

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Caring for Cognitive Impairment

Webinar No 8: Improving the hospital environment

CARING FOR COGNITIVE IMPAIRMENT



Join the campaign and make a difference
cognitivecare.gov.au #BetterWayToCare

Outline

How to improve the hospital environment for people with cognitive impairment

- NSQHS Standards
- Environment design principles
- Putting the principles into practice
- Questions



Presenters

Richard Fleming

Executive Director Dementia
Training Australia

Jill Marjoram

General Manager, Lithgow
Hospital

Questions

- You can type your questions or comments in the control panel as we go along
- The session will be recorded and the recording and slides uploaded on the campaign website
<http://cognitivecare.gov.au/>

CARING FOR COGNITIVE IMPAIRMENT



Cognitive Impairment

is an important safety and quality issue for all Australian hospitals



Patients with cognitive impairment such as dementia and/or delirium have more falls, pressure injuries and functional decline



Dementia and delirium are poorly recognised



30-40% of delirium cases can be prevented



Learn how to recognise cognitive impairment



Prevent delirium



Act to keep people with cognitive impairment safe

**We can
all make a
difference**

NSQHS Standards (second edition)



Clinical Governance Standard



Partnering with Consumers Standard



Preventing and Controlling Healthcare-associated Infection Standard



Medication Safety Standard



Comprehensive Care Standard



Communicating for Safety Standard



Blood Management Standard



Recognising and Responding to Acute Deterioration Standard



Safe environment for the delivery of care

The environment promotes safe and high-quality health care for patients.

Item	Action
Safe environment	1.29 The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose
	1.30 The health service organisation: a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce b. Provides access to a calm and quiet environment when it is clinically required
	1.31 The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose
	1.32 The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet patients' needs, when it is safe to do so
	1.33 The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people

