Physical Environments for Long-term Care

Ideas Worth Sharing

Edited by Pat Armstrong and Susan Braedley

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Service Employees International Union Healthcare

Swedish Association of Local Authorities and Regions

The Council on Aging of Ottawa

Unifor Canada

INTRODUCTION

Pat Armstrong and Susan Braedley

Originally the idea of an occupational therapist, the garden was developed 12 years ago when the facility was operated by the city. A landscape gardener was hired and designed the garden based on a modern version of an old monastery garden. Divided into four sections and 2,500 square meters, it is centered around a fountain with fish (not operating when we were there) and an 18th century gazebo (heated all year and including seats as well as a tablecloth covered round table) intended to emphasize openness. The idea is to stimulate all the senses and bring people outside every day, escaping from the inside harsh light, shiny floors and noisy halls of the nursing home. The green house has a table and chairs, a great place to sit in the rain, have coffee, and hear the rain on the roof. The manicured grass is intended for barefoot walking, which should encourage balance (although we wondered if workers have time to help put shoes on and off there). Meadows around the edges are designed to follow the sun, the paths of fine gravel are intended to sound like roads and the wood chip ones to encourage balance maintenance. The stone ones are easy to use with wheel chairs and are cleared all winter. All are designed for safety. You can have a glass of wine here and come to a peaceful end, he said. Candles can brighten the garden in winter.

At the centre of a large long-term care complex in a major Swedish city, the fountain's tinkle and birds' songs, the flowers' perfume and the scent of grass, the texture of different materials on the various paths, and the multiple, rich colours of the bushes and trees created a physical

> *environment for comfort, relaxation, stimulation, and activity as well as a perfect place for a quiet lunch in the gazebo.* (Fieldnote, Sweden)

The occupational therapist with the idea for the garden described in the fieldnote above explained the philosophy behind his work.

> What I find, and this might sound a bit sort of corny, is that… maybe there could be a train of thought by some people and even some of the residents …that they're here really just to see out their days and they've done everything that's going to be useful in their life. And I think that's utter nonsense. You know, **this could be a new beginning for a lot of them**. And I've seen so many different examples of… I mean I have some people who come to my sessions amaze me because I just didn't realize how old they were. I'd done a lesson for someone the other day, six ladies, and the youngest was 94. And thoroughly enjoying it and taking it on and getting a real buzz out of it… And as I say I hope I've got the ability of making people feel that they are participating even if they're not to an extent if you understand what I mean…The buzz I get out of it is to see some ladies or gentlemen come in to start with the attitude 'Oh I can't do that' or 'I won't do that' and by the end of a session open up and really sort of go from there to there and can't wait for the next session. . . **And as I say it sounds corny but new beginnings is something. . . It doesn't matter what, for most people, what infirmities you've got or what ailments or anything that could sort of prevent you from doing an activity.** You can get round it, you know, and there's still plenty to enjoy at any level. **And as I say I hope I've got this ability that I can make them feel that they've participated and done a useful, meaningful piece of work.**

We begin with this garden and the interview with this occupational therapist (OT) for several reasons. First, the OT provides an eloquent argument for focusing on capacities rather than on incapacities; for working to bring joy to life in long-term care. This small book is intended to do the same. Second, the garden illustrates the importance of physical environments and of constructing those environments based on explicit ideas about care. Like the garden, this book is about ideas in practice; about ideas worth sharing. Third, in speaking with us

at length about his philosophy and designs, his contribution illustrates the kinds of complex, sensitive and detailed information we gathered in the research that is the basis of this book.

The subject

This book is about promising practices for physical environments in long-term residential care.

By long-term residential care, we mean places that provide around the clock nursing and personal support, are subject to some government regulation, and have some form of public funding. Most commonly called nursing homes, they provide residents with more than what is usually understood as nursing care. In addition to meals, housekeeping and laundry services, they also offer assistance with the activities of daily living such as eating, bathing and dressing, as well as social, physical, and recreation programs intended to stimulate and engage residents. The people who live in these homes have chronic conditions — ones that cannot be cured by modern medicine — and most have some form of dementia. As admission criteria have become increasingly restrictive in all high income countries, more and more nursing home residents require high levels of assistance with daily living as well as some medical care. A growing number of residents die within six months after they enter the home. Although still mainly a place for older women, the closure of chronic care, rehabilitation and psychiatric hospitals in many jurisdictions means that more residents are male and more are younger. And especially in North America, the resident population has also become more racially and culturally mixed. These places are called homes because many people live there over the long term and because the emphasis is intended to be on the kind of care offered at home, often described as social care rather than as medical care.[1] Not incidentally, calling them homes also allows governments to require residents to pay for their accommodation as they would at home.

In most high income countries, there is a new emphasis on home care or on what is often called aging in place. Far less attention is paid to long-term residential care. As the World Health Organization[2]

points out, “strategies for providing long-term care have been low on government agendas everywhere”. Yet many people still need, and many will need, such care. They need it because they have complex needs that cannot reasonably or effectively be dealt with at home. They need it because they do not have homes, or they do not have homes that can accommodate complex care work. And they need it because they have no one at home who is able to provide for their care needs.

It is often assumed that women provided such care at home in the past and should do so now, removing the need for long-term residential care. But there is little evidence to support such a claim. Women never provided at home the kinds of care now required as more and more people with complex care needs live longer. Moreover, most women are now in the paid labour force and families are much smaller, leaving fewer people at home to provide care. In short, there can be little doubt that home care is not a viable substitute for long-term residential care and that long-term residential care is too often neglected in government strategies.

A senior manager we interviewed in Ontario explained to us that the

> average length of stay or living in the home is 18 months and every day I say ‘If you had only 18 months to 24 months of life left what do you want it to be?’ And it’s our job to make that the best it can be and so it’s a very empowering and enriching thing to do.

We seek to contribute to that work. This book is one of several publications we have written as part of our project to make nursing homes places where residents, workers, families, volunteers, and managers are treated with dignity and respect and where joy, as well as appropriate care, is a goal.

Physical environments are a critical component in reaching that goal. **By physical environments, we mean everything from the location of a nursing home and the structure of gardens to the floor coverings, chair arms, and spaces for memorials.** Physical environments are about more than setting the conditions under which care can be provided and lives lived. They also shape and reflect

how care and life in nursing homes are understood. Medication carts dominating hallways, prominent nursing stations mimicking hospital designs, and brackets for rubber gloves outside every room, for example, all indicate the presence and importance of clinical care in ways that constantly remind everyone that this is a place for the sick. But physical environments can also signal the possibilities for both residents and workers to build on their capacities. The sense garden described above is just one such signal. As Public Health England puts it in talking about the determinants of health, the "attractiveness of the environment influences people's readiness to be physically active and to socialise with their neighbours".[3] This attractiveness can be even more important when your life is lived in one long-term care home and when it is where you work many hours each day.

Although across high income countries the populations in residential care have become more similar, the physical environments and policies that shape them cover an enormous range within and across countries. Regulations specifying minimum standards on issues such as access to windows and keeping medication locked up are common, but here too there is considerable variation in the regulations and considerable room within them to shape spaces differently. Ontario regulations, for instance, specify that every resident should have a bedside table, while Swedish regulations require pantries — or what we would call small kitchenettes — in every room.

Not surprisingly, funding also plays a significant role in shaping the physical environment. For example, some jurisdictions provide funding that supports private rooms for everyone while others also fund semi-private or even multiple resident bedrooms. And it is funding for adequate staff that allows workers to take residents to the sense garden.

This variation provides a rich source of evidence on alternatives for structuring the physical environments in long-term residential care. Both people and the conditions under which they live vary. What works well for female residents born in rural Norway may not work well for male residents in urban or even rural Canada who may also have emigrated from other regions and countries. Moreover, there are multiple people involved in and outside long-term residential care.

What works well for residents with dementia in the UK may not work for their care providers or their families. But we may learn from those practices and from the conditions under which they are effective.

Too much research looks for universal patterns and solutions, eliminating variation and conflicting interests. In contrast, we seek to recognize differences and identify ideas worth considering by those on whom they have an impact, allowing them to do so in ways that take their particular context into account. We also seek to recognize conflicting approaches and interests, looking for ways to balance them rather than ignore them or choose one side. **This is why we talk about promising practices rather than about best practices or a single, right way.** The research leads to questions with possible answers, to ideas worth sharing. Some entail financial costs but many are simply issues of planning, design, or organization.

The evidence

This book is based on evidence gathered in a project on "Re-imagining Long-term Residential Care: An International Study of Promising Practices", funded for seven years by the Social Sciences and Humanities Research Council of Canada and in a shorter project on "Health Aging in Residential Places", funded by the Canadian Institutes for Health Research and the European Research Area on Aging Project. Researchers of health research from six countries are involved in the projects: namely, Norway, Sweden, Germany, the UK, the US, and Canada. The five major unions in the Canadian health care sector are partners, along with an employer association and a seniors organization.[4] These partners keep us connected to those who work and live in residential care, provide advice on where we should look for ideas worth sharing, and help keep our publications grounded in their experience.

We are looking for conditions in long-term residential care that support active, healthy aging for residents and staff, taking gender, racialization, contexts, and individual capacities into account. They are conditions that allow residents, staff, volunteers, and families to flourish or at least enjoy as much as possible their time in long-term care. The

physical environment is itself a condition, a setting creating limits and possibilities for health and joy.

In conducting this research, we have used two basic strategies. The first, ongoing approach involves producing analyses of funding, payment and ownership; staffing and work organization; approaches to care such as that expressed by our Swedish occupational therapist; and means of ensuring accountability, such as reporting on injuries. Our work on these areas can be found on our website http://reltc.apps01.yorku.ca/.

This research provides the background for our second strategy, the one that is the primary basis for this small book. Called rapid, site-switching ethnography, our method involves taking a team of 12 to 14 researchers into a long-term care home to observe and interview. We have conducted ethnographic research in 27 different sites, with at least two studies in each country involved in the project. The homes ranged significantly in size, location, age, and ownership, although most were non-profit. They also varied in terms of the models of care, with The Eden Alternative, Dementia Care Matters, and The Gentle Persuasive Approach just some of the examples of models we saw in practice.

To identify homes to study, we interviewed union representatives, community groups, and government officials to ask where they would go to find promising practices and why they would select that home. While issues such as ownership, staffing and overall approaches to care were high on the list of factors contributing to the suggestions for homes to visit, most of those interviewed also identified physical environment issues such as location in relation to the community, floor plans, outside spaces, home-like atmosphere, and staff input on design as the basis for selecting these homes for promising practices.

Based on these recommendations, we approached homes to ask if they were willing to have us look for promising practices in their places. This most commonly involved providing us with background information on such matters as floor plans, staffing, and ownership and allowing us to observe and interview over a week. We also conducted shorter "flash" ethnographies at another home in the same jurisdictions.

Teams that go in to study these long-term residential care homes were both interdisciplinary and international. Although each team was different, they all involved researchers from multiple countries and multiple education backgrounds. They worked in pairs and on three shifts, with the first shift starting at 7 am and the last ending at midnight or later. We also made sure we included week days and weekends in our stay, based on the assumption that the involvement of families and volunteers would vary over this time period.

This approach allowed researchers from different countries and different perspectives to observe and talk with the same people in the long-term care home and to constantly compare how they understood what they saw and heard. So, for example, in one site Bob James, who is a Canadian physician and former medical director of a nursing home, was paired with Anneli Stranz, a Swedish woman just finishing her doctorate in Social Work. The physician was much more likely than the social worker to notice how medications were stored and delivered while the social worker paid particular attention to the places where staff could rest and have quiet time away from residents.

Each night, those team members not on shift met to discuss the day and the entire team met midweek and at the end of the week. These meetings allowed us all to reflect on what we thought we saw and heard and to compare what we learned, adding more voices and more perspectives to the research. It also allowed us to identify discrepancies, issues worth pursuing further, and missing information we needed to seek out. For example, one researcher reported they were told that the blue section in the linoleum confused a resident who tried to dive in to the water. We followed up on the story to ensure it was not simply apocryphal. This led us to ask questions in each site not only about floor coverings but also about colours.

These reflections also taught us how much we have been trained to look for negative practices rather than for good ideas worth sharing. It is often much easier to see when a chair does not allow a resident the leverage to get out of it or to see how a toilet placed close to a wall does not allow a walker to fit around it than it is to notice that the low counter on the nursing station allows those in a wheelchair to see over

it. To counter this tendency, we daily reminded ourselves to look for ideas worth sharing and at the end of the week we together worked to identify both what we saw as promising practices in that place and what conditions made them promising for whom.

But comparisons and reflections went further than one site. Carrying out the same kind of research in all six countries allowed us to compare across countries as well as within them. Medical carts provide one example. In an early site visit, such carts filling the hallway seemed a normal part of the routine in places that rely so heavily on medication. It was only when we visited a home without carts that we realized they were not the only way to provide necessary pills. This is also an example of two other important contributions of the comparisons and reflections. They allowed us to see what was missing. We started to notice when there was no urine smell, when there was no nursing station, when there was no lock on the door or when there were no ringing bells. Seeing what had negative consequences allowed us to appreciate what did seem promising, for whom it worked and why. These comparisons and reflections allowed us to consider options and their consequences, asking questions and rethinking old assumptions. A Swedish colleague, for instance, started to wonder if their notion that organizing long-term care homes into home areas for 11 or 12 residents created social spaces that were too small, after she saw larger units in other homes that allowed residents to socialize with a more varied population.

We now have well over 500 interviews conducted with the entire range of people involved in long-term residential care. We have hundreds of documents about the places we studied and a thousand pages of fieldnotes. And we have the notes on our many reflections and our lists of promising practices. Together they provide an incredibly rich source of evidence on ideas worth sharing and worth trying. Here we focus on those that relate primarily to the physical environment while recognizing the complex relationship between the physical environment and what goes on within it.

"It's not all about Me"

When we walked through the doors of the long-term care homes in our study, our research teams discovered that it is easy to judge a home's appearance, décor, layout and "feel" based on our own preferences, comfort levels, culture and assumptions about what we think we would like in old age. We had to get over these initial reactions and look carefully to see with fresh eyes. We wanted evidence of what "worked" to produce conditions of dignity and respect for residents and workers.

Working together in international and interdisciplinary teams helped us toward this goal. As we have mentioned, each team was composed of diverse groups of researchers and students who were different from each other in terms of age, gender, country of origin, training and understandings of what matters in long-term care. Working with others who "see" differently, we worked diligently to get beyond "it's all about me" to discover what kinds of conditions promoted dignity and respect from the perspectives of residents and staff, as well as of families, volunteers, managers and others involved in care.

In talking to many people about our research projects, including residents, families, workers, managers, owners and policy makers, we discovered that most people have set ideas about what they think they would like — or what would appeal to their mother or father — in a nursing home. But many of the promising design ideas we share in this book became visible to us only when we were able to realize that we could not identify promising physical environments by considering what we imagined we would like as older people. We had to do a lot of listening, analyzing and learning about what worked to enhance everyday living and relationships of care, dignity and respect for residents and those who care for them.

For example, a first impression might be "This place is just like a nice hotel. Look at the lovely carpet and soft lighting! Really classy. Mom will love it here."

But after looking and listening in our research, we discovered that

many carpets make rolling wheel chairs, walkers and equipment more difficult and soft lights are often inadequate for older eyes.

We also learned that what was promising in one place wasn't necessarily promising somewhere else. For example, including antiques in the decor is often assumed to provide old-fashioned charm that will make older people feel comfortable, and in some places, this seemed to be true. Yet, we discovered that antiques are not necessarily a good idea. In some places, contemporary surroundings were appreciated by residents, who enjoyed the bright, modern ambience. For some, old things provoked memories of the past that included bad experiences of suffering, violence, war and loss. Often we heard that "cozy" surroundings were preferred. Coziness was found in small groupings of comfortable furniture that invited people to sit with others, have a spot to put down a beverage or a snack and resembled private home environments in terms of the scale of furniture and other items.

"It's not all about Medicine"

In every jurisdiction we visited as a research team, residents came to live in long-term care homes because in order to sustain life they needed 24 hour, seven day a week support, usually related to severe and persistent disabilities or diseases such as dementia. In some residences, treating these medical conditions appeared to be central to planning and arranging the physical environment. These residences looked like hospitals, with formal nurses' stations, long corridors with many resident rooms on each side, heavy, high medication carts, curtains around beds, lots of institutional or commercial-style furnishings, workers dressed in uniforms that indicated their profession or occupation and surgical gloves and other signs of medical treatment prominently displayed on doors or walls. While medical care is very important in long-term care homes, this emphasis on medicine provided a daily reminder and constraint for residents, preventing them from living their lives and relating to staff as people rather than as patients.

When we visited residences where physical spaces were organized to promote living, medical matters did not suffer because they were included in more subtle ways. These physical spaces had less prominent

nursing stations or none at all. They included medicine storage in resident rooms or medication carts that looked like tea trolleys. They also featured lots of cozy corners and pleasant areas to walk, sit or socialize. Some places had areas to do a puzzle, care for plants or enjoy music. In these homes, it wasn't all about medicine. Rather, it was all about life led as fully and healthfully as possible.

"It's not all about Safety"

We all want residents and staff to be safe in long-term residential care homes. However, eliminating as much risk as possible for residents sometimes means eliminating opportunities to live life as well as possible. To identify promising practices for long-term care environments, we need to evaluate safety issues carefully. Sometimes the absence of risk meant that residents' opportunities for healthful and enjoyable living were minimized in the name of risk prevention. In others, opportunity for risk was also opportunity for some autonomy.

