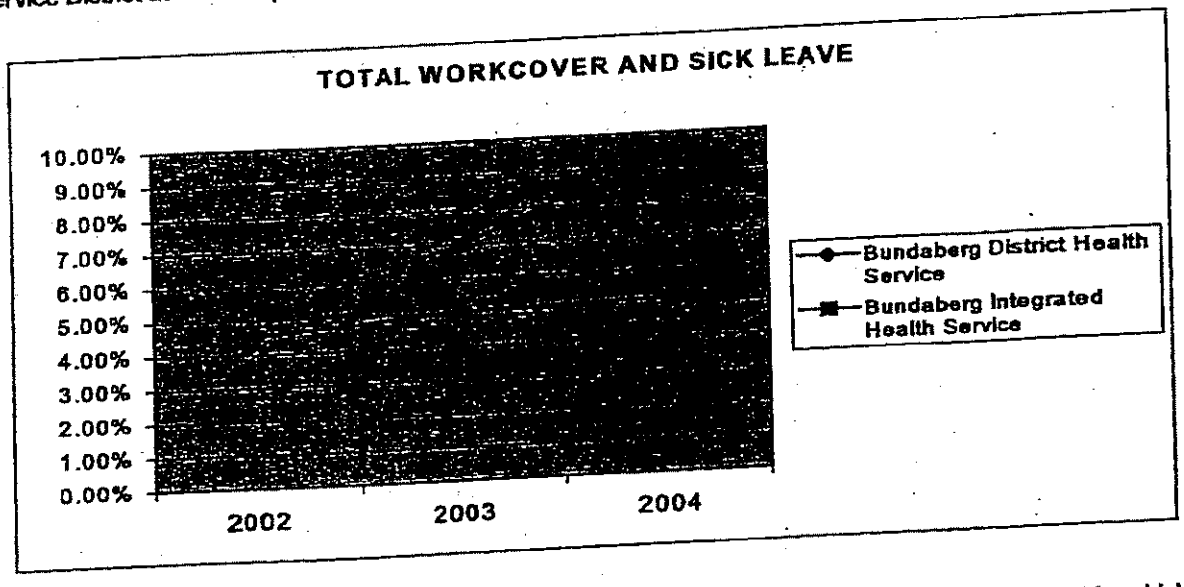
The alternative proposition by people interviewed is that some staff (in the inpatient unit) have personalised issues such that they use incident reports and issues not to improve the running of the service, but as a source of complaint to pursue agendas. Specifically, that concerns are raised to diminish the authority of management and "get rid of the Service Director".

There is no doubt that the conflict arising out of the change process is now personalised between individuals. This cannot continue for many reasons.

Obviously, such a work atmosphere is not conducive to good morale or a positive work environment for health staff. Importantly, given the polarisation between some in the inpatient unit and management and to some extent, between the inpatient unit and community staff, achieving close integration of patient care between inpatient care and community care is unlikely to be optimal.

It is therefore fundamental that this situation be resolved justly.

Of interest, the sick leave / workers compensation data for the BIMHS is higher than for the Bundaberg Health Service District as a whole (see graph below):



The Terms of Reference require comment on management practice, organisational culture or leadership which may amount to workplace bullying or harassment of staff.

The issue of management bullying / harassment has been formally tested on a number of occasions as the result of allegations:

1) Stage 2 Grievance reviewed by Prado and Fawcett 2002 – not sustained.
2) Stage 3 Grievance reviewed by Pocklington Devine 2002 – not sustained.
3) Fair Treatment Appeal relating to the above two reports declined 2003
   Note 1, 2 and 3 related to the same initial allegations
4) Internal audit report March 2004 (separate allegation) – not sustained.

Specific incidents with specific individuals are also being examined in the usual way through other avenues such as WorkCover. Whilst some WorkCover claims have been accepted, my understanding is that WorkCover has not found unambiguously that management practices constitute harassment or bullying.

There were a significant number of interviewees who believe that the workplace is not healthy and that management does bully and intimidate and harass staff. The theme of these allegations is that staff who do not agree with managerial direction are nominated as "incompetent or resistant to change". They are then subtly bullied through withholding of information or withholding of opportunities for career advancement. Concerns in this regard were raised about a perceived lack of transparency in recruitment and selection.