Presenter

Richard Fleming

Executive Director
Dementia Training
Australia





Dementia
Training
Australia

Improving the hospital environment for people with dementia

Professor Richard Fleming
Executive Director, Dementia Training Australia

Funded by the Australian Government



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OF WOLLONGONG
AUSTRALIA

UNDERSTAND ALZHEIMER'S
EDUCATE AUSTRALIA
FIGHTEMENTIA.ORG.AU



LA TROBE
UNIVERSITY



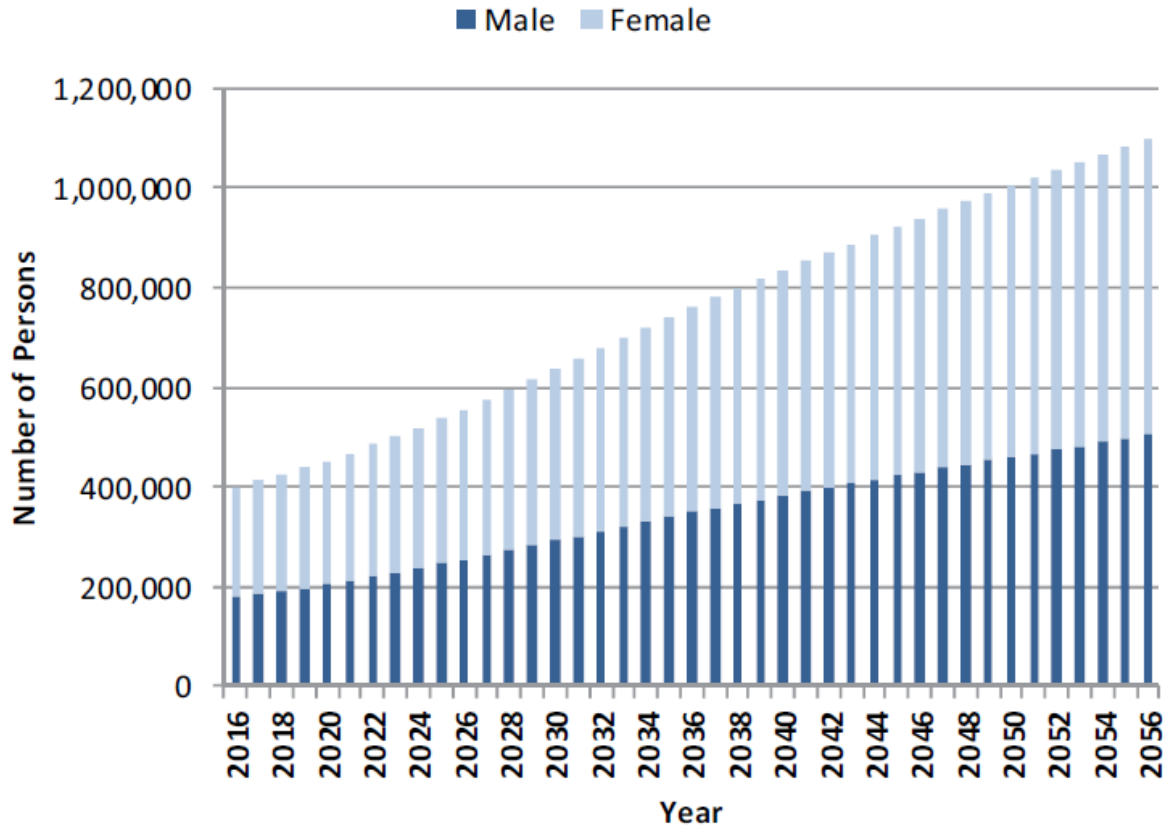
Queensland University
of Technology

UNIVERSITY of TASMANIA | WICKING
Dementia Research & Education Centre



THE UNIVERSITY OF
WESTERN
AUSTRALIA
WESTERN AUSTRALIAN CENTRE FOR
HEALTH X AGEING

Dementia in Australia



Source: Economic cost of dementia in Australia 2016-2056. Brown, L., Hansnata, E. and La, H.A. NATSEM at the Institute for Governance and Policy Analysis, University of Canberra, February 2017



Length of Stay in hospitals

People with dementia stay in hospital almost twice as long as those without dementia, averaging 16.4 days of care compared with 8.9 days for other patients*

*Australian Institute of Health and Welfare 2013. Dementia care in hospitals: costs and strategies. Cat.no. AGE 72. Canberra: AIHW.



Average costs of hospital care

Where dementia was the principal diagnosis, the average cost was \$13,434 per episode compared with \$5,010 for people without dementia, a difference of \$8,424. In other words, the average cost of hospitalisation for a person with a principal diagnosis of dementia is almost 2.7 times more than for a person without dementia.*

*Australian Institute of Health and Welfare 2013. Dementia care in hospitals: costs and strategies. Cat.no. AGE 72. Canberra: AIHW.



Australasian Health Facility Guidelines

Part B - Health Facility Briefing and Planning
0135 - Older Persons Acute Mental Health Unit

Uncontrolled when printed

Revision 2.0
01 March 2016



**DESIGNING
FOR PEOPLE
WITH DEMENTIA**

- wandering;
- repetitive noisy behaviours;

UNIT DESIGN

Mental health facility design requires a conscious balancing of the requirement to provide an effective therapeutic environment for acute mentally ill consumers, with the need to provide consumers, carers, visitors and staff with a pleasant, spacious, light filled, comfortable, and non-threatening facility that is domestic in style.

The following principles, originally prepared to guide the design of dementia units, are also applicable to this Unit (Adapting the Ward: for People with Dementia, Fleming, R., Forbes, I. and Bennett, K., 2002):

- provide a safe and secure environment;
- plan for small consumer groups: eight consumers for severe dementia and up to fourteen consumers for moderate dementia;
- provide good visual access so consumers can see everywhere they need to go;
- reduce of unnecessary stimulation;
- highlight useful stimuli;
- provide for planned walking;
- use familiar decor from the consumer's early adulthood;
- provide opportunities for privacy and community;
- provide appropriate facilities for visitors to retain links with the community;
- make the environment as domestic as possible; and
- and encourage consumers to use their abilities.