For example, in many residences, we saw windows that could not be opened, or windows that required a staff member to open them or a special key to open them that was not available to residents or visitors. These requirements discouraged residents and visitors from opening windows for fresh air, and added something else for already very busy workers to attend to. We heard many complaints about these windows. Fears that residents might misuse window openings in some way and injure themselves or others meant restrictions. Some jurisdictions, such as Ontario, specify that windows accessible to residents cannot open more than six inches. This seems a good compromise, but the regulation does not specify that windows **must** open nor that some windows that open **must** be accessible to residents.

We discovered that physical environment design must balance safety concerns with residents' rights to be as active and capable as possible in their own lives.

"It's not all about Décor"

Interior decoration is often what strikes us most when we walk into

a long-term care home. Interiors vary widely, based on culture, taste, and approach to care as well as on how money is spent in the facility. We tend to feel most comfortable with décor that is familiar and suits our tastes. However, our research teams learned that interior décor was both more important to social relations than we realized and also mattered in ways we hadn't expected.

In a residence in Texas, we were struck by the luxurious, large suites assigned to each resident. These suites contained not only a bedroom area and separate, private bathroom, but also an expansive sitting area. We had never seen such large, well-appointed resident rooms. In doing our research, however, we discovered that residents ended up spending the bulk of their days in their own rooms, leading residents to experience more loneliness and isolation compared to other homes where residents had only communal areas to sit, do activities and watch television.

In a residence in the United Kingdom, our initial impression was that the home was messy and cluttered. There were tables covered with knickknacks and walls filled with art, crafts and posters of famous faces. Plants, books, decorative plates, stuffed animals, dolls and doll carriages plus a jumble of other items seemed to fill every available corner and surface. There was colour and music everywhere. Some of our team worried about how it could ever be kept sanitary, while others were appalled at the "mess". Some thought it looked like a kindergarten classroom, and wondered if it was respectful. But once again, we had to look with fresh eyes to discover that this stimulating environment provided substantial benefits to many of the people with dementia who lived there. They didn't seem bothered by the hyper-stimulating surroundings, choosing to interact with environments that they enjoyed. One resident happily dusted and polished a table full of brass items, much as she may have done in her own home. Another resident routinely spent her mornings in an area full of plants and garden items, where a nature sounds recording could always be heard. There were no nurses' stations and almost no physical reminders of medical care. These absences did not seem to hamper the quality of medical care in this home.

“It’s not all about Model”

Some nursing home physical environments are purpose-built to conform to an explicit model of care, such as the Eden Alternative, Dementia Care Matters and others. We also saw nursing home physical environments that seemed to be designed and organized with medical care in mind, although this was not evident in their written philosophy. We saw very old buildings and brand new ones.

We found that while many features in specific models seemed to help promote positive conditions of life and work for residents and staff, these models were also insufficient to ensure it. **We found ideas worth sharing in all manner of physical environments, and also ideas to leave behind in all models.** The various models, design regulations and other guides that we reviewed in our research shape physical environments in ways that support some aspects of care. However, in each of them we identified examples from their physical environments that failed to take into account issues we consider in this book. Models tend to prescribe one “best” way for everyone without taking context, such as community history, culture and location, into consideration. While we saw many promising aspects of the physical environment in each of these models, their effectiveness in promoting dignity and respect depended on their implementation and their location, among other factors. And the impact varied for staff, residents, families, volunteers and managers. We offer a range of ideas collected from our research, many that can be applied in a wide range of long-term care physical environments without requiring new construction or even a construction crew. These ideas were collected with our emphasis on bringing joy to life in long-term care, rather than on finding a single right way.

We began this chapter with a fieldnote and quote from an occupational therapist who took the time to share his vision and its realization with us. We thank him and all of many residents, families, staff, volunteers and managers who participated in this study, who opened their residences to our teams, shared with us the many ways they interacted with their physical environments and helped us identify ideas worth sharing. If you are one of the many people who participated in our

study, we hope you will recognize some of your contributions in this short book. If you are one of the thousands of others we expect to read this book, we know you will thank them too.

We also want to thank the Social Sciences and Humanities Research Council of Canada. Without the seven years of funding to plan and carry out this research, we would not have been able to capture the rich, complex and diverse conditions in long-term residential care. And we thank as well the Canadian Institutes of Health Research and the European Research Area in Ageing 2 Project. The funding from these bodies allowed us to conduct important additional site visits and do more effective knowledge sharing work.

In addition to this little book, our research team have produced many other publications from this project and have many more publications planned. A bibliography of the publications available as of fall, 2016 is included in the back of this book.

The rest of this book is organized into chapters that take up an issue that we think matters in planning and organizing physical environments. These chapters, written by team members who participated in our ethnographic studies, delve into the complexities involved in designing long-term care homes that can bring joy to life. You will note that there is sometimes overlap in the material among the chapters, showing that some aspects of physical environments for long-term care have multiple effects and implications. Issues such as carpets, toilet placement, lifts and windows may seem simple and straightforward, but our research shows that these elements are sometimes complex, with significant consequences for those living and working in these settings. We hope this research is useful to them and to you.

NOTES

1. Organization for Economic Cooperation and Development. 2011. "Help Wanted? Providing and Paying for Long-term Care." *OECD.org*. Accessed February 29, 2016. http://www.oecd.org/els/health-systems/47884930.pdf.

   –––. 2015. "Health at a Glance 2015." OECD.org. Accessed February 29, 2016. http://www.keepeek.com/Digital-Asset-Management/oecd/social-issues-migration-health/health-at-a-glance-2015_health_glance-2015-en#.

2. World Health Organization (2002) *Ethical Choices in Long-Term Care: What Does Justice Require?* Geneva: WHO, page 5.

3. Public health England *Physical Environment* http://www.wmpho.org.uk/topics/page.aspx?id=1538. Downloaded August 18, 2016.

4. Partners include the Canadian Federation of Nurses Unions, Canadian Union of Public Employees, the National Union of Public and Government Employees, the Service Employees International Union, Unifor, The Ontario Association of Non-Profit Homes and Services for Seniors and the Council on Aging, Ottawa.

5. Ontario (2015). Long-Term Care Design Manual. Ministry of Health and Long-Term Care.

LOCATION MATTERS

James Struthers

Location is often a neglected issue in planning for and organizing long-term residential care. Yet the 'where' of long term residential care (LTRC) plays an important role in the overall quality of life for residents, family, volunteers and workers. A residence's site location shapes relationships with the surrounding community for residents, visitors, volunteers, families and staff. Further, the history and culture of "place" can be reflected in residence design and décor to enhance and strengthen these relationships.

Getting outside

Real estate costs and prevailing attitudes that older adults deserve 'peace and quiet' in pastoral landscapes have biased the location of LTRC homes away from busier urban cores. In our research, we found these suburban locations were often detrimental to residents' quality of life. Newer suburban care homes, despite attractive exterior designs, often prove more challenging for residents wishing to get outside, precisely because of their locations. The location of one Ontario home less than a decade old, although situated on 19 acres of land, seemed to limit walking and wheelchair excursions.

> I notice all of the construction, both on the busy highway on which it is situated and on the surrounding land…There are strip plazas, a couple of hotels, car dealerships, small businesses…I note immediately that it would be difficult to walk anywhere with ease

> as the highway is busy and there is only a small area with a sidewalk right in front of the nursing home. (Fieldnote, Ontario)

Other researchers noted similar sentiments. "The nursing home is near a highway and within walking distance from some supermarkets. But there are no sidewalks and to walk along the highway seems to be risky" (Fieldnote, Ontario). It "doesn't feel like it is part of the community" (Fieldnote, Ontario). Although the home had an attractive outside garden, it was usually locked and difficult for residents and family members to access without the help of staff.

> In summertime we should where resident, whatever, they competent, incompetent, they should have, like, fresh airing outside…This be very, very difficult. The time is not really enough for them. (Interview with RN, Ontario)

A new facility near a major American city presented similar locational challenges.

> A huge three-tiered expressway currently under construction can be viewed across an empty field behind the facility's rear parking lot. The building is…located in the rear area of what appears to be a recently developed industrial/commercial and emerging suburban zone on the outskirts of [the city]. The surrounding area is flat and rather bleak. (Fieldnote, United States)

Another suburban American site discouraged easy entrance or exit to the surrounding neighbourhood. It was

> off a main highway, that has large chain stores…as well as small non-chain stores in strip plazas scattered along either side, along with gas stations and hotels …On the side streets …all houses, apartment units are gated and fenced…The [home] is gated with a luxurious front entrance (security station and speaker system at the double gate, which is black cast iron) …The grounds are surrounded by black cast iron fencing and red brick posts. (Fieldnote, United States)

In contrast, being situated within the dynamic heart of a city adjacent

to a large, historic downtown market emerged as a key locational advantage for one older Ontario care home we visited. Residents, staff, and family members told us how much they enjoyed easy access to the shops, boutiques, restaurants and cafés which surrounded them. "Oh, I love that," the wife of one resident remarked. "Because then once in a while I do shop and have a lunch." She also enjoyed taking her husband out for walks and a meal with her son in one of the many market restaurants. "This location is very good. It really is" (Interview with family member, Ontario).

A woman resident told one of our team how much she valued "going out for walks in the area…on her own. She doesn't get lost" and pointed to several pieces of art she had purchased on her excursions (Fieldnote, Ontario). A male resident, incapacitated by strokes, told us he "stays fit [because] I get out as much as I can…I go to the market… And there's lots of people and that's the way I keep my mind fresh…I think the location is very good" (Interview with resident, Ontario).

No group valued access to stores, food, people and transit more than the growing population of younger, mobility impaired residents. One woman with MS told us how she "regularly leaves the residence to go downtown" (Fieldnote, Ontario). A paraplegic woman described how "occasionally I do go out shopping with the miniscule amount of money that I have …and buy personal needs, you know shampoo, soap, whatever. But that's just a chance to get out and interact with different people" (Interview with resident, Ontario). The home's volunteer coordinator also explained how crucial it was for getting residents outside for walks. "Just let them live. So volunteers are now allowed to accompany residents, you know, go to market. We're located in such a nice area for that, so it's okay" (Interview with Volunteer Coordinator, Ontario). Volunteers also emphasized that the home's location mattered.

> If it was my family member or myself, I wouldn't want to be out, you know, old highway 16 miles from anywhere …[You want] somewhere you can go out and get a cup of coffee or a meal in a restaurant or something. (Interview with volunteer, Ontario)

Community Integration

European sites provided many examples of how LTRC homes could be closely embedded within surrounding landscapes and neighborhoods as well as within an integrated continuum of care. Approaching a site in Germany, located close to assisted living, daycare, and home health care services, one of our researchers was "struck by the small village 'feel' even before we enter the home…There really is a sense of being in an enclave …We are into a village with homes crowding the road on either side" (Fieldnote, Germany). Another was

> surprised at what is located just up the street …There is a beautiful treed walking path just on the other side of the kindergarten, which sits adjacent to the LTC home property. The streets are narrow and as I walk I note the old brick homes with clay tile roofs, very quaint village feel …There are independently owned stores including a bakery (since 1875 on the sign), butcher/cheese store, 2 pubs, and a casual restaurant, dentist, variety store, two hair salons, a pharmacy, a store with various things like a Stedman's, and one with house furnishings and accessories (vases, throw cushions, etc.) all on one street. (Fieldnote, Germany)

A downtown home in a large Swedish city also had a "daycare centre … Most of the residents come from the surrounding areas and are familiar with a park area close by the nursing home." There was also a nearby hospital whose doctors were "responsible for the nursing home … [T]his closeness was useful as residents in the somatic ward were sicker than before." The surrounding shopping area also allowed staff to

> Occasionally …bring a resident with them to the grocery store as an outing, in order to purchase ingredients for the Sunday dinner to be prepared on site. This activity gave some of the residents a sense of competence and association with their former civil lives. All of this produced a touch of homeliness. (Fieldnote, Sweden)

In Norway, community integration was also fostered by locating daycares and kindergartens next to care homes. In one facility in an older area of a large city residents could easily view children in the

kindergarten playground next door. A community accordion band also used the home's first floor auditorium for its weekly practices and provided free concerts for the residents in exchange (Fieldnote, Norway). In Germany, children from the daycare and kindergarten "situated right beside the facility…came into [it] and [did] activities with the residents" (Fieldnote, Germany).

In a smaller Norwegian city, a new LTRC home was seamlessly integrated into a pre-existing cultural and recreational centre located a short walk from the region's main shopping mall. A kindergarten and daycare was situated beside the home. Assisted living units populated the surrounding hills directly behind it. LTRC staff spent one day a week delivering home care to those needing it in the assisted living units so that if or when they needed to transition to a higher level of care, they would already be familiar with the home's staff and milieu.

> I exit the facility and walk directly across the central square to the shopping mall …supermarket …bank, flower store, and many clothing stores exist underneath a glass roof …This juxtaposition of the mall across the square from the nursing home, reminds me a bit of [the older downtown home in Ontario]. In both locations, it is easy for families and individuals to combine shopping, cultural activities, going to the library, to the movies, swimming and music lessons with visiting a nursing home. In fact, here it has been normalized for all ages. If you want to have a great banana smoothie or a soft ice cream, you get them INSIDE the nursing home/cultural centre, rather than in the shopping mall. (Fieldnote, Norway)

Décor and heritage

Perceptions of 'home' are embedded within an awareness of larger neighbourhoods and communities located in time. Incorporating a sense of history, culture, and place within the décor of care homes can help to reinforce important emotional connections between location, identity, and memories of everyday life. A popular resting spot at the junction of two hallways in the memory unit of one Ontario home recreated a local bus stop. Surrounding it were large photographs of streetcars and buses from an earlier era of the home's history

(Fieldnote, Ontario). In a Manitoba home a memorial open kitchen and dining nook, named after a volunteer who fought for the home's creation, was located inside the entrance for the convenience of visitors and staff (Fieldnote, Manitoba). A German home featured "communal corners" at the intersection of hallways, equipped with water bottles and "bigger couches as a kind of invitation to residents to sit there together." The entrance and hallways throughout the home were also decorated with large pictures of elderly adults donated by an artist. Although "most of the residents, visitors and staff appreciate them very much," others wondered "whether old people want to be surrounded by pictures of other old people." This home also featured "a book with every resident's name and picture, date of arrival and — as the case may be- the day of the 'farewell'" (Fieldnotes, Germany).

Similar use of historical photographs, artifacts, and art specific to a care home's history, geography, and heritage as well as memorials to former residents, staff and volunteers featured prominently as markers of community and identity in some homes visited in Nova Scotia, Manitoba, British Columbia, the United States, Norway, Sweden and the United Kingdom. In contrast, other homes in these same jurisdictions featured only generic art and décor, contributing to an overall sense of placelessness. The wall art in one suburban Ontario facility appeared "to be what has been donated from [warehouse poster] sale mistakes" (Fieldnote, Ontario). Another researcher remarked that there was "nothing linking the nursing home to the city, to [the region], or even to Canada. It was typical nursing home art" (Fieldnote, Ontario).

Different perspectives also swirled around the balance between modernity and heritage in care home design and décor. The modern design of a home in one major Scandinavian city struck some researchers as being very much about "contemporarity" rather than place. "The décor is not particularly related to [this city] but it is certainly distinctively Swedish modern. The pictures do not reference the locality particularly. It is hotel style, in a way that could be anywhere in northern Europe, I think, and would transfer well beyond" (Fieldnote, Sweden). Another remarked on corridors which were "decorated with pretty wallpaper and beautiful furniture and art — they looked almost like tableaus…The impression I got was as much that of a hotel as that

of a nursing home." A nurse who had worked in the home's former structure, however, warned against being

> "blinded" by all the great art and the great design. The old home had had old period furniture and cozy living rooms. "That's what old people like", she said. The atmosphere of the old [home] was special …The entire staff …had had a sense of ownership of the home and took pride in working there. (Fieldnote, Sweden)

In contrast, a resident said how much she liked that the "common rooms are not too cluttered. It appears roomy and free (in other words, she clearly appreciates the modern and simple design that nurse thought old people did not like" (Fieldnote, Sweden). Even in the same location, in other words, choices in design and décor mattered greatly and strongly affected perceptions of "home," "time," and "place" among those who lived and worked within its walls.

Staff perspectives

For workers living close to a downtown Ontario care home, proximity meant less stress getting to work. "I don't live very far from here … so in the morning I wake up [and] …it takes me 10 minutes." She and some of her colleagues liked the flexibility of being able to come in a bit earlier or to stay a bit longer so as not to feel rushed in feeding residents (Interview with food service worker, Ontario). Workers also appreciated opportunities to have staff parties together in restaurants in the nearby market area (Interview with cleaner, Ontario). Others, particularly part-time staff, resented long commutes from the suburbs and the high cost of downtown parking.

> Sometimes, it almost seems like it's not worth your while to come for two hours just because by the time you get here, you know it's a …20-minute drive …and then when you come here there's never any parking …I had to pay for parking. So for me to pay for parking when I'm only here two hours, it's not worth it. (Interview with meal helper, Ontario)

For those employed in a rural Nova Scotia home the absence of public

transportation meant long highway drives, especially under hazardous winter conditions, which were especially stressful.

> Well, put it this way. I've tried to leave three times and I'm still here…I didn't want to do the travelling …It's about a half hour each way so an hour a day and just winter driving, I'm not really liking it … So, it wasn't that I wanted to leave here because I didn't like it. It was because I wanted to find something closer to my son. (Interview with care aide, Nova Scotia)

Homes which either provided or were located close to child care were highly prized by staff. A Norwegian facility located directly beside an elementary school made it possible for some employees, who lived in apartments in the care home building, to view their children at recess in the playground (Fieldnote, Norway). Other homes visited in Norway, Sweden and Germany also had daycare and kindergartens either onsite or very nearby (Fieldnotes, Norway, Sweden, Germany). In a more rural Norwegian community, the public library, gymnasium, community swimming pool, and cinema were situated in the same complex as the long-term care home, allowing staff to combine recreational, cultural, and workplace activities (Fieldnote, Norway). A large American integrated care home rented out low-cost townhouses directly across the street to its staff, although they were scheduled for eventual demolition to make way for a planned facility expansion (Fieldnote, United States).