I remain unaware of any specific findings which endorse categorically, behaviours consistent with management workplace harassment or bullying. There are references, both in previous reviews and by many interviewees of a "direct", "confrontational" and "controlling" management style. This seems likely to be valid. There are also references in previous reviews to "errors of judgement" on the part of management. There was no evidence provided to show staff appointments have been outside Queensland Health guidelines.

It is obvious however, that an unacceptable workplace situation exists. It is clear that many inpatient staff feel undervalued, intimidated and unappreciated and that considerable personal animosity exists within the service which requires resolution.

There is clearly now a loss of trust, a loss of respect and sensitivity around communication which must be resolved for the service to "be the best it can be" and to be truly integrated in all facets of service delivery. This problem is most evident in the relationship between some members of the inpatient unit and management and between some members of the inpatient unit and other mental health workers.

THE WAY FORWARD

The following recommendations suggest a mechanism to move the service forward and to establish a healthy workplace. Some of the recommendations echo some of those of the Brown Report of 2000.

1. **The permanent appointment of key leadership positions:**

   Recommendation 7

   Key leadership positions within the BIMHS be filled on a permanent basis as soon as possible. In the current situation it may be prudent to ensure significant external overview of the selection process to provide the successful applicants with credibility within all parts of the service.

Recommendation 8

It is also recommended that all vacant permanent positions within the BIMHS be reviewed, and if considered necessary positions, that they be filled along similar lines to those referred to above. The requirement for transparency of process is critical to the future credibility of the successful applicants.

2. Role Definition

Recommendation 9

The role of Service Director is already clearly defined as administrative, not clinical. The Service Director should not be involved in clinical situations, should not be asked for or provide clinical advice or comment on clinical issues. If the primary purpose of the meeting is to discuss clinical issues it is inappropriate for the Service Director to be present. This recommendation should be seen in association with Recommendation 3. These recommendations are interdependent, as it is critical that the Service Director has the structure to delegate clinical issues to clinical staff. It would then be mandatory that these delegations occur.

The adequacy of a parttime Clinical Director, in terms of available time should be considered.

3. Change Management

Recommendation 10

All senior staff should be provided with change management training.

4. Mediation

Given the current situation, significant mediation is now required within the service. A prerequisite of this is a clear statement on the role, importance and likely future of the inpatient unit. The statement must be unambiguous. The determination of the role, importance and likely future is likely to require high level facilitation from the Mental Health Branch.

The central issues for mediation centre around issues of mutual trust, respect, affirmation of worth and behaviour modelling these aspects.

Successful mediation is critical to the future smooth functioning of an integrated unit.

Recommendation 11

It is recommended that extensive, expert mediation be sourced and resourced to deal with the existing interpersonal conflicts.

5. **Conflict Resolution**

The presence of a Local Consultative Forum (LCF) may provide a forum where the many issues that arise might be addressed.

Recommendation 12

That consideration be given to establishing a Local Consultative Forum (LCF).

6. **Period of Consolidation**

There is clearly significant change which has already occurred within this service which appears to place it at the forefront of mental health services in Queensland. A proposal for further significant change in being a pilot site for a new model of care "Recovery" is currently planned for Bundaberg. The wisdom of embarking on further significant change at this time is questionable.