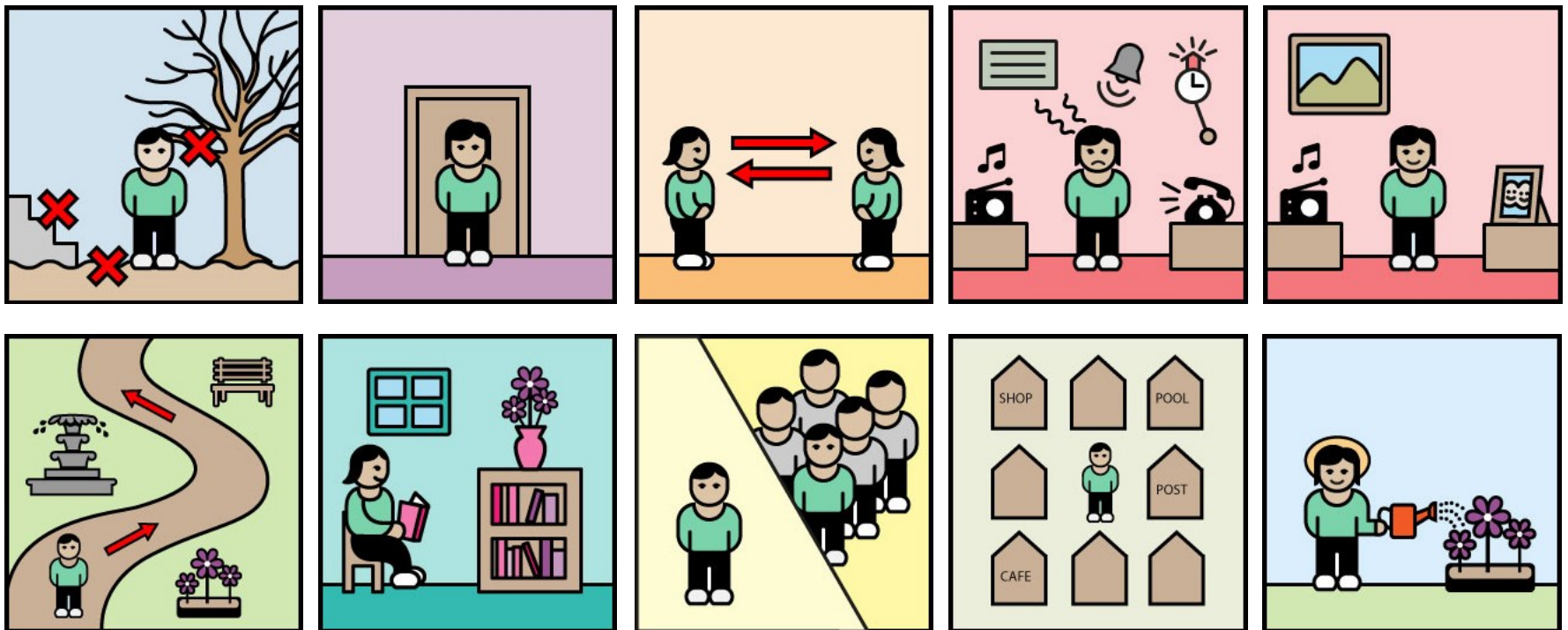
Aged Health Network

Key Principles for Improving Healthcare
Environments for People with Dementia



<https://www.aci.health.nsw.gov.au/resources/key-principles>

Key principles of designing for people with dementia



Key principles

PRINCIPLE 1: Unobtrusively reduce risks

PRINCIPLE 2: Provide a human scale

PRINCIPLE 3: Allow people to see and be seen

PRINCIPLE 4: Reduce unhelpful stimulation

PRINCIPLE 5: Optimise helpful stimulation

PRINCIPLE 6: Support movement and engagement

PRINCIPLE 7: Create a familiar space

PRINCIPLE 8: Provide a variety of spaces to be alone or with others

PRINCIPLE 9: Provide links to the community

PRINCIPLE 10: Support the values and goals of care



PRINCIPLE 1: UNOBTRUSIVELY REDUCE RISKS



Reduce potential risks and where safety features are provided, e.g. fences, security features on doors or windows, ensure that they are not obvious.



This photograph was taken at a residential aged care facility owned by HammondCare. © HammondCare

PRINCIPLE 1: UNOBTRUSIVELY REDUCE RISKS



Reduce potential risks and where safety features are provided, e.g. fences, security features on doors or windows, ensure that they are not obvious.

People with dementia require an internal and external environment that is safe, secure and easy to move around if they are to make the best of their remaining abilities. However, obvious safety features and barriers will lead to frustration, agitation and anger and so features introduced to reduce potential risks should not be obvious.

1.1 Applying the principle in practice

Creating a secure, safe and healthy environment will require a focus on managing people entering and leaving the inpatient unit and minimising potential hazards within the inpatient unit.

Ensure:

- a fence around a secure area is continuous and well maintained, designed to blend into the landscape, does not allow for climbing (in or out), and gates are secured (but allow for controlled coming and going)
- entry and exit to the inpatient unit can be controlled unobtrusively
- window design prevents exit (or entry) and the extent of window opening is controlled
- access to patient kitchen, and appliances within it, can be controlled
- all floor finishes are slip resistant, changes in floor surface are clearly marked with colour or texture, floors are graded to prevent ponding, and an appropriate cleaning regime is in place to maintain surface integrity
- staff are able to see patients easily

Avoid:

- fences and gates with openings or horizontal members which can be used as foot holds and planting near the fence which can be used for climbing
- windows that can be opened and allow for climbing in or out
- an open plan kitchen with unrestricted access to appliances which could be dangerous
- unnecessary changes in floor finishes, run off from air conditioners or rain water which wet outside floors, steps, hobs and set downs
- glare from light fittings and floor surfaces

Consider:

- using vegetation to hide a fence so it is not foreboding or institutional and the placement of latches to avoid their use from within the secure area
- designing the fence so that it is integrated with the topography of the landscape or is hidden by vegetation so that the height is not visually imposing
- screening the entry from inside the inpatient unit and providing other points of interest nearby to prevent patients being continually confronted by a locked door
- using decorative screens and louvers to control people leaving by a window
- using a half height door with key pad or a bench with an up-stand (a short wall, usually with a continuation of the bench on top) to limit access to a patient kitchen, including a cupboard that contains appliances, a lockable knife drawer or isolating the power as an alternative method of protecting patients from injury from appliances
- using concrete rather than pavers which can become uneven and cause tripping
- selecting fittings that provide support to patients but do not emphasise their need for assistance

1.2 Evidence base

The confusion which accompanies dementia determines the need for a variety of safety features to be built into the environment. Among other things, they often include the provision of a secure perimeter¹³. There is some evidence of an overemphasis on safety in British¹⁴ and Australian healthcare facilities providing care to people with dementia¹⁵ and it is important to note that patients may respond negatively to a safety or security measure if it obviously impedes their freedom^{16, 17}. This can be mitigated by providing these unobtrusively^{18, 19}. In the case of a perimeter fence, for example, shrubbery can be used to hide a fence that prevents someone wandering off.

Sometimes the safety of other patients has to be given priority. If an inpatient unit is likely to be used by people with dementia who may harm themselves or others, then access to a segregated area may be required²⁰. These areas may include more space (at least 30 square meters per patient)²¹, a garden, a quiet area, a seclusion suite, activity and games room as well as a specific model of care^{20, 22, 23}.