Staff in a Swedish home were encouraged to "bring people outside every day, escaping from the inside harsh light, shiny floors, and noisy halls of the nursing home," into a beautiful "Garden of the Senses" as well as to use it themselves in order to avoid burnout. "While we were there, four care workers sat in the garden with 8 residents" (Fieldnote, Sweden). In other locations workers expressed frustration that they seldom had time to take residents outside (Fieldnotes, Ontario, Norway).

> Sometimes I like to go help to walk and you can't because you have so much residents and you don't have much staff. If we had extra staff, you know …one staff could chip in and it would be much better

> because if that resident want to go at least somebody on the floor watch that person. (Interview with care aide, Ontario)

Workers in homes visited in Norway, Germany, Manitoba, and Nova Scotia particularly appreciated the ability to purchase low-cost food from on-site kitchens, canteens, and dining nooks located in first floor lobbies which "invite in family, staff, and community" (Fieldnotes, Norway, Germany, Manitoba, Nova Scotia). Homes that were embedded within larger medical infrastructures also made it easier for staff to access physicians, lab tests and, in some cases, even better salaries (Interview, with CEO Ontario; Fieldnotes, Ontario, Sweden). Others argued that hospital-like settings were incompatible with a sense of home. "That makes it difficult to create a natural kind of environment for aging people" (Interview with social worker, Ontario).

The greater physical separation of residents in newer care homes built on modular "neighbourhood" designs could also create a sense of estrangement and even exhaustion for staff.

> Some of the [care aides] felt that it was better at the old building because it was more intimate and that here the residents were lonely. [They] also talked about the distance between the houses and felt that there was too much walking. One [aide] said that no one wanted to be a float (between two houses) as there was too much running around. (Fieldnotes, Nova Scotia)

Others complained that "here you only know your own neighbourhood. Only a few activities are held in the big room for everyone . . .The old home was quaint …now it is more formal" (Fieldnotes, Nova Scotia). Asked what she missed about working in the older home before it was rebuilt a nurse replied, "nothing, except maybe the social aspect. Here they are all spread out and she doesn't see the old gang anymore" (Interview with LPN, Nova Scotia).

KEY QUESTIONS

- What opportunities are there for residents, family members, volunteers and staff to get to shopping, restaurants, cultural centres and parks close to the home? What kinds of access is there to the outdoors, so that people can enjoy the outdoors as independently as possible?

- How can continual and spontaneous opportunities for inter-generational contact be maximized in the location and design of long-term residential care so that children and adults can engage with and learn from each other?

- How does the homes' location enhance or enable service integration with home care, hospital services and assisted living? Are there aspects that allow for smoother transitions for residents among facilities?

SPACE MATTERS

Hugh Armstrong

> We walk in the front foyer with parquet-style wood flooring and trim, in which five residents are already sitting on the central benches and one is in a wheelchair beside them. Two residents are reading newspapers and others are chatting. Straight ahead is a little parlour, which is old fashioned looking and inviting… I note the art work everywhere, and various small sculptures around. Up the hallways are situated wooden and wicker arm chairs, café table and chairs with a vase of flowers in the centre, and large wooden armoires. (Fieldnote, Germany)

We get the sense from this note that the nursing home is "inviting," both to visitors and to the residents who are up and about, reading and chatting. It's not just the wood that's inviting. So are the old fashioned arm chairs, the flowers, and the works of art. It's "home-like" and shows evidence of healthy social engagement among residents.

Size matters

Some promising features of all homes are obvious, if not always present. There is no disputing having "public washrooms on the ward [that] are clean and well-equipped, with faucets that turn easily, pump soap and paper towels that are always available, and a waste basket … near the door" is a good idea (Fieldnote, Ontario). We found, however, that favourable assessments were much more common when the units lived in were relatively small, sometimes with as few as nine residents

per house (my preferred term, elsewhere called a neighbourhood or ward or by some other name) and ranging up to about 20 residents. If larger than 20 or so, the houses tended to be more institutional, even hospital-like, in their feel. As would be expected, residents in smaller units are more likely to recognize each other and their habits. So too are staff, at least if they enjoy stable work assignments. Houses that are too small may however induce boredom, and nine residents per house may be too small. As one senior manager told us, "Smaller units are no panacea for better care" (interview, Ontario).

Larger facilities that incorporate several houses have their distinct advantages. Economies of scale can be achieved, in management positions and in "back room" services like bulk purchasing, payroll, routine building maintenance and security, and well-equipped staff lounges. They are also more likely to be able to include specialized facilities like hairdressing salons; large multi-purpose rooms for religious services, concerts, meetings and celebrations with members of the outside community; palliative care units on site or close by; therapy and other rehab facilities, and so on.

It appears that the overall facility needs to serve at least 80 or 100 residents in order to take advantage of these economies of scale. Beyond 120 or 150, however, the chances are high that familiarity and intimacy will be hampered. One site we visited with 80 residents was organized so that the receptionist was also responsible for distributing resident-specific meal menus to all the residents at their assigned dining room seats. She knew them all by name and condition, and knew all their regular visitors by name as well. The same was true of the facility's executive director, who told us that 100 residents per facility would be most efficient (interview, Manitoba).

Getting around

Another design feature concerns the capacity of residents to wander, to not be confined in a small space with 10 or 15 other residents. One way to accomplish this is to enable them to move among connected houses. Yet long corridors suggest institutional and not home-like arrangements. One solution is to intersperse corridors with "a range of

sitting areas" (interview, United Kingdom). Quiet lounges, TV lounges, a view onto a garden can help the building to assist resident orientation or "way finding." Accessible small gardens shared by one or two houses can also promote "horticultural activity" (interview, Ontario), which is healthy in social, physical and cognitive terms. Meanwhile, we heard the complaint at one home that too much space to wander can also mean too much staff time and effort spent walking between houses when staff has responsibilities for keeping track of residents or for transporting supplies, food and so on (Fieldnote, Nova Scotia). And no matter how attractive the staff lounge, it's of little use if it's too far removed to get to on a break.

Wanderers present a challenge at another small home, which has 64 residents, some with moderate dementia, in four units. The management's posted response to a Resident Council complaint reads in part:

> The Home is very open concept that allows plenty of light and space for residents. It does not have a secure unit; all residents are free to walk around the Home. Some residents get confused and don't realize they have ended up in someone else's room…staff does hourly checks on residents known to wander and try to keep them out of other residents' rooms. Most of the residents who wander are cooperative and are easily re-directed; they don't mean any harm. (Ontario)

Necessary controls on wandering throughout the building are much easier in a smaller facility.

Having nursing stations in a small unit can "create a barrier between staff and residents, and the impression of a hospital" (interview, United Kingdom). These spaces can also attract "hanging out" by staff, and thus have been removed from some facilities. Other facilities have located their nursing stations at the intersection of two or more houses, allowing straight sight lines for staff. Nursing station counters can be low to facilitate observation by wheelchair-bound residents, and can have spaces wide enough for them to get behind the counter. These design features are easier to introduce when there are fewer residents

to keep an eye on. Indeed, sight lines may be irrelevant where houses are sufficiently small.

Resident views

Resident views are also important. Residents often prefer to look out onto "lively" scenes, perhaps near the nursing station or at the elevator. One Canadian home is nicely situated overlooking a park with a stream, and with abundant birds and animals, including deer, all fed by the staff. Residents can certainly be seen viewing nature out their large windows or out in the park area itself, but they congregate more frequently on the other side of the facility, keeping watch on the busy main thoroughfare and the shopping mall across it. They and many of the residents of other homes welcome the sight and sound of traffic. At more than one home, residents can see children playing in a daycare centre that is associated with the facility. A couple of other small facilities are planning such centres.

Views can however present problems. They may remind some residents that sadly they can no longer get close to their former neighbourhoods or to the beautiful mountains they can see out the window.

To and from resident rooms

The size and configuration of resident rooms present another consideration. If all the rooms are singles (with adjoining rooms available for couples wishing to live together), then resident privacy is enhanced. It is further enhanced if, in addition to ensuite toilets and basins, the rooms are all equipped with showers. Residents then do not have to be escorted, perhaps in nightgowns or pajamas, down the hall or even past the living/dining area to the common bathroom. On the other hand, at one facility "the bathtub room…has been transformed into a spa-like environment: blue towels, candles (which have been lit prior to our arrival!), stones, scented oils, soft lighting" with the result that "now baths are positive" according to our guide. This is particularly important as many residents fear showers and prefer baths (Fieldnote and interview, Norway).

Another design feature is to make the doors to individual rooms appear to face the street rather than simply a corridor, however long the corridor. The lighting in the corridor can look like street lighting, and the rooms' doors can be painted in different colours. The hand rails along the corridors can be made to blend into the overall decor, making them appear less hospital-like. Alternatively, the corridors may be carpeted, providing a more home-like feel and a reduction in noise. The challenges here are with hygiene, given the prevalence of spills of various kinds, and with the additional effort needed to push wheelchairs, along with medication and laundry carts. One upscale facility in the U.S. employs a full-time "carpet technician" to clean up spills. Once we saw him arrive to do his job before any nurse arrived on the scene to attend to a resident who had fallen and been cut. More than one staff member complained to us however of a sore shoulder from pushing wheelchairs over the carpeting. They are also difficult for residents who use wheelchairs or walkers. Floors made of cushioned, non-slip, non-glare materials are preferable to carpeting, for both residents and workers.

A home-like atmosphere

Residents, and especially family members and facility managements, want their facilities to appear to be as home-like as possible. One way to achieve this is to allow, even encourage, residents to bring some of their own furniture and decor to their rooms. Their beds are almost always provided by the facility, and equipped with mattresses that can reduce pressure ulcers, side bars that can help prevent falls, and other features to enable raising and lowering. Most rooms have ceiling lifts to aid in moving residents to and from beds and toilets. A typical room we saw also had "furniture from home (old chair, little dresser, mantel clock, pictures, old lamps, [and a] flower table cloth) …that makes the room feel cozy" (Fieldnote, Norway). Another site was favourably described as being "like a private flat or house" (Fieldnote, Germany). At a yet different site, however,

> The decor was very modern and new, made possible by a large donation. It was explained that the philosophy on decor was to reflect now and the future, not the past. They [management] refused

> old furniture offered by families… [Rather] they 'want families to be proud' … as furniture reflects assumptions about residents, as well as access to funds." (Fieldnote, Norway)

And at a fourth, very small site, furniture from home was discouraged more prosaically because it was deemed hazardous or difficult to dispose of when the resident dies (interview, United Kingdom).

Furniture from home, and more generally tastes in furnishing, decor and special attractions, are issues for which there is no correct answer. Consulting with staff certainly helps, as does consulting with residents where practical. 'Home-like' may conflict with concerns about infection control and safety. And while wall-mounted hand sanitizers and alarm bells, for example, may be needed, they will reinforce a perception of hospital-like medical care in what are claimed to be homes.

Inside individual rooms

Another source of spatial tension involves individual rooms. Rooms that are too large and grand discourage residents from common areas and thus social engagement. In one instance, each large room "has a regular size closet, and comes equipped with a bedside tray, bedside table, dresser (all matching the wooden bed), flat screen television on the wall, wall clock, cork board with activity agenda, telephone (resident pays cost), and as many wingback chairs as desired. Residents are encouraged to bring items from home to make their room feel as much like home as possible. Each bedroom has an adjoining bathroom with a walk-in shower…white oak cabinet and white ceramic basin (some are without drawers to accommodate a wheelchair at the sink), toilet, safety pull chords at shower and toilet, and safety rails. The light switches and alarms are all at a level that can be reached while sitting in a wheelchair" (Fieldnote, United States). Residents were observed leaving their rooms primarily for meals and occasionally for organized activities, not for chatting. Meanwhile, in some other facilities very small rooms meant cramped, uncomfortable quarters with little or no space for items brought in to supplement the most functional of beds, tables and a single chair provided by the facility. On our rare glimpses of these rooms, they felt imprisoning. On the other hand, some homes

defended their double rooms on the grounds that they provided company, including company from visitors to their roommates. In part to compensate for small, functional rooms, some facilities adapt common spaces to the expressed preferences of particular residents. One facility has now set up a bar which was recently the site of a woodworking bench and tools.

KEY QUESTIONS

- To what extent are items like wall-mounted hand sanitizers, alarm bells, medication trolleys, and even nursing stations needed?
- Given that residents, especially those with dementia, understandably like to wander, are smaller facilities, and smaller but readily accessible houses within them, preferable? How small is too small?
- To what extent should residents and their families be encouraged to provide furnishings and decor for resident rooms? To what extent should considerations of safety and hygiene, and of staff and facility efficiency, limit this provision?

STAFF MATTERS

Jacqueline Choiniere

Long-term residential care, while home to many of the most vulnerable members of society, is also the work setting for direct care providers, dietary workers, housekeeping workers, therapists, managers and more. As a supervisor in a German LTRC agency told us: "it's what we said during the introduction, that it's only possible to do good work if you feel good at work". Our site visit interviews and observations support our initial assumption in this research project; namely, the conditions of work are the conditions of care. And the physical environment is a critical component in those conditions. This chapter explores some of the promising practices in physical design and the related conditions of work within these spaces that we've encountered in different jurisdictions.

Space to support work and care

In addition to our assumption that the conditions of work are the conditions of care, we recognize that care is a relationship, which means organizing long-term care settings to facilitate staff-to-resident and staff-to-staff engagement. The diversity of approaches we encountered in how staff work spaces were designed reflected differences in how care — and care work — were conceptualized at the same time as those spaces shaped care.

Sightlines provide an example. In one southern U.S. nursing home, an octagonal-shaped nursing station gave nurses and other staff clear

sightlines into all hallways. But what staff could keep in sight reflected what was considered important, as fieldnotes from a BC site indicate:

> As on all the floors, the nurses' station is positioned behind the dining area. It has a central view of all three hall way "neighborhoods" on this floor …but as with all other floors, there is no view of the dining area.

Nurses in this home did not assist in the dining room and could not see residents eating, even though eating was the major event of the day. Sightline issues tended to be raised in homes that congregated large numbers of residents in the same area. If there are 38 residents in the area and if nursing staff members are expected to do much of their work from a nursing station, then they need to be able to see in all directions. Yet, in most of the North American homes we visited, the high counters prevented nurses sitting at these stations from seeing out and prevented residents in wheel chairs from seeing in. The physical space was organized in a manner that seemed to separate residents from staff and limited nurses' engagement with residents or even other staff.

But we also encountered homes where nursing stations were not at the centre of nursing work. The nursing station had been completely removed or significantly altered, rejecting the notion that staff work needs to be conducted away from residents. The following observation was made in a UK long-term residential care site.

> All of them [nursing stations] have been made into common areas for residents, with sofas, chairs, tables and paintings on the walls. "Residents used to knock on the windows of the nurses' stations without being able to enter", we were told. "Staff used to hide in the nurses' station, which was no good". (Fieldnote, UK)

As a staff member put it, "earlier we used to have very good nurses' stations. Now we have beautiful 'corners' for the residents" (Interview with R.N., UK). A researcher observing in that site notes: "No one directly pointed to possible downsides of having had the nurses' stations removed" but there was a suggestion that some staff work was made more difficult.

This issue became visible in the design of a long-term care setting in Nova Scotia. One researcher reflected on the issue of privacy for both residents and staff created by the physical design of the main eating/gathering area. As a fieldnote indicates, this space included the kitchen, dining area, lounge, as well as

> …the counters where drugs are stored, and the communications centres, which have places for some resident records as well as for the public phone and computer for skype. It is an attractive area, one that keeps staff visible to residents and to each other but it also means that staff are recording and preparing for particular resident needs in a public space where they can be frequently interrupted and heard.

This researcher was concerned that conversations about residents' bowel movements were occurring in the dining area and about the possibility of distractions from interruptions. Yet, this same researcher also noted that this design helps avoid unnecessary separation or barriers between residents and staff, and that staff members did not seem concerned with this open space.

Design can also serve to connect or separate staff from each other. In one Swedish nursing home for example, staff reported that the circular structure of the home allowed them to contact each other more easily. It also facilitated residents' mobility, enabling them to walk without wandering away. However, the long broad hallways that connected different sections of a nursing home in Nova Scotia, allowing residents to take long walks, also meant not only that staff could be far apart but also that they walked a long way to do their work.

The size and shape of the room, as well as the equipment, also influences the care work. In a UK home, we observed staff running up and down the stairs, each time having to take extra moments to stop to open and then shut a gate installed to prevent resident falls. We saw a small dining room in Ontario built before large wheelchairs were common. The resulting crowding made it hard for staff to move among residents while they were eating. Similarly, the small residents' rooms we saw in a UK home made it difficult to clean around the personal items and heavy chairs. In a Nova Scotia home, we saw toilets squeezed

up against the wall, making it difficult for staff members to stand on both sides of the toilet to assist the resident and in Manitoba we saw ceiling lifts that were not placed over the bed, thus making them hard to use to assist someone in the bed.

At the same time though, we saw large, private rooms in Norway that had lots of room to move furniture and people around. The hardwood floors were easy to clean, the space around the bed made it easy for two workers to help each other with a resident, and the lift, on a track that led to the bathroom, allowed workers to move residents easily. This same home had facilities that made the work more pleasant for both residents' and staff. Fieldnotes from our tour tell the tale.