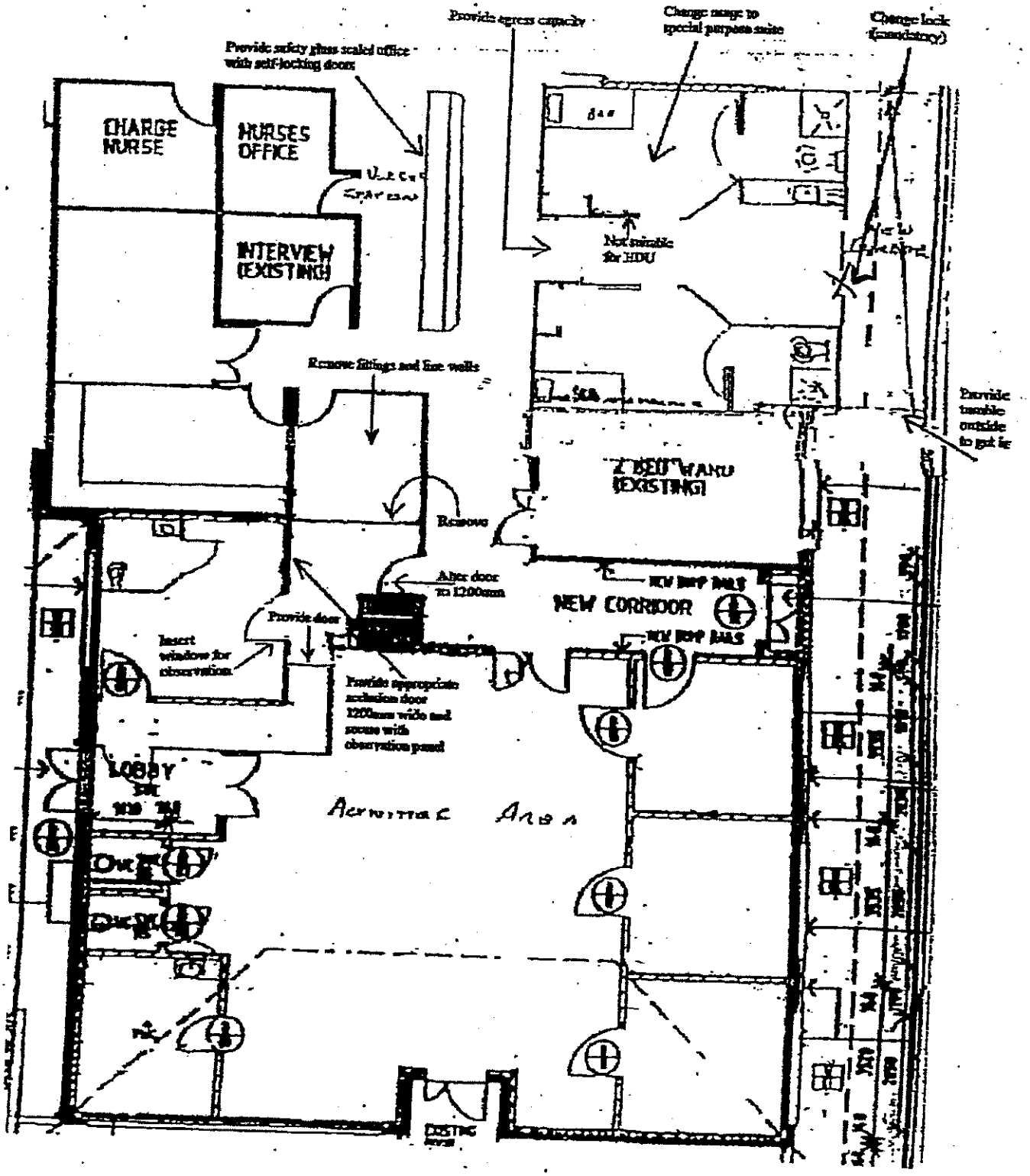
Recommendation 13

It is recommended that further consideration be given to the suitability of BIMHS as the pilot site for the Recovery Model. A period of consolidation of recent achievements should be considered until the recommendations in this report have been addressed.

Clinical Issues

There were no specific issues of patient care that I became aware of that required referral to the Director-General. I note one item of correspondence of potential concern had already been sent to the Health Minister.

APPENDIX Y


Provide safety glass sealed office with self-locking doors
Provide egress capacity
Change usage to special purpose suite
Change lock (mandatory)
CHARGE NURSE
NURSES OFFICE
INTERVIEW (EXISTING)
Not suitable for HDU
Remove fittings and fire walls
Remove
Alter door to 1200mm
Provide door
Insert window for observation
Provide appropriate seclusion door 1200mm wide and secure with observation panel
NEW CORRIDOR
LOBBY
ACTIVITIES AREA
EXISTING