The benefits of locking these facilities is under debate²⁴. The prevalence of locked psychiatric units in the U.K. and Sweden ranges from 25–73%^{25, 26}. Gudeman²⁷ stated that acute psychiatric units in general hospitals are locked because of community perception that the patients are dangerous, for the convenience of staff, and because of stigma and hospital-wide resistance. His opinion is that when units are unlocked few disasters occur and patients are less stigmatised and better able to integrate into the community. Haglund et al. (2005) found that the staff mentioned more disadvantages than advantages to having locked doors. A study carried out in 100 UK psychiatric acute admission inpatient unit showed that while a significant proportion were locked at all times there was an extremely large variation in the approach to safety due, it was argued, to the tension between the nurses' desire to foster dignity and freedom and the need to provide security²⁸. There is little, if any, literature on the effect of locked doors on outcomes, such as prevention of harm, use of psychopharmacology or staffing levels.

The prevention of falls is another key safety concern²⁸⁻³⁰. People with dementia are eight times more likely to experience a fall than those without³¹. The provision of care in a specialised behavioural management area has been shown to reduce falls³². A significant reduction in injuries associated with falls has been achieved by providing furniture that puts the person with dementia

closer to the ground through the use of bean bag chairs, futons and mattresses placed on the floor³³. This approach is in direct contrast to the practice of putting up bed rails, which simply ensure that if a fall does take place, it occurs from a greater height than normal. Evidence from a study involving 2000 patients suggests that the physical restraint of cognitively impaired patients does not reduce the risk of falls³³. A recent review of the literature on people with dementia falling in hospitals concluded that multi-faceted approaches are required to reduce falls and that there is insufficient evidence to support dependence on any single approach such as the use of restraints or modifications to the environment³⁴. This view is supported in a thorough review of the use of restrictive devices to minimise the risk of falling in people with dementia³⁵.

1.3 Expected Outcomes

- 1) Existing inpatient units will be audited to identify the absence of safety features required by people with dementia.
- 2) Existing inpatient units will be audited to identify obtrusive safety features.
- 3) The results of 1 and 2 will be addressed by the development of an approach to optimise the provision of unobtrusive safety features.
- 4) Plans for new inpatient units will take into consideration the provision of unobtrusive safety features

1.4 Quality measures

System measures	Agreed environmental audit tool is available for staff and external consultants.
Patient measures	Number of inpatient units used by people with dementia audited for the provision of unobtrusive safety (total and percentage of such units in the facility)
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Port Macquarrie Hospital
Granatelli & Stone - Architecture and Design
www.granatellistone.com.au
Tel 6621 6627 Fax 6622 6755



PRINCIPLE 3: ALLOW PEOPLE TO SEE AND BE SEEN



The built environment shall enable the patient with dementia to see their destinations and be seen by staff.

An environment that allows people to see their destination will help to minimise confusion. It should also enable staff to see the patient from where they spend most of their time. This assists with the monitoring of the patient and reassures the patient.

Total Visual Access



This photograph was taken at a residential aged care facility owned by HammondCare. © HammondCare

Total Visual Access: the view back up the corridor to the dining room and kitchen



This photograph was taken at a residential aged care facility owned by HammondCare. © HammondCare

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3.1 Applying the principle in practice

Ensure:

- all key locations (eg sitting room, patient's rooms, patient kitchen, toilets, showers, outside) can be easily seen by patients and staff
- a staff base can be seen from corridors and wards used by confused people.
- a clear route exists between toilet, patient's rooms and sitting room
- the sitting room is located in a prominent position in the unit and is identifiable when leaving a room (eg by its scale, form, colour), any entry doors to the room are glazed to allow people to look inside, windows have low sill height to encourage view in and out of the room
- good visual access to outdoors from rooms and sitting room
- the toilet pan is visible when the door to the toilet is open

Avoid:

- repetition of building form, scale and colour which doesn't distinguish between sitting rooms, wet areas and patient's room
- obstructing the view in or out of the sitting room (eg by closing curtains or using solid doors)
- glare from windows

Consider:

- views when leaving inpatient unit and entering corridors to ensure it is easy for a patient or visitor to see where they can go and what they may find if they head in a particular direction.
- introducing sidelights to sitting room doors to allow patients to see inside the room and identify its purpose before entering
- placement of windows, window sill height, the use of glazed doors
- designing doors and windows so their function is clear (ie windows don't look like doors)
- locating patients with dementia in rooms with good views to and from staff base
- designing staff base to enable unobstructed viewing of patients by staff and staff by patients.
- providing easy access to safe outside area, locating and designing outside areas so they can be easily viewed by patients and staff
- providing good visual access to doors leading to the safe outside area
- providing good visual access to doors leading inside from the safe outside area
- designing staff access routes and service corridors to provide back up observational glimpses of all outdoor areas likely to be used by patients
- minimising glare by using light paint colours around windows to reduce contrast around windows, orientation of windows, adjustable internal window shading treatment such as curtains or blinds, outside awnings

3.2 Evidence base

Confusion may be reduced by caring for a person with dementia in a simple environment. The simplest environment is one in which the patient can see everywhere that he or she wants to go to from wherever they are. While healthcare buildings are often large, if they are seen as being made up of many different components this principle can be applied to each part of the building.