> We were shown a therapy pool that is wheelchair accessible, meaning you can take your wheel chair in the pool. It is kept warm — 33° — and is used for "therapy," we are told. It is good for stroke, cancer and other types of conditions. Babies from the community also use it. There are lots of floating devices. We are then taken into the ward and shown the bathtub room, which they have turned into a spa. It smells strongly of melting candles, and there are candles lit everywhere in beautiful glass holders. White robes, blue towels, aroma therapy sticks, little touches that make it feel like a spa. I am immediately soothed by the environment.

Bathroom design is particularly important. Staff in an Ontario home emphasized that they could lower the lights in the large bathroom and help residents with dementia who feared showers to have a relaxing time in the walk-in bath that quickly filled and emptied. The resident was happier and the work was easier and more rewarding.

Staff involvement with design

When we interviewed people who worked in government, unions and community organizations about where to go for promising practices and why, one reason they gave for recommending a place was the involvement of staff in design. We had evidence for lack of consultation when a group from the Yukon contacted us about our research because their municipality had not consulted effectively with those who would

work and live in the new building. According to them, the location had no public transit and meant long car trips for both staff and families — if they had a car. Furthermore, the only place where necessary drugs were available 24 hours a day was the hospital, which was a long way away when a resident suddenly needed much more pain relief at midnight.

We also saw design that created health hazards for staff, suggesting they had not been involved in the design. One researcher noted the following in an Ontario home:

> …Another issue, which I had observed during the two previous days, was that the carpet flooring was unsuitable both for residents in wheelchairs and for the staff who have to struggle to move various trolleys down the hallways …The rec therapist later told [us] that she has a sore shoulder from pushing wheelchairs over the carpeting.

Yet there were several examples of spaces that suggested workers had input into the design and decoration of the space. In one fairly new LTRC home in Nova Scotia, kitchen workers were involved in designing the kitchen space, according to their work needs. Our fieldnotes indicate that:

> All the appliances are modern and high tech, with stations for different aspects of the production. They have three very large, cooled areas for food; one for fruit, vegetables (and we can testify that they use real carrots, broccoli, celery etc.) and meat (we saw large roasts and other whole meats to be cooked); one for frozen food and one for drier goods. It was clear that much of the food is "made from scratch". These, and another large storage area, are directly accessible from a loading dock. She took us to another storage area for things like dishes, and showed us their special dishes for those with sight issues and special utensils for those who have arthritis. The kitchen clearly revealed an understanding of their work processes and needs.

The space was large enough for us to tour with ease and the two cooks present were clearly proud of their space.

In a Norwegian home, the staff personally selected all of the furniture and pictures on the walls. They also organized the garden space, selecting the plants and planting them to their design. In another Norway home, team members reported that, while a consulting team had selected the art, including "professional photos of people and historical local views as well as some signed lithos …the team included some nurses from this home". A Manitoba home consulted their cleaners when the managers discovered that:

> they had been using rags for everything, which were made from the old underwear of residents …When they looked into this more deeply they discovered they didn't know how these rags reacted chemically with other products. A new pilot project is using micro-fibre cloths exclusively. They are colour-coded. Pink for cleaning. Orange for danger of infection. They realized staff were "very possessive" about their cloths. They [the cleaners] called attention to the problem and picked out the colours for coding. (Fieldnotes, Manitoba)

Space for staff to get away

While work setting design is very important, staff also need to be able to take breaks away from work. We heard that their break rooms should not only be comfortable but should also be near enough to their work that they did not spend too much time getting there and far enough from residents to give staff a real break. Moreover, they should allow staff to have fun together, away from the residents — another critical component in the design. Workers also pointed out that they needed the space to grieve. As a receptionist in Manitoba explained:

> It happens that you get really close. This one I was really close to the resident and very close to the family so it was very hard for me this morning. Even when she was going out I had to hide in there because I just didn't want to see her going. So you get really attached.

While we also heard that staff needed lockers to store their clothes and other belongings, they did not want these to be at the centre of their break room.

Not all homes we studied had break rooms that fit the needs staff identified to us. Those settings that lacked space, or provided inadequate space included one in Ontario where a staff member reported that "we are not allowed to eat on the floor [in the area], but the staff room downstairs is too small, and the cafeteria is closed".

In contrast one researcher noted that the staff room in a Swedish nursing home was outfitted with:

> …coffee/latte maker, water and sparkling water taps (which are in the units as well), ovens microwaves, fridges and lots of tables… a corner with a library and several comfortable chairs. We are also shown a nap room for staff.

There was a large balcony with a view, as well as a computer for connecting with friends and family. In a Norwegian nursing home, researchers observed a staff break room that was large and bright with a bowl of apples (for staff) on the table. These spaces, along with access to cafeterias offering good, inexpensive food throughout the day and even into the night, were identified by many staff as critical to their health.

A break room is not the only kind of space that can help rejuvenate staff. In an Ontario nursing home, the union negotiated a fitness room for staff. Fitness classes are offered for a very low fee. The day we toured the space, several women were busy on the treadmill, getting ready for work. A quiet space for memorials or contemplation was also raised by several staff as necessary for care in a place where so many people die.

In a German nursing home, the manager explained that:

> … [we] attach great importance to wellbeing of the residents but also have the same focus on the staff. Only if staff is happy can they offer the same to residents. … staff is the major capital and [we] base policies on this in order to be able to perform good care.

This comment is an acknowledgement of the intimate linkages among effective workspace, work satisfaction, staff wellbeing, and the quality

of resident care. And space alone does not mean appropriate care. Having adequate numbers of staff to provide the care that is needed is a foundation for promising practices

KEY QUESTIONS

1. How can staff be involved in the design of the building and the equipment?

2. What spaces do workers need to be able to work together to provide appropriate care?

3. What spaces do workers have to get away and do those spaces have the services as well as the equipment they need?

FEATURES MATTER

Ruth Lowndes

> Look out into the world. Look at the sunshine. Look at the trees. Look at the people. It's your home, not an institution. You have to create that environment. (Interview with family member, British Columbia)

Features are the amenities and details that can promote or decrease resident quality of life. Some features also ensure the health and safety of staff and residents, yet are often overlooked in design planning. In our research, we have aimed to identify features that help to create comfortable, inclusive, and safe environments. These often simple but important details shape experiences of sound, sight and movement for all those who live, work and visit long-term residential care (LTRC) homes.

Sounds matter

> I hear her singing to herself: a lively tune in an otherwise silent place. Silent, except for the buzzing call bells that keep alarming… they continue for minutes, then get quicker until finally someone responds. It is eerily quiet aside from the constant 'beep, beep'. (Fieldnote, Ontario)

Harsh, insistent and dissonant noises create unpleasant auditory soundscapes, which are particularly difficult for those with hearing impairments or those who may want to listen to television, music or engage in conversation. Sounds such as call bells, door buzzers,

telephones ringing, and noisy carts being pushed down hallways can be disruptive. **Sound reducing measures** provide a much calmer, less institutional ambiance. One Canadian LTRC home we visited had a soundless system:

> [T]hey use a light signal system. There is a light high up on the wall and the manager explains the green light means staff is in the room, white indicates the resident is looking for assistance, and the red indicates fire…The staff has pagers and residents wear badges as part of the [silent] GPS system: there are also monitors to show where people are all the time. (Fieldnote, Ontario)

In this same LTRC home a researcher expressed, "I was surprised at the relative lack of noise during the visit …I felt that most sound was at conversational levels" (Fieldnote, Ontario). This observation was echoed by another researcher, "We walk around the care home… It is very clean, quiet …very little noise." The absence of sounds in this particular home is considered promising because unsettling noises were captured in many field notes taken during other site visits.

Sights matter

Sight must also be considered in building designs: promising features incorporated views. We found that residents with cognitive and/or physical limitations often cannot leave their residence area, and staff is too busy to take them outdoors. The quote that opens this chapter eloquently points to the significance of being able to see the outside world. We asked this same family member if her parents, who live in a LTRC home, use the viewing areas at the end of the hallways. She replied, "I bring them out. The staff won't bring them out there because they have to be at the central nursing station where they can see them all." Residents are often positioned in front of nursing stations so they can be monitored for safety reasons, and too often cozy spaces with window views are left unused. However, at a German site, we noted common shared resident areas with full kitchens plus dining and lounging areas for up to 12 residents who spent the majority of their days there:

> The room is bright with natural light from the big windows in three of the four walls. On one side they look out onto a children's playground and an open field. One resident is dosing in her chair with the sun going down in the window where she sits relaxing. (Fieldnote, Germany)

Furthermore, we observed residents enjoying **windows that open to let in air and outdoor sounds**, which are also designed to avoid falls or escape. Windows that open allow residents to hear birds singing or children playing outside, to hear people walking and cars passing by in urban areas, and to smell fresh air coming into the LTRC home. We noticed this feature in a Norwegian site, where residents who lived in a dedicated dementia unit had window views and patio doors in their bedrooms that they were able to open and use to independently exit into the enclosed garden space. This feature simultaneously offered safety, freedom of movement and access to the outdoors. In another site in Nova Scotia, Canada, residents' bedrooms had windows with an outdoor view and also had **windows into hallways**. Curtains on these corridor windows also allowed for privacy.

In contrast, in another Norwegian site, a woman resident, who informed us that she had not been outside for three years, showed us her bedroom window view of a cement wall.

> She sarcastically comments on her "beautiful view" a few times throughout our weeklong visit. She brings us into her bedroom and asks us to look outside. We see a big gray wall of the building her bedroom window faces. (Fieldnote, Norway)

In addition to ensuring views, positioning windows low on walls allows residents the opportunity see the outside world while lying in bed or sitting in their wheelchair, instead of staring at the walls or the ceiling.

Lighting matters

Lighting that residents can control reduces dependency on staff to turn on/off lights and adjust window shades; soft, indirect lighting

is superior to fluorescent, which strains eyes. In Manitoba, Canada, we saw quality window blinds that let in natural sunlight and were easily adjusted to provide the appropriate amount of shade. In an Ontario LTRC home, diffuse lighting was installed along with smaller, strategically positioned windows, which reduced glare as one researcher described: "[t]he small windows of the chapel/meeting room bring light to various areas of the room but don't provide intensive light in any one area" (Fieldnote, Ontario).

Mobility support matters

Autonomous resident movement requires certain features such as **arms on all seating**, which were missing in some LTRC homes we visited. Arms are required for residents to grasp while changing positions from sitting to standing and vice versa. **Non-plastic furniture** further prevents slipping and provides added comfort. We noted small wheels on the back legs of dining chairs in Sweden that made moving to sit up to the dining table much easier for both residents and the staff who assisted them (Fieldnote, Sweden).

In order to maneuver independently down hallways, hand railings are used by many residents who walk, as well as those in wheelchairs. "A blind resident navigates toward us down the hallway …she uses the railings, in addition to using her red and white cane" (Fieldnote, Ontario). In another site, a "male resident …is shuffling along in his wheelchair, using his arm to grasp the rail around the outside of the nursing station to move himself along" (Fieldnote, Manitoba). In this particular place, hand railings extended across the nursing station, which facilitated autonomous movement across the common area. Additionally, **hand railings that look decorative** and match the décor, which we saw in some LTRC homes, are aesthetically pleasing and prevent a hospital-like atmosphere.

> On your left is the nursing 'communication centre'. The desk is low, allowing [residents in] wheelchairs to see over, and the space has a wide entry to allow wheelchairs to enter because residents should have access to all the spaces. (Fieldnote, British Columbia)

Residents preferred reception desks and nursing stations with **low counters**, which permitted those in wheelchairs to see and communicate with staff; high counters and walls conversely create barriers and segregation. For example, a nursing station in one Norwegian LTRC home was an enclosed "bricked-in space with few windows" preventing residents from interacting with staff who were working in this room.

Storage of furniture and equipment away from hallways reduces the institutional feel and permits unobstructed resident movement. In a Manitoba home, attractive cupboards were built into half-walls to store furniture, thereby avoiding clutter while also creating extra open space in the common areas.

Recreation matters

Dedicated **spaces for books and plants** offer relaxation and both independent and collective recreational opportunities. For instance, in British Columbia we saw an indoor green room adjoining an outdoor garden area, both of which were conveniently located by the main lounge; all spaces were well-used by residents and visitors:

> [T]he "Green Thumbs" gardening room opens into the garden with indoor plants and real gardening…tools, gloves and pots that are obviously used! [There are] a lot of clusters of comfortable chairs, a jigsaw and games cupboard, a "fireplace" with bookshelves (with books!) on either side. The communal space downstairs here is really vast, but it appears intimate because of the way they have created "rooms" within it. Lots of "home" notes here. (Fieldnote, British Columbia)

In our research, we observed accessible, inviting spaces, both inside and outside, in multiple sites that offered meaningful recreational and socialization opportunities like gardening, playing games, working on puzzles, and reading books, all of which enhance residents' quality of life. Within private spaces in some sites, we noted compact **refrigerators** in resident rooms, enabling access to food and beverages of choice 24/7. Additionally, **internet access** in resident rooms, seen in

some LTRC homes, provides the ability to keep connected with family, friends and the wider community in comfort and at times that are convenient.

Health and safety matters

Frontline staff knows what structural features are required to carry out work safely and efficiently. However, across many sites staff told us that their input was not sought during design planning and other decision-making processes. Frontline workers further reported that sometimes their concerns are not listened to by management:

> If they [staff] have complaints you [management] need to listen and see what you can do to fix it so that then people don't feel like it's a hassle to come to work, you know. They're happy because they know if they have a problem if they come to you something is going to be done …But it's those little things that we all feel like we're not appreciated, we're not listened to …(Interview with receptionist, Manitoba)

For instance, in the design phase for a new Ontario LTRC building, the staff was promised a lounge, but ultimately this structural feature was not included. "I think when they designed this building I don't know, maybe they didn't think about the staff …When we moved to this new building we don't have a place to eat. [They had to] move an office and give us a lunchroom. But it's so tiny, you know" (Interview with PSW, Ontario). Another staff member echoed, "It's a tiny little lunch room that fits eight people" (Interview with PSW, Ontario). We found that staff prefer to have dedicated spaces, such as lounges, so they can leave the often busy, sometimes chaotic and/or emotionally draining resident area environments during breaks to recharge, which is critical for their health and wellbeing.

Toilet fixtures, lifts, and flooring are other features that impact staff health and safety. A common issue is that **bathrooms need to be spacious** and **toilets need to be installed away from walls** to make access easier for residents who use wheelchairs and walkers, and for staff to assist residents when required. A western Canadian LTRC facility that was built

three decades ago requires costly reconfiguring of bathrooms. A staff member reported, "A lot of residents don't even use the toilet because they can't get the wheelchairs in there. They can't get …the residents transferred to the toilet" (Interview with dietitian, British Columbia). A registered nurse confirmed that the building was not designed for increasingly frail elderly with complex needs who are entering LTRC.

> Our bathrooms aren't wheelchair accessible. You can't get a lift in. You can't get all the equipment that you need into them. So some of those residents have been here for a long time and they're aging in place so their needs are different from some of the other residents that we're now getting more of which are higher need residents. (Interview with RN, British Columbia)

In a Nova Scotia site that opened recently, the residents' bathrooms were missing certain features:

> All the rooms are private with their own bathroom. There is no shower in these bathrooms and the toilets are up against the wall, making it difficult for staff to help people on and off the toilet. The ceiling lift does not go into the individual bathrooms. (Fieldnote, Nova Scotia)

When asked if they would make any changes to the physical structure, in addition to having larger bedrooms that would more effectively accommodate maneuvering of walkers and wheelchairs, staff confirmed they would extend the current ceiling lift tracks into more spacious bathrooms:

> [A]ll these people who are building new facilities have a perfect opportunity. What is it? I'm sure it's cost. I'm sure of it because, you know, it does add considerable cost to have that piece of [ceiling lift] tracking and you also have to have either a U or a circle or something. But if we could have ceiling lifts over the toilets. But we would need the space and those bathrooms may not be big enough as they are. (Interview with Occupational and Physiotherapists, Nova Scotia)

Lifts above beds that extend into residents' bathrooms were observed in some sites, however we saw in some homes that ceiling

lifts were not installed in every bedroom and, as above, did not always extended into bathrooms. In one site in British Columbia, ceiling lifts were not installed directly over beds, and were fraying: beds needed to be moved so that lifts would work properly. In yet another Canadian site, ceiling lifts were not included in the new building design and carpeting was installed, both of which impacted health and safety.

> This building should have had ceiling lifts in every room, especially second floor and first floor. I don't know why they did it so cheaply. And that's a big thing because it's hard on your back moving these Hoyer lifts on the carpet. And another thing, it shouldn't be carpet … Hard on the back. Hard on the body. A lot of girls are complaining. (Interview with PSW, Ontario)

Portable assistive apparatuses for lifting residents into and out of bed/wheelchair/bathtub such as sit-stand lifts, chair lifts, and sling or Hoyer ™ lifts, are often used in LTRC homes instead of expensive ceiling lifts. However, staff reported to us that although ceiling lifts make resident rooms appear more institutional, they are preferable. As this worker points out, flooring also matters. Staff members strain to move assistive devices, including Hoyer lifts, along with other equipment such as cleaning, laundry, and food carts across floors; carpeted floors are particularly difficult to move large, heavy equipment over. Residents also struggle to maneuver their walkers and wheelchairs, not only over the carpets, but also over transition strips and ridges that connect carpeting to other types of flooring. Non-glossy, non-slip, **impact-absorbing flooring** is most promising for ease of movement, for standing and walking on for long periods of time, and for hygienic purposes. We saw examples of these kinds of floors, including floors that resemble hard wood in Sweden, and smooth carpet tiles in Texas.

KEY QUESTIONS

- How can design features enhance quality of life?
- How do design features promote staff and resident health and safety?
- How can staff be involved in design processes in meaningful ways, to address such issues as equipment needs and positioning, flooring, etc. in order to create high quality conditions of work and care?