This principle defined the plans of the units for the confused and disturbed elderly built by the NSW Department of Health in the late 1980's which were shown to improve self-help, socialization and behavior⁴⁷,⁴⁸ and it is associated with improved orientation⁴⁹,⁵⁰. Disorientation has been found to be less pronounced in L, H and square shaped units where the kitchen, dining room and activity rooms were located together⁵¹ and where the straight layout of the circulation system (ie without any change of direction of the corridors) provided good visual access.³⁷.

Good visual access also provides benefits for the staff. If staff can see the patients from the places where they spend most of their time, this reduces their anxiety. At the same time the visibility of the staff to the patients helps them to feel supported. Staff working in facilities with good visual access spend less time locating and monitoring their patients⁴⁶. The decentralisation of the nurses' station to small bays located so as to improve monitoring by staff, and visibility of staff to patients, has been found to reduce the use of the nurse call system and, by implication, improve contact between staff and patients⁵².

3.3 Expected Outcomes

- 1) Existing inpatient units will be audited to identify issues with visual access.
- 2) The results of the audit will be used in an approach to improve the visual access available to those patients who have dementia.
- 3) Plans for new inpatient units will take into consideration the provision of good visual access for patients who have dementia.

3.4 Quality measures

System measures	Agreed environmental audit tool is available for staff and external consultants.
Patient measures	Number of inpatient units used by people with dementia audited for the provision of good visual access (total and percentage of such units in the facility)
Staff measures	Staff identified by hospital as responsible for environmental auditing are trained in administering and interpreting the environmental audit tool.

PRINCIPLE 3: ALLOW PEOPLE TO SEE AND BE SEEN



The built environment shall enable destinations and be seen by staff.

An environment that allows people to see their destination will help to minimise confusion. It should also enable staff to see the patient from where they spend most of their time. This assists with the monitoring of the patient and reassures the patient.

3.1 Applying the principle in practice

Ensure:

- all key locations (eg sitting room, patient's rooms, patient kitchen, toilets, showers, outside) can be easily seen by patients and staff
- a staff base can be seen from corridors and wards used by confused people.
- a clear route exists between toilet, patient's rooms and sitting room
- the sitting room is located in a prominent position in the unit and is identifiable when leaving a room (eg by its scale, form, colour), any entry doors to the room are glazed to allow people to look inside, windows have low sill height to encourage view in and out of the room
- good visual access to outdoors from rooms and sitting room
- the toilet pan is visible when the door to the toilet is open

Avoid:

- repetition of building form, scale and colour which doesn't distinguish between sitting rooms, wet areas and patient's room
- obstructing the view in or out of the sitting room (eg by closing curtains or using solid doors)
- glare from windows

3.2 Evidence base

Confusion may be reduced by caring for a person with dementia in a simple environment. The simplest environment is one in which the patient can see

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Avoid:

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- glare from windows

Consider:

- views when leaving inpatient unit and entering corridors to ensure it is easy for a patient or visitor to see where they can go and what they may find if they head in a particular direction.
- introducing sidelights to sitting room doors to allow patients to see inside the room and identify its purpose before entering
- placement of windows, window sill height, the use of glazed doors
- designing doors and windows so their function is clear (ie windows don't look like doors)
- locating patients with dementia in rooms with good views to and from staff base
- designing staff base to enable unobstructed viewing of patients by staff and staff by patients.
- providing easy access to safe outside area, locating and designing outside areas so they can be easily viewed by patients and staff

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**DESIGNING
FOR PEOPLE
WITH DEMENTIA**

PRINCIPLE 4: REDUCE UNHELPFUL STIMULATION



Visual and auditory stimulation that is not helpful to the patient with dementia shall be reduced to the minimum required for the operation of the service.

Because dementia reduces the ability to filter stimulation and attend to only those things that are important, a person with dementia becomes stressed by prolonged exposure to large amounts of stimulation. This may lead to agitation, aggression or withdrawal. The environment should be designed to minimise exposure to stimuli that are not helpful. The full range of senses must be considered. Too much visual stimulation, for example, is as stressful as too much auditory stimulation.



Reducing Unhelpful Stimulation:

hiding a door



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4.1 Applying the principle in practice

Ensure:

- there are separate entrances and circulation routes for deliveries/services and patients
- a discreet entry to the inpatient unit, not easily observed from the main public areas of the unit
- any door bells that will be used by visitors or for deliveries are only audible in staff areas
- doors to storage areas and other facilities used by staff are unobtrusive, doors to patient areas do not have the same finish as service areas
- staff bases are designed to reduce noise transfer and to allow staff to have conversations without them being heard in other parts of the inpatient unit
- staff paging/call monitors are located so the noise from these is not disruptive to a patient
- doors close quietly
- provision for easily accessed and obvious storage of a small number of clothes with storage of items not likely to be used in next 24 hours in a less obvious location.

Avoid:

- the entry to the inpatient unit opening into a sitting room,
- locked entry doors being clearly visible to patients
- deliveries coming through the patient entry to the inpatient unit, deliveries proceeding through patient areas
- loud bells, piercing tones, flashing lights and public announcements
- noise from the service entry intruding on patients
- large wardrobes with many doors, locking wardrobes, overcrowding a wardrobe with a lot of contents
- mirrors in corridors

Consider:

- ways in which the entry to the inpatient unit can be screened
- locating cupboards and service areas to minimise their impact on key patient areas
- acoustic isolation measures
- installing sound attenuation around doors
- the use of signage so that it provides information that is relevant to patients/visitors only in patient/visitor areas
- the use of signage so that it provides information that is relevant to staff only in staff areas.

4.2 Evidence base

As a person with dementia experiences difficulties in coping with a large amount of stimulation⁵, the environment should be designed to reduce the impact of stimulation that is unnecessary for their well-being¹³. There is strong evidence that people with dementia are less verbally aggressive where sensory input is more understandable and where such input is more controlled¹⁸.

Many patients are extremely sensitive to their auditory environment and in particular to noise levels which at times may be high. This calls for a high degree of control of the acoustics in the inpatient common spaces^{7, 10, 54, 55} if aggression is to be avoided¹⁶.

Busy entry doors pose particular problems for staff and patients as they are a constant source of over stimulation and offer a temptation to leave. These problems can be significantly reduced by reducing the stimulation^{46, 57, 58}.

The goal is to provide the patient with an optimum level of stimulation. This requires achieving a balance between reducing unhelpful stimulation and enhancing stimuli that aid orientation and engagement as described under the next principle.

4.3 Expected Outcomes

- 1) Existing inpatient units will be audited to identify sources of high levels of stimulation.
- 2) If the results of the audit suggest that there are high levels of unhelpful stimulation an approach will be developed and implemented to reduce it.
- 3) Plans for new inpatient units will take into consideration the need to avoid high levels of unhelpful stimulation.

4.4 Quality measures

System measures	Agreed environmental audit tool is available for staff and external consultants.
Patient measures	Number of inpatient units used by people with dementia audited for the presence of high levels of unhelpful stimulation (total and percentage of such units in the hospital).
Staff measures	Staff identified by hospital as responsible for environmental auditing are trained in administering and interpreting the environmental audit tool.

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Unhelpful stimulation may contribute to falls

On the impact of a specialized geriatric services falls prevention program

Susan Maddock, RPT,
MaryJane McIntyre BSc.PT,
Susan Gal, BSc.PT,
Mireille Landry BScPT,
Rory Fisher, MB, FRCPC,
Barbara Liu, MD, FRCPC







PRINCIPLE 10: SUPPORT THE VALUES AND GOALS OF CARE



A clear statement of the inpatient units values and goals of care shall be available and used to guide decisions on the design of the built environment.

An environment that embodies the values and goals of care, e.g. provides opportunities for engagement with the ordinary activities of daily living to support rehabilitation goals, will assist the patient with dementia to respond appropriately and the staff to deliver the desired care. The values and goals need to be clearly stated and the building designed both to support them and to make them evident to the person with dementia and staff. The building becomes the embodiment of the philosophy of care, constantly reminding the staff of the values and practices that are required while providing them with the tools they need to do their job.



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10.1 Applying the principle in practice

Ensure:

- the philosophy of care is clearly articulated
- patients can engage with meaningful activity in preparation for their discharge
- places where meaningful activities (such as those relating to daily life) can be pursued are included in inpatient units

Avoid:

- creating a setting which does not allow for the philosophy of care to be realised

Consider:

- the role of the hospital in the life of the community and how this can be a positive one
- the use of art and sculpture in the hospital
- how the design can respond to the range of life experiences that patients will bring (rather than to only one scenario)
- the different cultural and socio economic backgrounds of patients and how this affects the way care is perceived and responded to

10.2 Evidence base

Over the last twenty five years there has been extensive interest in providing 'homelike' environments for people with dementia⁹⁴. This is the approach that was reflected in the first edition of *Adapting the Ward*.

Whether the values and goals of care are focused on the ordinary activities of daily life or not, the need to have a clearly formulated philosophy of care to guide the design of healthcare facilities has been recognised. Poulter describes this:-

"Health care providers are beginning to recognise the important role physical space plays in defining quality care experiences- not only for patients, but also for visitors, families, physicians, and staffers. One of the most notable trends is many hospitals' efforts to incorporate the concept of holistic care in facility design. Whether it's the familiar Planetree model philosophies such as "Patients First" or the "Healing Environment," or some other attitudinal framework, the goal is to meet patients' biological, psychological, and social needs and help them attain higher levels of wellness. And these efforts are paying off-in increased patient, family, and physician satisfaction"⁹⁵ Page 5

The advantages of going beyond a simple medical model aimed at the efficient delivery of medical services is becoming apparent⁹⁵ and in Australia can be seen in the design of the new Royal Childrens' Hospital in Melbourne, for example. The application of this approach to the development of appropriate models of care for people with dementia, and their embodiment in the built healthcare environment, remains largely unexplored. However, a systematic review of over 600 papers on the impact of art, design and the environment in mental healthcare⁹⁶ concluded that

"...exposure to the arts may reduce anxiety and depression in specific groups of patients. Further, there

is evidence that the arts can positively affect clinical and behavioural outcomes." (Page 92)

This underlines the opportunity for the creative use of the environment in the pursuit of a variety of goals.