FOOD MATTERS

Tamara Daly

When would you like breakfast and what do you prefer to eat? Would you like to make your coffee or tea? Would you like to see out a window? Would you like to eat with one friend or many? Would you like a glass of wine with your dinner? Physical spaces shape where and how we dine, what food we eat, and what choices we have. Such choices are particularly important to those in long-term residential care, where food is not only central to survival but also the main event of the day. Food is a critical component of care work and the food spaces create the conditions that limit or promote workers' ability to provide a pleasant and safe eating experience.

Despite the importance food and of the physical environment in which it is prepared, served and eaten, dining environments are often restrictive for residents, their families and friends, and for the staff who provide care. Nevertheless, we found promising practices that promoted dignity for residents, workers and visitors. This was particularly the case when dining spaces allowed flexible, social, culturally attentive dining care and accommodated preferences.

Flexible spaces allow relational care

When at 7:35 am on a Sunday morning we entered the floor of a Norwegian nursing home, we smelled fresh coffee brewing. In their meeting room adjacent to the main lounge, staff poured their mugs full and had a team huddle to discuss and plan for the up-coming day

before residents woke for breakfast. They offered us steaming mugs and invited us to join their congenial discussions. We would be offered coffee at other times too from the coffee machine available to all. Staff would get some and drink it together with residents at various points throughout the day.

The combined kitchen/dining room smelled of breakfast by 9:00 on that Sunday when residents slowly trickled in at their leisure to a dining experience that was relaxed in pace. They were greeted by morning coffees, toast and open-faced sandwiches with fresh cucumber and brown cheese, which is a Norwegian staple. With 17 people living on the whole floor, there were nonetheless two separate dining spaces, each with full kitchens. Each dining area — at opposite ends of the floor — was dedicated to only eight or nine people. The spaces were intimate, with most tables set for two people. During the meal, staff pulled up chairs and sat down to help with dining, to chat or to serve residents according to individuals' needs. By 9:25 am some residents had finished eating, and others moved to sit in the adjoining sitting room. A religious service was put on the television.

On another day during morning breakfast, while the care aide was out of the dining room for a moment, an assistant nurse came in to check on one of the women who was still at the table, eating very slowly. The aide sat down facing her and took one of the open faced sandwiches from the plate. He said "mmmm", then chatted with her while he ate this sandwich. He was modeling eating for the resident. She followed his lead and immediately started to eat. Once she was done, he got up and started to clean the kitchen. She moved to the family room to take a nap. The whole encounter was done quite naturally without fuss or bother. A bit later, one resident emerged for breakfast at 11:45 am and was easily accommodated for breakfast food, even while the care aide was busy making a fragrant curry for lunch with grated carrots, potatoes, red peppers and cubed chicken breast.

In this home, dining and kitchen spaces supported daily routines in which staff prepared the breakfasts and lunches and ordered the food for the seventeen residents. We spent time observing while lunch was being made and the fridge was being stocked up with supplies,

including frozen ground meat, juices, butter, shrimp spread, other cheeses for making sauces. We remarked on some unfamiliar items, and the care aide sliced a piece of brown cheese — a common sweet and nutty Norwegian cheese that is eaten on bread — for one of us to try. Later that afternoon, banana cake was baked in the oven on the floor, made from scratch, and served warm. The aroma filled the unit. Dinner later that night was a salad plate and vegetable soup that came from the central kitchen. The soup was warmed on the stove, and served directly from the pot. Soup was followed by ice cream sundaes with chocolate and caramel sauce. There were big smiles as the residents ate it all with gusto.

The kitchen and the food, located where residents lived, encouraged social interaction among residents and between residents and staff, as did the flexible seating and dining areas. At the same time, the kitchen meant appetites were stimulated by cooking smells and portions could be easily adjusted to individual tastes.

Physical space for food and dining can create a home-like environment

How food spaces are organized have a profound impact on whether or not it feels like a home and on whether or not residents can participate as they would at home.

A home-like environment featuring a communal space centered on dining was key to the care model practiced in one German home. Residents could join "common shared units", and participate in meal preparation and activities in an airy "great room". The space contained a kitchen with cupboards and amenities designed for a home including a kitchen "island", a large activity table and smaller tables, couches and chairs. The island allowed staff to do food preparation while still engaging directly with the residents. Residents also participated in food preparation, for instance by cutting potatoes and onions for meals while remaining seated at a table. Indeed, the first thing we saw as we entered was a resident with dementia slicing an onion, with other residents providing advice. Like most women, she had cooked every day and that memory was still clear.

This particular German model allowed for flexibility. Those who wanted to participate did. There was also the option to have meals prepared in the main, central kitchen. Food preparation performed by residents was not a scheduled activity, but a normal part of their living and eating together. Bottles of water stayed on the tables at all times so that residents always had drinks or could pour more. A fruit bowl sat out on the counter from which staff would take and peel bananas, cut off pieces for different residents and then have a small piece themselves, so as to engage the residents.

This flexible and social approach to food was also highlighted during our observations in the Norwegian home discussed above, and reinforced by a family member in Norway who noted that: "The Saturday and Sunday staff know me, so we talk and they thank me for helping [my sister] with the food. They always offer me food and some coffee" (Interview with family member, Norway).

She underscores how the relationship to food and dining is welcoming and flexible. This flexible approach helped to create a home-like environment made possible by the kitchen design and location.

Furthermore, homes that included a café near the entrance to the building for drinks and snacks or a cafeteria for staff, visitors, residents — to go "get a coffee" a meal or a treat — managed to create a sense of belonging. For instance, in an urban Nordic home and a rural Nova Scotian home, community members from the surrounding neighbourhoods could eat at the long-term care home's cafeteria. The café helped prevent social isolation and provided an affordable meal for those community members who came to take meals there, while also bringing community members into the care home in ways that promoted social relations for residents as well. This was also the case when community organizations had spaces within facilities. In a Vancouver home, a Chinese community organization was preparing a meal in the residents' kitchen. Residents were participating and the discussion was lively as the women exchanged recipes and techniques for shaping eggrolls.

Flexible routines

The location of kitchens and the equipment for serving food shapes what choices residents, staff and families have. One of the common complaints about long-term care is that residents' lives become too scheduled and their options limited. In contrast, in one Texas home the on-site kitchen and the policies connected to it meant food was available and made to order 24 hours per day. This included everything from sandwiches to hot food such as grilled steaks. Given that those with dementia often switch their days and nights, this approach seemed promising for dementia care. This flexible approach was part of an overall strategy that placed food at the centre of their care strategy. It was made possible in part because the long-term care home was part of a larger facility that included a retirement home. It placed a priority on dining, although it should be noted that this home spent about three times as much money on food compared with what is common in some Canadian homes. Even pureed food was improved by the availabilty of choice cuts of meat. However, as we saw in Germany, making some appetizing food available around the clock need not cost this much if there is an accessible kitchen where staff can prepare a quick snack.

Daily choice of dining options and portion sizes depends to a large extent on the equipment. In one BC home, for instance, hot carts are wheeled around to each table and residents are allowed to choose what and how much to take. Discrete signs placed at each resident's regular seat table alert staff to any food issues such as allergies or diabetes. At a Nova Scotia home, eggs, toast and cereal are prepared in the kitchen of each resident area but hot food is prepared by staff in the central kitchen. The kitchen staff wheels a cart with the hot meals from the central kitchen to each home area, and then to each group of residents, serving them from the cart. In both instances, residents can better see, smell and approve of their own food choices. In the Nova Scotia case, the kitchen staff also gets to know, and exchange pleasantries with, the residents.

Flexible dining spaces are important for workers, residents and visitors

Flexibility of the dining space was also important. We saw dining spaces that were exclusively used for dining and partitioned off from the rest of the home. In one Ontario home, those who were cognitively aware ate together in family-like dining room that created a congenial, home-like environment. However, the dedicated dining spaces we saw in other homes tended to be significantly crowded in ways that made it difficult to maneuver the modern wheelchairs and difficult for staff to move freely to help residents eat. More common in the most recently-built homes were integrated dining and communal spaces that allowed more flexible meal times. Our fieldnotes from a BC site indicate that "there is an immediate impression of warmth and comfort here. A large open space broken up into areas and with comfortable, upholstered chairs". The dining room was part of this space. The room was later reconfigured for a Chinese festival, making multiple use of a congenial space while simultaneously making it more congenial, as another set of field notes indicates:

> There is a feeling of activity here on the ground floor — of things happening all the time. Like a home. (I think having a working kitchen might help here). There is a newspaper on the chair and another at the Nook counter. Four people are playing a Chinese word game over in an alcove by the window. A nature show is playing on the TV in one cluster of couches and chairs. There is a Chinese calendar on the wall and two paintings created by a group of residents (and identified as such).

The flexible space allowed residents, families and staff to move around easily in response to preferences and need.

The flexible spaces for dining contrasts sharply with a large, but very institutional dining room in another home, where food was delivered in stacked metal carts and the posted sign — directed to families and visitors — indicated that flexibility was not allowed (emphasis ours):

In order to increase accuracy of meal trays, please **do not interrupt the dietary staff** while they are preparing the trays. For safety and respect reasons, wait away from the meal serving area until the tray you are waiting for is prepared.

Different tastes and attention to culture

Food is about place and about the sense of home. As the demographic composition of the older adult population changes in Western countries, there needs to be accommodation to cultural tastes and incorporation of cultural dishes. Pasta and brodo (broth) should be served at an Italian home just as fish is required at a Scandinavian home. With homes that are integrated, there should be attention to different tastes incorporated into the menu, and food selections must meet multiple tastes but also cater to specific tastes. Kitchens and dining rooms require the necessary equipment, dishes, cutlery and storage to make culturally appropriate food service possible.

Portion size was also a theme that emerged in our observations. A home in the United Kingdom prepared the meals in bite-sized or appetizer-sized portions with a variety of choices offered, and had the serving pieces and kitchen equipment, including refrigerator spaces, that made this possible. This method seemed to assist with residents' appetites and was similar to the Norwegian approach of small open-faced sandwiches.

KEY QUESTIONS

We observed many promising practices that reinforced how much food and dining matters to physical environments:

- How can food and dining be central to relational care and a key part of the day for residents and staff?
- Does the physical organization of food allow for eating throughout the day and for the preparation of culturally appropriate food?

LOCKS AND DOORS MATTER

Ruth Lowndes, James Struthers, Sally Chivers, and Frances Tufford

Locks are important design elements in long-term residential care homes. They promote privacy and safety and they also control and prevent residents' autonomy in daily living and in moving around the home. Our research teams became interested in how locks and doors were used in different LTRC homes, in order to think through how some designs and arrangements promoted dignity and respect for residents and staff, and others did not. We found that doors and locks present tensions in design. Although these built environments are often promoted as being the residents' home, institutional policies, practices and building configurations often impede the ability to set up home-like conditions. These included locked areas that were usually designed to promote safety, especially for residents with dementia who may become disoriented, or lose their way. Yet, locked doors and secure resident living areas, as well as inaccessible physical spaces, affect workers who use these spaces, and impact residents' privacy, mobility, autonomy and ability to enjoy social connection within and beyond the LTRC home.

Bedrooms

Locks and doors were significant in residents' bedroom design, which varied among the sites we visited. Some had bedrooms shared by two and as many as three or four residents, while others had individual bedrooms and bathrooms shared by two residents. The majority of sites had individual bedrooms. Most managers, nursing staff, residents, and

family members in all of the jurisdictions in our study viewed private bedrooms as the best option for residents, both in facilitating privacy and as a way to avoid the spread of infection, although some noted that shared rooms helped to combat loneliness and created more opportunities for seeing visitors.

While privacy is difficult to provide when the rooms are designed to be shared, having one person per bedroom also does not guarantee privacy in practice, as we often observed. The placement of doors was important. In one case, doors were placed so that if left open, people passing could see the areas where commodes were used for toileting. While curtains were available, busy staff sometimes did not pull them across the area, leaving a resident exposed.

> Sitting in the alcove [in the hallway] …I see that a man is sitting on a commode in his room. They have forgotten to pull the curtains. I move out of sight but he has already seen me and leans forward to pull his own curtain across. Very embarrassing. (Fieldnote, Ontario)

On a different day at the same site, a researcher noted: "Walking down the halls in the morning [it's] very quiet. Most residents [are] not yet up. But most of the doors are open (privacy seems to be a 'spotty phenomenon')" (Fieldnote, Ontario). In this particular LTRC home, bedrooms were often treated as public domains, rather than private spaces. Residents did not have privacy and were at times left in vulnerable situations: this lack of privacy was amplified by the fact that some rooms were shared with one or two other residents. In contrast, in another Ontario site, residents' single bedroom doors were most often closed and staff were observed knocking and announcing their presence prior to entering, thus promoting privacy, dignity and respect for residents.

Further, in a LTRC home in British Columbia, residents had single bedrooms with locks on their doors to which they held the keys. Staff always had access to these private spaces in case of an emergency because they had keys as well. The ability to lock private spaces offered autonomy, while also providing a sense of safety from other residents who may, for example, suffer from dementia and wander in or have a tendency to pick up and carry away personal items. This was

of particular concern for a family member interviewed at a Manitoba home, which prohibited locked resident doors.

> You see things like there's no locks on the doors but there's a thief running around here and it's somebody with diminished capacity that doesn't know any better and they're a kleptomaniac kind of thing but you can't put locks on the doors and stuff goes missing from my mom's place every once in a while …But these people here have a protocol and they follow it to a T or as much as I've seen. (Interview with family member, Manitoba)

Also observed at the BC home, residents could attach signs on the front of their bedroom doors expressing wishes for privacy and boundaries. For example, one sign read, "Please leave the door open a little when Phyllis is in her room" (Fieldnote, British Columbia). In the Manitoba home residents wanting privacy could affix a bright red facsimile "STOP" sign to a white Velcro sash stretched across the open doorway to their room (Fieldnote, Manitoba). Having signs on slightly or even wide open doors allows residents to choose a level of privacy that they prefer while also allowing staff a glimpse in to assure themselves that everything is okay.

Kitchens and laundry rooms in resident common areas

Locked doors and closed off areas to kitchens and laundry rooms were design features we also considered in the residences we visited. In some LTRC homes, locked doors and closed areas divided residents from both independent access to food and fluids and participation in activities of daily living, including food preparation and laundry tasks. However, in other homes, we saw kitchens and laundry areas that were always open and available for residents.

Some sites had a laundry room on each unit for use by residents and/or family members. In one place we visited, having an accessible laundry room in the secure living area allowed one resident in particular to keep busy, which had a calming effect on her. Having an accessible laundry room, can enhance resident quality of life through engagement in useful activity.

Our research teams observed kitchens that were built as part of closed, locked serveries, to which only dietary staff had access. For instance, in an Ontario site, an enclosed servery, to which residents' meals were delivered from a main kitchen located elsewhere in the building for plating and serving, was built in between two dining areas. As the result, cooking aromas were not enjoyed in resident areas, nor could residents participate in food preparation or get snacks and beverages for themselves between meals. Neither non-dietary staff nor residents had access to the servery where the refrigerator and cooking appliances were located. These design choices restricted the ability for care staff and residents to prepare and/or cook food, or to simply grab a cold drink when desired.

Whether kitchens were locked as part of risk management strategies or remained open were further determinants of accessibility. In one Canadian home, safety concerns spurred a decision to begin locking the kitchens, which were designed as separate, closable rooms off the dining areas. As a result, these spaces could no longer be accessed without a key, which was held by staff.

> He walked to the kitchen door, tried to open it and discovered it was locked. Turned away, and walked out of the room. 10 minutes later he was back and did exactly the same thing…a care aide saw him, came into the dining room and asked "Roger, do you want a drink?" He spoke up this time very clearly. "Yes, I would like a glass of water." She unlocked the door and got him an ice-filled glass of water. He thanked her, took the water, and left. The care aide then relocked the door. (Fieldnote, Ontario)

Locks have a dual nature, providing a sense of safety and security but also producing a sense of entrapment and exclusion, as illustrated above. Locks also reinforce unnecessary dependency in activities that many residents could do for themselves, and might enjoy doing for other residents. For instances, we saw unlocked refrigerators and bottles of water sitting out on tables throughout some LTRC homes. In these sites, we observed residents independently pouring drinks for themselves and for other residents whenever they were thirsty.

Open and secure resident living areas

Sites we visited also presented a range of designs that facilitated accessibility and/or inaccessibility within and between resident living areas, from those which were secured with no possibility of exiting to get fresh air or exercise, to those with open access to both indoor common areas and outdoor spaces.

In a Canadian home, within a secure resident living area, accessed via code pad, residents could not move freely through the rest of the building or go outside to the enclosed garden, and they had little space to wander or relax in their locked area.

> Looking again at the chairs lined up against the wall, facing away from the TV; seeing that the activity room is closed, along with the dining area, I can't help thinking that…this secure unit is a much less family or resident-friendly environment for socialization… There is simply no place for residents to congregate in smaller groups with each other or with volunteers or family members, apart from their own rooms. Its form does not suit its function. (Fieldnote, Ontario)

Secure living areas that block residents' access to activity rooms, gardens, or interesting spaces create segregation between residents with advanced dementia and other residents, and prevent opportunities to engage in activities that could enhance their quality of life. Further, group activities are often organized in central locations within the LTRC homes such as activity/meeting rooms, garden areas, or chapels rather than in the locked resident areas. We witnessed on our visits numerous instances of residents being excluded from events because staff were not able to escort them and they could not leave their secure area unaccompanied.