The domestic, or homelike, environment may continue to be of interest in a healthcare setting because of the expectation that patients will be discharged to continue with their lives in as independent a way as possible. In a domestic, or homelike, environment the goal of care is to maintain the person's activities of daily living abilities for as long as possible. This requires that they have access to all of the normal household facilities and encouragement to use their abilities⁹⁷. It has been shown that the introduction of a small number of homelike features into an institutional environment resulted in a reduction in pacing, agitation and exit seeking⁹⁸ and improved social interaction and eating behavior⁹⁹.

10.3 Expected Outcomes

- 1) Existing inpatient units will be audited to identify the availability of a clear statement of the values and goals of their care of people with dementia.
- 2) Should no clear statement of the values and goals of care for people with dementia exist one will be developed.
- 3) The features of the physical environment that impede the implementation of the values and goals of care will be identified and an approach developed and implemented to improve them.
- 4) Plans for new inpatient units will take into account the need for the units to provide support for the staff to express the values in the delivery of care and assist them in achieving the goals of care.

10.4 Quality measures

System measures	Agreed tool for auditing the values and goals of care is available for staff and external consultants.
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Presenter

Jill Marjoram

General Manager
Lithgow Hospital



Ward Design for Cognitive Impairment

Prepared by **Jill Marjoram**
General Manager – Lithgow/ Portland

April 2018

OVERVIEW

- Lithgow Hospital -
- Inpatient Unit - 38 beds
- Mixed patient type, increasing numbers of older people
- increasing number of patients with cognitive impairment



DEMENTIA TRAINING AUSTRALIA
**ENVIRONMENTAL
DESIGN RESOURCES**

The goal of this collection of resources is to improve environments for people living with dementia. The resources introduce the reader to a systematic way of looking at the built environment and provide tools which can be used to make improvements.

Resource 1 describes the challenges to residential aged care and health care services of the increasing number of people with dementia, and reviews the literature on designing aged and health care buildings to support people living with dementia.

Resource 2 describes how assessment tools can be used to identify the strengths and weaknesses of existing buildings and lay the foundation of plans for improvement.

Resources 3, 4 & 5 introduce tools that have been developed for the assessment of environments where most people are mobile, higher care environments and public and commercial buildings.

Resource 6 is a guide to designing environments for older Indigenous people.

Kirsty Bennett is an architect who has pursued her commitment to creating enabling environments for people living with dementia through architectural practice, writing, education, research and speaking engagements.

Professor Richard Fleming PhD, a psychologist, is the Executive Director of Dementia Training Australia. He has published papers on environmental design, reminiscence therapy, reality orientation, depression, assessment of the elderly and service evaluation.



Dementia Training Australia



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DEMENTIA TRAINING AUSTRALIA

**ENVIRONMENTAL
DESIGN RESOURCES**

RICHARD FLEMING
KIRSTY A BENNETT



Dementia Training Australia



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INITIAL ACTIONS

- Review using DTA tool
- UK Kings Fund Enhancing the Healing Environment tool

TOGETHER
**ACHIEVING
BETTER HEALTH**



Health
Nepean Blue Mountains
Local Health District



THE EYE OF THE CAMERA



Unobtrusively Reduce Risks

The strong colours can be seen from a distance and invite entry into staff only zones.

CONSIDER camouflaging areas that patients should not enter

ALLOW PEOPLE TO SEE AND BE SEEN



The nurse/reception desk is in the middle of the unit, with no visual access into the corridors

Consider ways to reduce the obtrusiveness of this area, and locate staff into the corridors

MANAGE LEVELS OF STIMULATION.

Note the Glare, clutter in corridors and on the many notice boards around the hospital.



Consider ways to reduce clinical clutter and unhelpful signage



Reduce glare



OPTIMISE HELPFUL STIMULATION.

In bedrooms the toilet doors are signed, but the poster designed for staff may actually 'stop' patients with dementia from entering the toilet.

Keep signage easy to read and easy to understand with words and pictures that assist patients to find their way

SUPPORT MOVEMENT AND ENGAGEMENT

There is capacity for an internal/external walking route leaving by the lounge room and re-entering by the reception area, however the fence currently ends at the lounge room and the rest of the garden is poorly maintained, and not safe.