We also observed various locking measures, including codes and alarms on doors and elevators, which are meant to reduce risk by keeping residents from wandering and potentially getting hurt or lost. In one Ontario site, a cleaner who had been working there a short period of time, "talked about the residents who always wanted to get out the door, saying she had to be extra careful, when opening the alarm-coded

main door exiting the unit, to ensure that someone wasn't trying to follow her out behind her cart" (field note, Ontario). Another researcher in this secure resident living area also captured this same tension.

> Hans … comes up to me and says "You have a key don't you?" No, I tell him. "Yes, you do. Why won't you let me out? I want to get some fresh air. Why don't you let me go out?" He's getting rather agitated, so I walk away …I return back to my earlier position … Florence moves up to the main exit door for the unit, trying to get out. "It's the last time I'm buying a ticket to Spain," she says. A PSW comes and leads her away. (Fieldnote, Ontario)

We saw many residents trying repeatedly to open locked doors. They often became agitated that they were unable to "get out." Locking measures create an institutional feel in LTRC homes, with alarms going off and codes needing to be used to gain access or exit, all of which restrict residents' autonomous movement both inside and outside their living areas and impede their quality of life.

An over-emphasis on locks and coding could also degrade the autonomy of staff, captured in the following field note.

> I was standing at the elevator on the first floor (around the 3 PM shift change) and noticed that staff were lining up to key in before going to their units. One PSW said to me, 'We have to do this, if I'm one minute late my pay will be docked.' I learned later that not only are they keying in a code, but they also have to place their thumbs on the pad as well (which means that their finger prints have been taken at some point). (Fieldnote, Ontario)

The ability to restrict access and exiting may be a strategy for navigating risk in the workplace but, as illustrated, may also reinforce factory-like working conditions for staff that are anything but "homey." In contrast, we saw LTRC homes that were intentionally built without locks on any doors, including doors that were used to exit the building.

> [In this home] there are no locked doors anywhere. All doors are open, and residents can come and go as they wish… The door to the

> stairs off the dementia unit opens and closes with an arm band but the residents can still use the elevator as it is not a falling risk… The residents can go to whichever common unit they want to. (Fieldnote, Germany)

In this German site, residents were not confined to one floor, and there were no locked doors between living areas or to the outside, thus they had freedom of movement. We noted the reduced level of agitation amongst residents, and the calmer, more relaxed "home-like" atmosphere in comparison to the sites we had visited with secure resident areas.

In a Manitoba site, their philosophy of care was, "This is the residents' home. Everything we do is for the resident. We don't go to work; we go to the resident's home. Over everything this is for the residents and they come first" (Fieldnote, meeting with CEO, Manitoba). In keeping with this philosophy, there were no secure areas, doors to meeting rooms were left open because residents should be able to go anywhere in their home, signage was kept to a minimum as in a resident's own home, and stairs were not used by staff so that they did not "walk through where residents live" (Fieldnote, meeting with CEO, Manitoba). A researcher described,

> the impressive interior design and architecture; small dining areas which transition smoothly into TV lounges; the wall length windows in the dining space leading to the garden areas … the high ceiling and arched windows of the shared "commons"; and the overall sense of ample "room to move" across … units. (Fieldnote, Manitoba)

This design without locks allowed for resident movement from the kitchen and dining areas to the sitting rooms and out to the common area, where the central nursing station was located, along with providing access to the chapel and activity room, and the outdoor gardens.

Similarly, a Nova Scotia home opened the entire place to residents during the day. The wide hallways and the absence of heavy closed doors or locked spaces made it easy for residents to move around in wheelchairs and walkers. We saw them regularly using these open

hallways, stopping to chat with each other or a staff member. In this site, each section was locked at night to help the reduced number of night staff keep track of residents.

LTRC homes with open living areas that allow residents with advanced dementias and those with other chronic conditions and frailties to meet, mingle and enter various home areas may be considered by some to be less safe than homes in which they are locked into separate, secure home areas. However, this assessment does not consider the benefits gained for residents who remain physically active and socially integrated. One staff member, who has worked in both types of settings, prefers the open living areas that permit mixing among various residents:

> When I worked at other places I have seen that it was not mixed and I thought it was good. But after I worked here if you asked me now I don't think it's a big deal…I don't find it chaotic … I've changed my mind … I don't feel [residents with dementia] should be segregated. (Interview with receptionist, Manitoba)

Outdoor areas

In some sites, residents could leave the LTRC home via doors designed to be opened independently, while in others, they were designed to be opened by staff. Further, some physical designs included easy outdoor access, such as gardens on site as well as nearby green spaces. One researcher noted such doors in Norway:

> Unlike any other facility we have visited, these residents can exit through their room's patio doors into the enclosed garden space on their own, and have a spectacular view of the gardens as well as the surrounding mountains. Their inward-facing patio doors are not locked because there is no egress from the garden area…They can even go out and collect berries! (Fieldnote, Norway)

This particular building design facilitated autonomous, independent movement from inside individual bedrooms to garden areas. In other sites we often saw residents who were unable to go outside because

they required assistance to leave their dedicated area and staff, although wanting to help, were too busy. As one staff member told us, residents "feel like they're in a cage. Everywhere locked up. This unit is so suffocated. They need something more" (Interview with PSW, Ontario).

In a LTRC home in the UK, there were no locked units, and a researcher noted "all the residents know the code to the internal and external doors and are free to go out as and when they please" (Fieldnote, UK). The codes in this site were used as a security measure for keeping strangers out rather than keeping residents in. Further, the accessible outdoor spaces were configured with residents' input:

> There are two outside spaces for residents to use, one which overlooks sea and where there are tables and chairs for residents to sit outside when the weather is good. The second area is to the side of the home and has a small greenhouse, and beds for planting some fruit and vegetables. The residents said that they wanted a children's playground to be included in this space because when the grandchildren and great grandchildren visit, they get bored and don't want to stay. By having the playground, the residents can spend more time with their families and also see the children playing. (Fieldnote, UK)

Building designs that allow for autonomous movement and incorporate residents' perspectives are promising in their ability to accommodate personal needs such as family visits, which are so important.

LTRC homes with open doors and extended access

In contrast to the above example, one Norwegian site had no locks and codes on external doors, and had a wide variety of recreational and cultural activities designed to invite the public in. The residents were connected to the outside world by incorporating several community uses into one facility, captured by a researcher:

> Children were moving in and out of the facility to visit the public library at one end, to take music lessons, to buy ice cream, or to

> attend swimming lessons. The sound of their voices, as well as accompanying music from the practice rooms, permeated the centre. (Fieldnote, Norway)

We saw other examples of bringing in the community, such as homes that had kindergartens or ones that housed other students as well as residents. This kind of integration results in an elevated level of accessibility with extended unlocking, offering freedom and connectedness, and as such has positive implications for residents' quality of life. As the director of the Norwegian home told us, anyone is welcome to participate in the multifaceted cultural activities; "We don't ask how old you are…We open the place up and invite them in."

KEY QUESTIONS

- How do locked and unlocked doors, as well as inaccessible areas, impact staff working conditions, and residents' privacy, mobility and autonomy, social connectedness, and overall quality of life and care?

- Perceptions and assessments of risk influence resident independence, privacy, access to the outdoors, and their ability to engage in everyday activities. How do risk management policies and practices promote resident autonomy, choice and freedoms?

- How can LTRC homes be built/redesigned to facilitate resident mobility, autonomy and privacy, as well as enable integration with the larger community, thereby offering extended unlocking with further possibilities for high quality of life?

CLOTHES AND LAUNDRY MATTERS

Pat Armstrong

In our site visits, concerns and comments about clothes and laundry were second only to those we heard about food. This is not surprising, given that clothes are central to residents' personality and dignity. In a communal setting, clothes are a way of establishing who you are now and who you have been. Clothes also serve as an indicator to families and visitors that staff are taking care.

Clothes require work and spaces in which to do the work. They need to be collected for cleaning, sorted, washed, dried, folded, returned and stored. We heard repeatedly from residents, families and staff about shrunken sweaters, lost shirts and bleached pants, indicating that allowing residents to bring their favourite clothes and ensuring that the clothes are returned to the right person in appropriate conditions is complicated. Furthermore, as a growing number of residents have complex health issues and are incontinent, clothes and bedding have to be changed more frequently. This not only means additional laundry but also additional health risks because more of the residents have reduced immune systems and because both their bedding and their clothes can carry infections as a result of incontinence. Balancing the need for infection control and protecting staff with the dignity of personal dress is no simple task, one shaped in large measure by the way laundry work is physically organized. Nevertheless, we saw some promising ways of creating spaces for clothes and laundry.

Promoting dignity, preventing loss

Fieldnotes from a German home indicate that

> Residents are dressed more nicely than I generally observe. They have leather shoes, dress pants, clean shirts and sweaters that do not appear worn or stretched and I do not see track pants. They are wearing fitted, quality skirts; ie. pleated, dress pants, cardigans, and collared blouses. Clothes match, like time has been taken in the choosing of items to put together for the day. One woman has a black bead necklace as well, another a small pair of earrings, tastefully attired.

Ensuring residents are "dressed more nicely" requires enough staff with the time to take care; time to allow residents some choice and time to assist with clothing that may not slip easily over aging arms or off legs that are not very flexible. But the physical space can also have an important impact on the condition of clothes and the possibilities for dressing well or at least having clothing options that allow residents to maintain their dignity.

Space to store clothes is a clear indicator of clothing options. A number of the homes we visited had a single, locker-size clothes space of the sort that is common in hospitals where people are expected to stay only briefly. These small cupboards and residents' complaints about them made us notice that in Texas each room had a double closet with enough room for a modest-sized personal wardrobe. The larger size closet not only meant residents could dress more like they did at home but also signaled that their stay need not be brief or without choices. For families — and especially the women in them — who do the personal laundry for their relative, the larger closet that accommodated more clothes meant fewer washes.

Other kinds of spaces for clothing provide important signals about possibilities for activities. A Swedish home, for example, had a bench near the door of each resident's room, with boots stored below and coats on hooks above. The coats and boots symbolized the real possibility of outings and made the place look more like home.

The approach to care and the way laundry machines are designed also shape clothing options. A focus on infection control usually means harsh chemicals and hot dryers for all the laundry, as we saw in some North American homes we visited. As a result, residents and families were warned to bring only clothing that could withstand such a process. A central laundry of this sort means as well that all clothes require a label indicating ownership. More than one family member and resident told us the labels symbolized a loss of their control over what they could wear. In addition, with a central laundry clothes were often destroyed or lost in the process of returning them to residents.

In the central laundry of some homes, there were machines designated for clothes and those designated for linens. With separate machines, the clothes were handled more gently and thus residents did not have to ensure all their clothes could withstand harsh treatment, providing more clothing options. At the same time, the linens that were more likely to spread infection received the full treatment. And with linens, there are not the same issues about loss and personal ownership that there are with clothes.

We saw a quite different approach to laundry design in a Swedish home. Our fieldnotes indicate that each resident had a room "with its own bathroom that included a washing machine used for that resident's clothing". The Swedish care aide put a load in while she was working in the room. She was able to sort clothes to avoid shrinkage and mixing colours, allowing residents more clothes options. Not incidentally, small machines in each room also meant clothes did not get lost. In addition, these individual machines limit cross-contamination with clothing from other residents and reduce the need for harsh chemicals on personal clothing. However, operations managers in Ontario pointed out to us that this approach not only involved significant initial investment but also required significantly more maintenance work.

Between these very different strategies of a central laundry and the washing machine in every room was the laundry room in each section of the home. By keeping the laundry in the area where residents lived, clothing was less often misplaced or went missing entirely. With the

smaller and adjustable machines, staff were able to sort personal clothing according to colours and fabrics. This too helped reduce cross-contamination while allowing residents to bring their favourite clothes in a variety of materials. As we were told in a U.K. home when we asked about whether residents could bring woolens such as sweaters, “we have a delicate cycle”.

Laundry and laundry facilities can promote dignity and prevent loss in other ways that go beyond providing clothing choices and protecting precious items. We saw a several homes with laundries intended for use by family and residents. Family members could do the laundry while they visited with their relative. A number of them told us that they felt they were contributing to care in a useful way while protecting cherished items of clothing. In Vancouver, for instance, a daughter of a resident explained that in her Asian culture it was very important to care for parents and doing laundry was one way to do so.

For residents, participating in doing laundry can simultaneously provide both some control over their own clothes and some meaningful activity. As one worker in Germany explained:

> We have a lot of women who live here, they’d love to do [domestic work], absolutely, they are welcome to help with that as simple as setting the table, washing up, pick stuff and go into the laundry and fold clothes and stuff, it’s good, it’s employment for them too.

But in order to allow residents to participate, the laundry space needs to accommodate their capacities. Our attention was drawn to the accommodation issue by a resident struggling to open a laundry room door and the difficulty he had maneuvering through the narrow door and in the small room. In contrast, in a Nova Scotia home the laundry had doors wide enough for walkers and even wheel chairs. Front-loading machines reduced the difficulty of loading and unloading clothes, making them accessible for most residents. The window provided light, air and a view.

Promoting pleasant environments, preventing injuries

How clothes and laundry are physically organized has a profound influence on how these homes look and smell, as well as on how residents are dressed. The physical environment also shapes how safe and rewarding the work is for staff.

In our research, we observed that central laundries, which were often services provided by specialized, private companies, tended to take and return laundry in bulk. This had consequences not only for clothing options as I indicated above but also for the home environment. Our field notes from an Ontario home described a "big linen trolley near the seat by the artificial plants. A dirty linen bag hanging from it is really stinky". In another Ontario home, the clothes were returned from the central laundry on large racks, which according to one resident make the home "look like Walmart's". She went on to say that residents respond by selecting what they want from the racks.

These negative examples helped us see more promising practices as we studied more homes in more jurisdictions. Fieldnotes from a Swedish home begin:

> First, the halls are very clear. No med carts, laundry, garbage or supplies are left in the hall, partly because there are lots of places to store them, partly because there are systems that move things quickly off the floor in covered ways.

In Nova Scotia, the laundry workers deliver small loads of clean clothes from the on-site laundry directly to cupboards in the main room. They place items in cupboard sections marked with individual resident's names where the clothes remain until they are returned by the care aide to the resident's room. The dirty laundry was stored in small bags that were collected at night, making them invisible to most people.

In a Texas home we studied, the linen was put in sealed bags in each room and the bags were transported individually to the laundry room on the floor. In another Nova Scotia home, each unit had separate clean and dirty utility rooms where the linen from each room is taken directly from

a resident's room and where the heavy linens are handled out of sight and smell. In a German home, there is a room that serves as the entry way to two separate residents' rooms. There was a storage area in the entry way, providing sealed containers for both soiled and clean linens. No smell was evident. Clean linen could be stored without entering a resident's room and the dirty linen taken away in the same manner.

The physical environment not only influences how the home looks and smells. It also shapes how safe the work is for staff. The work involved in laundering linens such as bedding and towels tends to be dangerous. These items are heavy especially when wet. Moreover, they are often contaminated with feces and other bodily fluids so washing involves both strong chemicals and high heat. They are also dangerous because linens can hide objects accidently left in their folds, such as needles.

While we studied places where workers reported severe back problems from heavy loads as well as allergies and burns from chemicals and stick injuries from needles, we also saw places that had designed environments to reduce injury. In several Canadian homes that laundered linens in-house, the laundry room had automatic dispensers for chemicals and thus avoided the hazards associated with measuring and pouring them. Workers were provided with gloves and sometimes masks to protect them from the smells and contaminants in the laundry room, although not everyone found them comfortable.

Smaller machines in some UK homes meant loads could not be too heavy. Smaller laundry bags also help. As one Canadian manager explained:

> You know, it just comes down to basics is really what it is. You know, you've got a bag and human nature is you're going to fill the bag until it's full. And just changing the size of the bag which sounds, you know, it's a minor thing. It's not a big deal but it was something that was never thought of. Well by making the bag half the size you can only put half the volume, therefore half the weight into the bag of laundry so when you go to drag it down the hallway and then lift it up to put it in the linen chute there's only half the weight… There's less weight. There's less injuries.

The placement of the laundry room also has an impact on worker health. The linen laundry room with a window that we saw in a Canadian home stood out as a pleasant place to work, in sharp contrast to the many windowless, hot basement rooms that put workers at risk. As one worker said, "if there is a fire, I would die here".

Remote laundry rooms also make it difficult for workers to get the rewards that come from interacting with other staff, residents and families. In a Manitoba home, the manager could not easily change the laundry location in the basement but she could change the location of the laundry worker. The laundry worker here picked up, washed, and returned personal clothing to each resident. This meant she developed a personal relationship with residents and their families. She knew who wanted their sweaters in the top drawer, clothes did not get lost and the laundry worker experienced the rewards of providing care.

KEY QUESTIONS

- Clothes and laundry are critical to care. In planning long-term residential care, then, we need to ask how can clothes and linens be stored, collected for cleaning, sorted, washed, dried, and returned in ways that create a pleasant environment and that support dignity for residents, staff and families?

- How can laundry facilities be organized to protect the health and safety of both residents and staff while offering more resident clothing choice and more possibilities for workers in responding to those choices?

- How can laundry be physically designed to allow families and residents the possibility of doing their own laundry without making this work difficult or obligatory?

- Are there ways to design laundry facilities that remove the need to label clothes and that prevent the loss and/or destruction of clothes?

CLEANING MATTERS

Susan Braedley

In long-term care homes, cleaning is a top priority, for many reasons. First, long-term care homes must be kept much cleaner than private homes or hotels, in order to prevent the spread of infectious diseases and viruses. This is particularly important because residents have decreased immune function due to the aging process, their medical conditions and related issues such as incontinence, memory loss, dementia, and decreased skin integrity. These circumstances make older people especially vulnerable to infection and disease. Second, cleaning matters because it supports residents' autonomy, quality of life and dignity. Due to their medical conditions, disabilities and frailty, some residents are likely to spill, drop things or make a mess in the course of participating in the activities of daily life. Easy cleanup means that residents feel supported and encouraged to continue participating in these activities.

Third, cleaning matters to everyone who lives, works, visits or volunteers in long-term care residents by keeping the environments free from stains, dirt and unpleasant smells, such as urine, garbage, and even strong chemical cleaners. Fourth, cleaning matters to the men and women who do this work. Cleaners must be able to do their job well without exposures to toxic chemicals or physical injury. Further, residents should feel comfortable with the cleaning staff who enter their rooms each day. Cleaners should be able to do their work in ways that allow for positive interactions with residents and without disturbing routines and rhythms of daily life in the residence.

Finally, cleaning matters because these residences are homes, not hospitals. Residents deserve environments that are cozy, pleasant and comfortable. While "easy-to-clean" suggests plastic seating, linoleum floors, and metal beds, residents' quality of life depends on environments that are more comfortable and attractive, as other chapters in this book have indicated. Cleaning must maintain comfort as well as infection control, making cleaning in long-term care residences a challenging and important design priority.

Attractive, easy-to-clean environments

In visiting long-term care homes in six countries, our team saw many promising practices that provided comfortable, attractive environments for care that were easy to keep pristinely clean.

Flooring was a big challenge in some long-term care homes, as some workers told us in Canada.

> Like in my facility we have a common area when you walk in and there's chairs and a TV and stuff. There's carpet in there and it is so gross and ugly. I said me and some of the girls will pull it out for free because it's jus… and that's one of the first things you see but the residents will sit there and spill their coffee or, you know. It's horrible.

We observed a promising alternative in one residence in Texas. Colourful flat weave carpet squares were used in one living area where residents often sat with a drink or snack. According to staff, the flat weave carpet was easy to keep clean and stained carpet squares were easily removed and replaced. In residences in Nova Scotia and Sweden, wood-look laminate flooring provided a pleasant, easy to maintain floor. In Manitoba, cushioned linoleum in varied colours both provided a safer surface if someone fell and added a lively touch to the decor. In many residences, we saw that the walls had rounded corners, instead of the usual 90˚ angles that can trap dirt and make cleaning more difficult.

In one Swedish residence, colour and pattern were introduced through wipe-able wallpapers, washable curtain fabrics and bathroom tiles that made the surroundings particularly attractive while also easy to

keep sanitary. In both Norway and Ontario, we saw living areas with comfortable, non-slippery leather-like upholstered couches and chairs that could resist spills and easily be wiped off. In Sweden, the residence kept a good supply of removable, washable fabric slipcovers for chair cushions, providing residents and visitors with comfortable, breathable fabric seats instead of vinyl. All of these options meant that residents experienced cozy comfort in a suitably clean, healthy environment.

Ensuring an absence of unpleasant smells and contamination issues, we saw garbage collection systems that allowed workers to remove garbage, including incontinence products, soiled bedding and towels from living areas throughout the day. Unlike residences where garbage or laundry sat in bags in the hallway until picked up, these residences had enclosed containers that were quickly transferred to appropriate waste handling or laundry utility areas located away from resident spaces.

Further, we found that residences with windows that opened and soundless, efficient ventilation systems had fresh air and fewer unpleasant smells.

Easy-to-use cleaning equipment

In some residences, cleaners were burdened with utility carts almost as tall as the workers. These carts were often heavy and awkward to maneuver, filled with large containers of cleaners, a large pail of water, a broom and mop, cleaning cloths and a large garbage holder. They squeaked and rumbled as cleaners trundled them from room to room. Frequently, workers had to leave these carts in hallways when cleaning because they were too big and awkward to maneuver safely in resident rooms, creating both a hazard and an eyesore. The carts towered over residents in wheel chairs, meaning that cleaners and residents could not see each other easily, creating a further safety hazard and a block to social interaction.

In contrast, in other homes we saw the promising use of light, quiet carts that were about waist high and held household-sized containers of cleaners as well as other needed supplies. As one Ontario worker

told us, “I love this cart”. In one residence in Sweden, a great deal of attention had gone into designing a light cleaning cart. With advice from cleaners, easily refillable containers for cleaning products were attached to the cart, and these carts were significantly smaller, lighter and quieter than others we saw elsewhere. Cleaners were able to maneuver into every space, while remaining visible to others. In our study, we noted that residents often want to chat with cleaners, and this style of cart ensured that cleaners can see and be seen. Further, the scale of the cart and containers reduces physical strain.

We also noted that some residences were making efforts to use effective cleaning supplies that were as non-toxic as possible. In one Ontario residence, the cleaning regimen had been carefully re-calibrated to ensure that disinfection concerns were met while also ensuring that cleaners were not exposed to harmful substances. In a Manitoba residence, after consulting with cleaners, the residence switched to colour- coded cleaning cloths, with each colour indicating where and on what the cloths had been used. This system prevented cross-contamination and simplified the cleaners’ work.

Knowing physical spaces, equipment and people

Residence physical spaces may be designed to be easy to keep clean and comfortable and safe, and convenient cleaning equipment can be supplied, but these conditions are not enough to maintain residences adequately. Cleaners must know their spaces and their equipment, and we noted that this occurred most often in residences where the management directly employed their cleaning staff, rather than hiring a cleaning company or agency. We noticed that when cleaners had good knowledge of their physical spaces and equipment, as well as the residents and other staff, cleaning seemed to be better and more integrated into the everyday life of the home, adding not only to its safety and beauty but also by creating relationships with residents and contributing to a sense of community in the residence.

Cleaners from sub-contracted cleaning companies were less likely to know the residents or staff. They told us that they worked many places and were not always assigned to work at the residence or in the same

residence areas. In one residence where cleaning services had switched to a sub-contracted private for-profit provider, some cleaners were retained by the new firm but changed their jobs, as one cleaner told us:

> I have fun with [residents] sometimes. I make jokes because actually for 10 years I was working on the third floor. That was my area for 10 years. Somehow when a new management, a new supervisor came they rotated us. Bad idea. Because now we're kind of like starting a new job. (Interview with cleaner, British Columbia)

In contrast we noted that when residences employed their own cleaners, these cleaners usually worked in the same areas, got to know residents, families and staff and became members of the residents' community as well as an extra set of eyes, ears and hands. They got to know resident and staff routines and preferences, as well as the specific cleaning needs and challenges in each area of the residence. These cleaners usually had a sufficient level of autonomy in designing their work so that they could use this knowledge to develop custom cleaning processes that produced a high level of safety and comfort, as well as significant job satisfaction.

> The cleaner tells me she is trying out a new approach to doing her floor today, to see if it works better. She is trying to avoid activities that go on that interfere with her cleaning, such as the decoration of the facility for Christmas that is in process, using volunteers. (Fieldnotes, Ontario)

KEY QUESTIONS

- What kinds of furnishing and surfaces allow for both cleaning ease, sanitary surroundings, comfort and beauty? We saw many examples of attractive surroundings and comfortable furnishings that were easy-to-clean and sanitary.

- What cleaning equipment and supplies are light, easy to maneuver and facilitate sight lines for workers and residents, including those in wheelchairs
- Have cleaners been consulted on the cleaning supplies, equipment and processes? These practices promote health and safety as well as comfort and familiarity for residents and staff.

- Employing permanent cleaning staff is a promising practice, promoting cleaner environments with flexible routines and relationships that suit residents' needs.

DYING MATTERS

Albert Banerjee and Alex Rewegan

Dying matters when designing environments for long-term care. While death has never been absent from residential care, with changes in the resident population, attention to dying is becoming more important than ever.

In many of the homes we visited, we were told that residents were entering older and/or sicker, needing more care and more complex forms of care. This means that many residents do not live in these homes as long as they used to, with an increasing number dying within months of their arrival. One Norwegian nursing home director told us that in the past, new residents would arrive with their suitcases, because this was going to be their home for a number of years. Now, while some residents still have years of life ahead of them, more and more arrive directly from hospitals without those suitcases and already in need of end-of-life care.

These circumstances mean that care homes cannot always accommodate the higher demand for care. In many of the homes we studied, there was a growing disconnect between what these homes where designed for — long-term living — and the current reality of these homes: more and more end-of-life care. The tension, as one Canadian dietician described it, was the following:

> I think one of the criteria for hospice is they have six months to live. We have many people who pass away before six months. So we're

> operating almost like a hospice but we don't have the structure or the system or the staffing resources to support that. I think that's where the issue is.

Design features can play a very important role in creating a supportive environment for residents at the end of their life, and for their families as well as staff members. One way that design can do this is by ensuring there are comfortable, welcoming places for staff, residents and family to discuss dying and to clarify the residents' preferences for the kind of care they want at the end of their life. These conversations are not easy to have, yet they are crucial for tailoring care, as one Canadian physician explained:

> If you get that conversation happening correctly then everybody starts to get more on the same page — that it's less and less about fixing things medically because we're past the being able to fix. We can support. We can comfort. And we can focus on asking the dignity question.

What kind of spaces do homes have for these conversations? Are they warm and comforting? Or are they cold and clinical? In one Canadian home, we were shown a room that had become the place for end-of-life conversations. It was a small room, big enough for a few people but not too big to lose intimacy. The walls were not painted in the cool white that was used elsewhere in the home. Rather, the walls were warmly decorated with earth tones and plenty of wood paneling. The room also had plants, comfortable chairs and plush couches. Books on spirituality lined shelves on the wall. There was even a stained glass window on the door with symbols representing various religions: the Christian cross, the Hindu Om, the Jewish Star of David. This room was initially imagined for spiritual care, but its design also made it the preferred place for conversations about dying and end-of-life care.

In addition to supporting conversations about dying, good design can help families spend time with their loved one at the end of their life or during serious illness. Many of the homes in our study offered at least one private room with a bathroom and fridge for families who wished to stay on site. Incorporating these spaces into the design of long-

term care homes can facilitate care and comfort for both families and residents. In a Canadian home, one researcher observed that

> when somebody dies or is in the dying process, the management/staff encourages their families to come and stay overnight in the family room but also volunteers are sitting with the residents. If somebody has passed away a heart will be put on his/her doors and on his/her place on the table in memorial of this resident and to allow the grieving process.

Design can also support other residents, staff and families after a resident dies. Many questions were raised in our research about the way design and the use of space can support the bereavement process. Is there space and time for the family and staff to grieve and say goodbye? Is the death of the resident hidden or is the resident's passing made visible somehow? Are there places and opportunities available for those who wish to express their thoughts and feelings?

For instance, we saw homes that had dedicated spaces to put pictures of residents who had recently died, light candles and place bouquets of flowers. In one German home we visited, the staff had put a stand near the front entrance upon which they had placed a large notebook that allowed residents, staff and family to express their thoughts. This was described as part of an ongoing effort to give dying more visibility, to make it a normal part of the home, as the following excerpt from a researcher's fieldnotes describes:

> She shows us the large book on the stand in the front. On the right are the pictures and names of residents who have just arrived and on the left are pictures and names of people who have died. I saw a resident in the morning looking at the right side of the book. [The nurse] explains that the palliative care subject took a long time to establish, and it is no longer a taboo… She tells us that one resident who was here for 23 years just passed away and people can write their condolences in this book.

Questions were also raised about how the resident leaves the home after they die. Is the body quickly removed from the room, hidden in

the basement, and then secreted out the back door? Or is the body taken out the front entrance? In many homes, residents' dead bodies are discreetly removed through back doors, while ensuring that residents do not observe the removal. We were told that this practice aimed to minimize residents' exposure to death, which was believed to be depressing for them. In contrast, at one Manitoba long-term care home, a ceremony to remove a resident's body appeared to be a meaningful practice for those who worked and visited. One researcher described this ritual in fieldnotes:

> We observed the ritual performed as someone who has died is leaving the nursing home. We saw staff walking slowly in a line behind the bier of the deceased person. The bier was covered with a beautiful patchwork coating. The ritual seemed to be spontaneously organized and lasted only a few minutes — the few minutes it takes to walk from the room of the deceased to the door where the hearse was waiting. This small ritual was a very moving moment. Actually, I had problems holding back my tears.

Those homes that did not hide death and gave the resident dignity even after they died were the ones that were most promising from the perspectives of those who live, work, and visit there. We were told that such practices can help make death less frightening. They also create trust, as residents could know that they would be respected upon their own deaths. This was comforting not only for residents but for their families and staff alike, as we hear one Canadian volunteer remark:

> … the way that [residents or family] see us treat someone's body after death is the way that they [think they] will be treated. I think the optics of that are important, and if you see the procession we have… we have a palliative care quilt that goes over top of the body and the stretcher service… and we have one for Christians and one for Jews, and the staff member always follows the body/courier person and sometimes a family member will come too and they come down and out the front door and it's very nice. It's very nice. The staff brings the quilt back in, and folds it. I feel good about it. And like I say, I think residents do too. They see that.

Finally, memorial and faith-based services were an important source of support during bereavement. Many of the homes we visited had dedicated spaces, such as small chapels, for memorial services. These venues allowed people to come together and grieve collectively. They also provided space to hold faith-based services which created a sense of community. As we were told in one home, the multicultural nature of the services offered was an important way of incorporating a diversity of cultural practices into the home. These faith-based practices were also supported by incorporating design elements throughout the home, as a Canadian spiritual director describes:

> Some residents might want to burn incense or have a little statue on their desk. Seven years ago because we had a number of Buddhist residents here … we erected a traditional Buddhist altar out in our garden area on the main floor and we have some statues of the Buddha. There's a few Hindu deities there also. We actually went to the stone quarry and we had to buy slabs of stone to make the altar and we actually had a Buddhist nun do the blessing of the altar. So they can burn incense there. We have it outside of course because it's hard to burn incense inside. We'd have all the alarms going off. So we try to figure out some way. We try to meet the needs the residents might have here.

In conclusion, we suggest that when designing long-term care environments in the future, as well as when adapting already existing homes, there should be serious consideration of the ways that the environment can be designed to accommodate the increasing frequency of death in long-term care. Our study has shown that, given the resident population is entering older and/or sicker, these facilities must be designed with *dying* as well as living in mind.

KEY QUESTIONS

- Are there places appropriate for conversations about residents' preferences for the kind of care they want at the end of their life?
- Is there room to provide high quality palliative and hospice care?
- What design practices can help make death and dying a meaningful part of the nursing home environment and accommodate a range of cultures and faith traditions?
- Are there spaces for ceremonies and places to memorialize residents?
- Are there spaces, including private rooms for overnight stays, for family use?

IDEAS WORTH SHARING

Pat Armstrong and Susan Braedley

Physical environments provide settings for living, for long-term care residents, staff, families, and volunteers. They provide the space that both shapes and signals limits and possibilities. Regulations, funding, and ideas about care are all implicated in the structure of long-term residential care, creating significant variation in structures. At the same time, policies and practices have a profound influence on how spaces are used. A garden can become inaccessible not only because the walkways are too narrow for wheelchairs and walkers but also because there are not enough staff to assist residents who need help to garden. Our research that took our teams into long-term care facilities helped us capture some of this complexity. While we did not set out to prove best practices but rather to identify ideas worth sharing, we did become convinced that there are important lessons to be learned about constructing physical environments. In concluding this book, we provide a list of these lessons, and some reflections on debates and tensions worth considering in designing physical environments for long-term residential care.

Our key lessons are:

1. Involve residents, staff, families and volunteers in planning and organizing physical environments. Staff are the experts on what they need for work; residents are the experts on what home, safety, and living spaces they require and desire. Families and volunteers can also make a useful contribution

to understanding how physical environments can help them participate effectively in long-term residential care.

2. Locate homes near as much as possible. In locating homes, think carefully about ease of access in terms of transportation for staff, families, volunteers and residents. Staff need to get there safely and quickly, and at odd hours. Families and volunteers are much more likely to visit and provide support if they do not have to invest large amounts of time and spend significant amounts of money to travel. And if residents are to participate in activities outside the home or visit services they require, they need to be able to travel with ease. Moreover, locating other facilities in the same building or at least locating long-term residential care close to the action provides stimulation for residents and attractions for staff, families, and volunteers. Consider parking needs and the expenses of parking for staff, families and volunteers.

3. Make small part of bigger. Small can be intimate and help build social relations. But, too, small can be claustrophobic and make it harder to ensure stimulation for residents while limiting the possibilities for continuity in care and protections for staff. Smaller sections within larger organizations can promote social relations but still provide economies of scale and a broader range of services.

4. Provide space to cook at least some of the food where the residents spend much of their time so they can smell the food being cooked, see it being prepared, and even participate in preparation.

5. Recognize death and dying as part of life in long-term residential care. Staff, residents and families need spaces for grieving as well as for supporting residents and each other through the last days of their relatives and those for whom they provide care.

6. Acknowledge the part clothes play in dignity and identity and how clothing choices are linked to the way laundry is done and by whom. Closets' space is important, given that these are homes. Smaller, adjustable machines located near the residents can simultaneously reduce injury from lifting heavy loads, allow more clothing choices and permit both residents and their families to wash the resident's clothes.

7. Think through how features such as the location of toilets and arms on chairs support residents' capacities and support staff in carrying out their care work.

8. Balance the need for a clean and safe environment with the need for a comfortable and attractive environment. Question whether removing risk means removing stimulation and autonomy for residents and staff.

9. Create workplaces that provide staff with both a place away from their work demands and appropriate space to interact with residents safely and effectively.

10. Investigate how privacy can be accommodated while ensuring safe care and how much locks protect rather than mainly restrict.

These lessons may seem obvious but we saw plenty of examples of such lessons being ignored, enough of them to warrant these reminders.

Debates and reflections

We also encountered and sparked many debates as we responded to the environments we saw and heard about in our site studies. Like the nurse quoted in the chapter on locks and doors, who changed her mind about having segregated sections for people with advanced dementias once she saw an integrated long-term care home in action, our team discussions and debates about whether or not a particular aspect of the physical environment was promising changed over the course of our week in a particular site and over the project as a whole.