Creating a safe and secure internal/external walking route consider ways to:

- ❖ ensure doors can be opened independently by patients
- ❖ reduce hazards e.g. uneven paths, raised concrete
- ❖ create a secure fence line around the larger garden

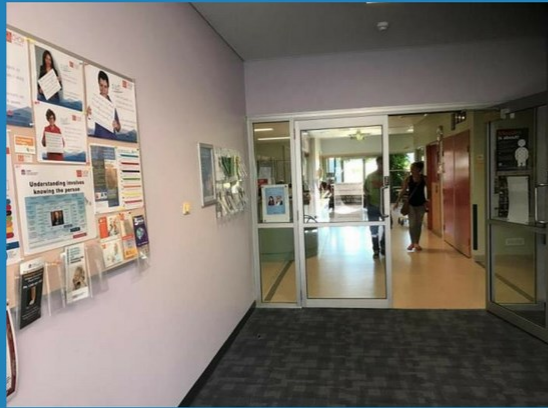




CREATE AN FAMILIAR PLACE

Consider ways to:

- ❖ assist patients to find their rooms more easily when the door is open e.g. a familiar bedspread, cushion etc
- ❖ reduce the clutter around the bedhead, arranging items for everyday use close to the patient



SIMPLE
ACTIONS -
NO COST

Signage review

Rethinking Clutter



SIMPLE ACTIONS - LOW COST

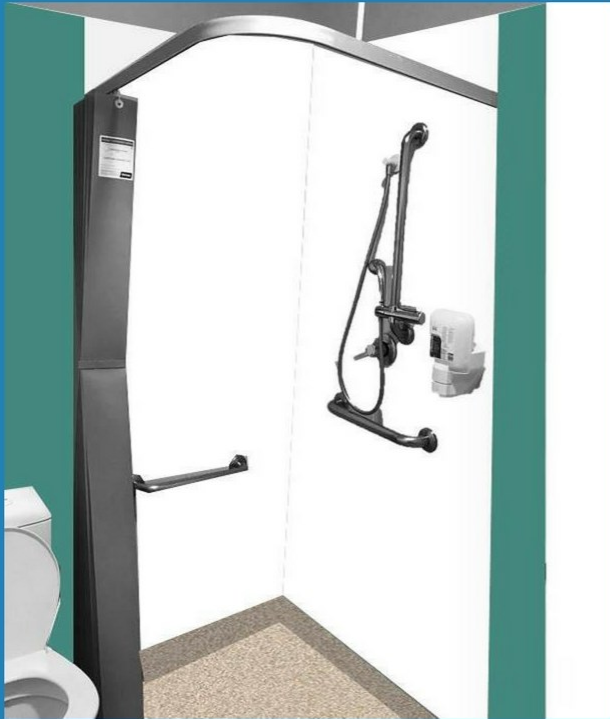


Paint Doors so staff areas
are less obvious

ACTIONS - HIGHER COST

Refurbish Bathrooms
Floor Coverings
Gardens and Outdoor
spaces.





Refurbish Bathrooms Floor Coverings

Lithgow and Portland 1st Steps

CARING FOR COGNITIVE IMPAIRMENT



Join the campaign and make a difference
cognitivecare.gov.au #BetterWayToCare

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Questions

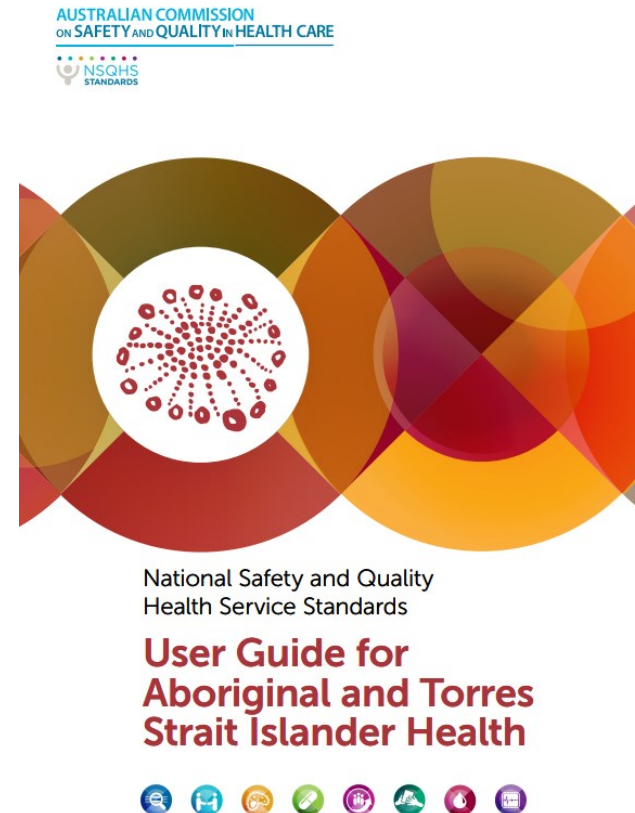
You can type your questions or comments in the control panel

Panel



Commission resources

- [NSQHS Standards \(second edition\)](#)
- [User Guide for Aboriginal and Torres Strait islander Health](#)
- [Caring for Cognitive impairment campaign](#)
-



Other resources

- [Dementia Training Australia](#)
- [Key Principles for Improving healthcare environments for people with dementia](#)
- [Dementia Enabling Environments](#)

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

CARING FOR COGNITIVE IMPAIRMENT



Join the campaign and make a difference
cognitivecare.gov.au #BetterWayToCare

cognitive.impairment@safetyandquality.gov.au

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Thank you