However, we continued to debate many issues. Memory boxes provide just one example. We saw various versions of these boxes mounted outside the door of residents' room. They held a wide variety of objects from wedding photos, to souvenirs, to medals, and ornaments. They were sometimes filled by family and sometimes by the resident or the staff. We were told they reminded staff, family and visitors of the fact that these residents had a past, that they were once young, active and contributing. One, for instance, held a copy of the book the resident authored and another held a picture of the resident when he was a hockey star. The boxes also helped identify the room for residents and others. But some boxes were empty, suggesting the resident had no one to fill them. And one manager told us that she did not put up memory boxes because she wanted residents, staff and families to live in the now and to think about the future. We debated these views within our team and the only agreement we came to on memory boxes was that these, and other debates, matter to us all.

Another issue up for debate was whether and how activities were accommodated. In a Texas home, we saw a well-used, lively space for physical and occupational therapy, with well trained staff who provided treatment not only to residents but to staff and to older community members, some of whom may one day live at the residence. This busy spot was lively enough to attract residents to the area immediately outside it, allowing them to visit with those who were coming and going. This area was also attractive and designed for visiting, for waiting for treatment and even had a place to get a snack. These activity spaces and their arrangement beside each other allowed for and supported not only the innovative health programs offered, but added significantly to the life of the home itself. In a number of homes, however, we saw activity rooms that were seldom or even never used. A small room set aside and fitted out to provide stimulation and soothing for people with advanced dementia, called a snoezelen rooms, sat unused in an Ontario facility. When we asked why it was not used, changes to recreation staffing levels were mentioned.

In another Ontario facility, we saw a large "spa" bath area filled with household supplies. This bath area was seldom is ever used for bathing, as there were shower options. The spa had become a substitute for a

non-existent supply cupboard. In several homes, we saw tucked into the ends of hallways, conversation and reading areas that were almost never used. Residents preferred to sit where they were likely to meet and see more people.

In several LTRC homes, we saw wonderful swimming pools, therapy pools and other recreational facilities that were designed to be accessible for those who used wheelchairs or who had little muscle control. In many homes, these facilities were available for those living in the community. We learned that having areas for activities was important, but where these activities were located within the home, what they were adjacent to, and whether there were staff, families and volunteers in sufficient numbers to assist residents and others to access and use these activity spaces were also important.

We reflected on similar issues related to staff spaces. In some settings, we saw staff areas that were frequently used for meetings, training and for completing paperwork. However, there was a tension between having designated staff spaces and areas closed to residents that prevented more staff-resident interactions.

In Sweden, we saw a bright and well-equipped staff space designed for breaks, complete with a full kitchen, large table and chairs, comfortable seating and a shower and locker room area. Yet, this wonderful space was used infrequently for workers' breaks, because it was located far away from the residents' home areas and required a long time to reach. Workers preferred to take their breaks in these resident areas, yet did not have any staff-only space in these areas. In one Ontario home, we saw direct care staff taking their evening break in a storage closet, in which someone had wedged a small chair and a television set. One care aide explained to us that leaving the floor on her break meant leaving her partner alone with many residents. They had set up this closet so that they could take a break but be within earshot. This anecdote illustrates once again the ways in which physical environments shape the conditions of work and care in LTRC homes, interacting with staffing levels, residents' needs and acuity and many other factors.

Another tension was inherent in community uses of space and facilities. In many homes, there were spaces for seniors' programs and dementia-related day programs. To us, this seemed promising, in that these programs brought many people into the facilities from the community, adding life to the residence and also involving many older community members who may be isolated and lonely into residence life. However, arrangements of these spaces often included locked doors that prevented residents from exiting their particular housing areas and visitors from entering them. As well, meals were offered and served to residents and visitors in separate areas, preventing opportunities for them to meet. This organization of space, rules and rituals meant that in a number of these facilities, there were missed opportunities to create community.

These are just some examples of the many debates and tensions we uncovered in our research. Yet, the many promising approaches and practices within these pages offer some ideas, questions and tensions worth considering, with the proviso that they need to be examined for their relevance to specific contexts and changing populations who need and deserve care.

We conclude with hope and determination. We continue our research with the knowledge that LTRC physical environments can be, and are being, built and organized to support conditions of work and care necessary to ensure residents and workers are treated with dignity and respect. We have seen that joy, fun and positive relationships can be supported by careful choices in physical environments. Our hope is that you will use this information to contribute to these environments. Our determination is to ensure that we share these ideas as widely as possible, to encourage even more long-term care design ideas worth sharing.

BIBLIOGRAPHY OF OTHER PUBLICATIONS FROM OUR RESEARCH

Adams, A. & Chivers S. (2013). Home Pages: Domesticity and Duplicity in Images of Architecture for Ageing. *Seachange Art/Communication/Technology AGE*, 80-102.

Adams, A. & Chivers, S. (2015). Architecture and Aging: The Depiction of Home in Sarah Polley's *Away From Her. Age, Culture, Humanities: An Interdisciplinary Journal*, 2.

Ågotnes, G., Jacobsen, F.F., Harrington, C., & Peterson, K.A. (2015). A Critical Review of Research on Hospitalization from Nursing Homes; What is Missing? *Ageing International, 41*(1), 3-16. DOI: 10.1007/s12126-015-9232-4.

Anneli, S. & Sörensdotter, R. (2016). Interpretations of Person-Centered Dementia Care: Same Rhetoric, Different Practices? A Comparative Study of Nursing Homes in England and Sweden. *Journal of Aging Studies, 38*, 70-80. DOI: 10.1016/j.jaging.2016.05.001.

Armstrong, P. & Messing, K. (2014). Taking Gender into Account in Occupational Health Research: Continuing Tensions. *Policy and Practice in Health and Safety, 12*(1), 3-16. DOI: 10.1080/14774003.2014.11667794.

Armstrong, P. (2013). Puzzling Skills: Feminist Political Economy Approaches. *Canadian Review of Sociology, 50*(3), 256-283. DOI: 10.1111/cars.12015.

Armstrong, P. (2013). Time, Race, Gender, and Care: Communicative and strategic action in ancillary care commentary on Monique Lanoix's "Caring for Money." *International Journal of Feminist Approaches to Bioethics, 6*(2), 118–121. DOI: 10.2979/intjfemappbio.6.2.118

Armstrong, P. & Braedley, S. (Eds.). (2013). *Troubling care: Critical perspectives on research and practices*. Toronto, ON, Canada: Canadian Scholars' Press.

Armstrong, P., Armstrong, H., & Choiniere, J. (2015). *Before it's too late: A National Plan for Safe Seniors' Care*. Ottawa, ON, Toronto: The Canadian Federation of Nurses Unions.

Armstrong, P., Armstrong, H., & Daly, T. (2012). The Thin Blue Line: Long Term Care as an Indicator of Equity in Welfare States. *Canadian Woman Studies 29*(3), 49-60.

Armstrong, P., Armstrong, H., & MacLeod, K.K. (2015). The Threats of Privatization to Security in Long-Term Residential Care. *Ageing International, 41*(1), 99-116. DOI: 10.1007/s12126-015-9228-0.

Armstrong, P., Armstrong, H., Banerjee, A., Daly, T., & Szebehely, M. (2011). Structural Violence in Long-Term Residential Care. *Women's Health and Urban Life: An International & Interdisciplinary Journal, 10*(1), 111–129.

Armstrong, P., & Day, S. (in press). *Wash, wear and care: Laundry and clothing in the life and labour of nursing homes*. Toronto, ON, Canada: McGill-Queen's University Press.

Baines, D. & Armstrong, P. (Eds.). (2015/2016). *Promising Practices in Long Term Care: Ideas Worth Sharing*. Ottawa, ON, Canada: Canadian Centre for Policy Alternatives.

Baines, D. & Daly, T. (2015). Resisting Regulatory Rigidities: Lessons from Front-Line Care Work. *Studies in Political Economy, 95*, 137-160.

Baines, D. & van den Broek, D. (2016). Coercive Care: Control and Coercion in the Restructured Care Workplace. *British Journal of Social Work, 0*, 1-18. DOI: 10.1093/bjsw/bcw013.

Baines, D. (2015). Neoliberalism and the Convergence of Nonprofit Care Work in Canada. *Competition & Change, 19*(3), 194-209. DOI: 10.1177/1024529415580258.

Banerjee, A. & Armstrong, P. (2015). Centring Care: Explaining Regulatory Tensions in Residential Care for Older Persons. *Studies in Political Economy, 95*, 7-28.

Banerjee, A., Armstrong, P., Daly, T., Armstrong, H., & Braedley, S. (2015). 'Careworkers Don't Have a Voice:' Epistemological Violence in Residential Care for Older People. *Journal of Aging Studies, 33*, 28-36.DOI:10.1016/j.jaging.2015.02.005.

Banerjee, A., Daly, T., Armstrong, P., Szebehely, M., Armstrong, H., & Lafrance, S. (2012). Structural Violence in Long-term, Residential Care for Older People: Comparing Canada and Scandinavia. *Social Science & Medicine, 74*(3), 390–398. DOI: 10.1016/j.socscimed.2011.10.037.

Braedley, S. & Martell, G. (2015). Dreaming of Home: Long-Term Residential Care and (In) equities by Design. *Studies in Political Economy, 95*, 59-81.

Chivers, S. (2013). Reimagining Care: Images of Aging and Creativity in House Calls and A Year at Sherbrooke. *International Journal of Ageing and Later Life 7*(2), 53-71. DOI: 10.3384/ijal.1652-8670.1272a3.

Chivers, S. (2016). The Show Must Go On: Aging, Care, and Musical Performance in Quartet. *Modern Drama, 59*(2), 213-230. DOI: http://dx.doi.org/10.3138/md.59.2.5.

Choiniere, J. (2011). Accounting for care. *Advances in Nursing Science, 34*(4), 330–344. DOI: 10.1097/ans.0b013e3182356c31.

Choiniere, J.A., Doupe, M., Goldmann, M., Harrington, C., Jacobsen, F.F., Lloyd, L., Rootham, M., Szebehely, M. (2015). Mapping Nursing Home Inspections & Audits in Six Countries. *Ageing International, 41*(1), 40-61. DOI: 10.1007/s12126-015-9230-6.

Daly, T. & Armstrong, P. (2016). Liminal and Invisible Long-Term Care Labour: Precarity in the Face of Austerity. *Journal of Industrial Relations, 58*(4), 473-490. DOI: 10.1177/0022185616643496.

Daly, T. (2015). Dancing the Two-Step in Ontario's Long-Term Care Sector: Deterrence Regulation = Consolidation. *Studies in Political Economy, 95*, 29-58.

Daly, T., & Szebehely, M. (2011). Unheard Voices, Unmapped Terrain: Care Work in Long-Term Residential Care for Older People in Canada and Sweden. *International Journal of Social Welfare, 21*(2), 139–148. DOI: 10.1111/j.1468-2397.2011.00806.x.

Daly, T., Armstrong, P., & Lowndes, R. (2015). Liminality in Ontario's Long-Term Care Facilities: Private Companions' Care Work in the Space 'betwixt and between'. *Competition & Change, 19*(3), 246-263. DOI: 10.1177/1024529415580262.

Daly, T., Banerjee, A., Armstrong, P., Armstrong, H., & Szebehely, M. (2011). Lifting the 'Violence Veil': Examining Working Conditions in Long-term Care Facilities Using Iterative Mixed Methods. *Canadian Journal on Aging, 30*(02), 271-284. DOI: 10.1017/s071498081100016x.

Harrington, C., Armstrong, H., Halladay, M., Havig, A.K., Jacobsen, F.F., MacDonald, M., Panos, J., Pearsall, K., Pollock, A., & Ross, L. (2015). Comparison of Nursing Home Financial Transparency and Accountability in Four Locations. *Ageing International, 41*(1), 17-39. DOI: 10.1007/s12126-015-9233-3.

Harrington, C., Choiniere, J., Goldmann, M., Jacobsen, F. F., Lloyd, L., McGregor, M., Stamatopoulos, V., & Szebehely, M. (2012). Nursing Home Staffing Standards and Staffing Levels in Six Countries. *Journal of Nursing Scholarship, 44*(1), 88-98. DOI: 10.1111/j.1547-5069.2011.01430.x.

Harrington, C., Hauser, C., Olney, B., & Rosenau, P. V. (2011). Ownership, Financing, and Management Strategies of the Ten Largest for-Profit Nursing Home Chains in the United States. *International Journal of Health Services, 41*(4), 725–746. DOI: 10.2190/hs.41.4.g.

Harrington, C., Schnelle, J., McGregor, M., & Simmons, S. (2016). The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes. *Health Services Insights, 13*. DOI:10.4137/HSI.S38994.

Jacobsen, F. F., & Mekki, T. E. (2011). Health and the Changing Welfare State in Norway: A Focus on Municipal Health Care for Elderly Sick. *Ageing International, 37*(2), 125–142. DOI: 10.1007/s12126-010-9099-3.

Jacobsen, F.F. (2014). Continuity and Change in Norwegian Nursing Homes, in the Context of Norwegian Welfare State Ambitions. *Ageing International, 40*(3), 219-228. DOI: 10.1007/s12126-014-9214-y.

Jacobsen, F.F. (2015). Understanding Public Elderly Care Policy in Norway: A Narrative Analysis of Governmental White Papers. *Journal of Aging Studies, 34*, 199-205. DOI:10.1016/j.jaging.2015.04.006.

Lanoix, M. (2011). Assembly-line care: Ancillary care work in post-Fordist economies. Work: A Journal of Prevention, *Assessment and Rehabilitation, 40*(1), 41-50. DOI: 10.3233/WOR-2011-1205

Lanoix, M. (2012). Labour as Embodied Practice: The Lessons of Care Work. *Hypatia, 28*(1), 85–100. DOI: 10.1111/hypa.12008

Lanoix, M. (2013). Caring for money: Communicative and Strategic Action in Ancillary Care. *International Journal of Feminist Approaches to Bioethics, 6*(2), 94–117. DOI: 10.2979/intjfemappbio.6.2.94.

Laxer, K., Jacobsen, F.F., Lloyd, L., Goldmann, M., Day, S., Choiniere, J.A., & Rosenau, P.V. (2015). Comparing Nursing Home Assistive Personnel in Five Countries. *Ageing International, 41*(1), 62-78. DOI: 10.1007/s12126-015-9226-2.

Lloyd, L., Banerjee, A., Harrington, C., F. Jacobsen, F., & Szebehely, M. (2014). It is a Scandal!: Comparing the causes and consequences of nursing home media scandals in five countries. *International Journal of Sociology and Social Policy, 34*(1/2), 2–18. DOI: 10.1108/ijssp-03-2013-0034.

Lowndes, R., Armstrong, P., & Daly, T. (2014). The Meaning of Dining: The Social Organization of Food in Long-term Care. *Food Studies: An Interdisciplinary Journal, 4(*1), 19-34. DOI: 10.18848/2160-1933/CGP.

MacDonald, M. (2015). Regulating Individual Charges for Long-Term Care in Canada. *Studies in Political Economy, 95*, 83-114.

Næss, A., Fjær, E.G., & Vabø, M. (2016). The assisted presentations of self in nursing home life. *Social Science & Medicine, 150*, 153-159. DOI: 10.1016/j.socscimed.2015.12.027.

Øye, C., Jacobsen, F.F., & Mekki, T.E. (2016). Do Organizational Constraints Explain the Use of Restraint? A Comparative Ethnographic Study from Three Nursing Homes in Norway. *Journal of Clinical Nursing*. DOI: 10.1111/jocn.13504.

Øye, C., Mekki, T.E., Jacobsen, F.F., & Førland, O. (2016). Facilitating Change from a distance – a Story of Success? A Discussion on Leaders' Styles in Facilitating Change in Four Nursing Homes in Norway. Journal of Nursing Management, 24(6), 745-754. DOI: 10.1111/jonm.12378.

Ronald, L.A., McGregor, M., Harrington, C., Pollock, A., & Lexchin, J. (2016). Observational Evidence of For-Profit Delivery and Inferior Nursing Home Care: When Is There Enough Evidence for Policy Change? *PLOS Medicine, 13*(4), e1001995. DOI:10.1371/journal.pmed.1001995.

Sivananthan, S.N., Doupe, M., & McGregor, M.J. (2014). Exploring the Ecology of Canada's Publicly Funded Residential Long-Term Care Bed Supply. *Canadian Journal on Aging, 34*(1), 60-74. DOI: 10.1017/S071498081400052X.

Struthers, J. (2013). Framing Aging Through the State: Canada's Two Senate Committees on Aging, 1963-1966 and 2006-2009. *Canadian Review of Social Policy 68-69*, 1-9.

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Canadian Federation of Nurses Unions
https://www.nursesunions.ca/

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http://cupe.ca/

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Physical Environments for Long-Term Residential Care: Ideas Worth Sharing reports on the findings of an international team of 26 researchers and more than 50 graduate students who went to six countries in search of promising practices in long-term residential care for older adults. The second in a series, this book provides concrete examples of promising practices for physical environments in long-term residential care. By physical environments, we mean everything from the location of a nursing home and the structure of gardens to the floor coverings, chair arms, and spaces for memorials. Physical environments are about more than setting the conditions for living and care provision. They also shape and reflect how care and life in nursing homes are understood. They construct limits and possibilities for residents, staff, families and volunteers. This book shows that joy, fun and positive relationships can be supported by careful choices in physical environments. Our hope is that readers will use this information to contribute to these environments. Our determination is to ensure that we share these ideas as widely as possible, to encourage even more long-term care design ideas worth sharing.

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