Design for dementia care: international models

No one design for a dementia care environment will suit all individuals, so it is good to see a rich variety of examples across the world to to learn from, say Peter Heijmen and Christopher Manthorp

Recognition of individuality is the engine that should drive approaches to care – and this should apply equally to design of the care environment. People with dementia are all so different from each other that there is no single design or philosophical approach that will be best for everyone. Fortunately, there are a number of diverse examples to learn from. We need only look across some borders.

Czaar Peterpunt, Amsterdam, NL

Czaar Peterpunt, a care home for people living with advanced dementia in the centre of Amsterdam (Netherlands), is a converted residential block, built in 1900. Since its conversion in 2006, 24 people reside there, split into four units each housing six people. Each of the units resembles a household in that it is an arrangement of rooms not much different from a large family home. Units have a domestic style kitchen with standard utilities, a dinner table for eight, a sofa and chairs around the television. Each group is taken care of by a single staff member, who functions in a way that Dutch culture would be comfortable describing as the head of the family. He or she cooks, does the laundry and helps the residents. The residents contribute as well whenever they can, peeling potatoes or folding laundry. Residents have a private room, easily located because distances are short, and the house is familiar and feels safe. In their rooms, they have a basin, but the toilet and shower are shared.

This home is a good example of a concept that is no longer experimental: about one quarter of dementia homes in the Netherlands are built along the small scale grouping concept, and the vast majority of new homes are being built to this pattern. Official government policy has promoted this model since early 2009, but it has been encouraged for a considerably longer period. Clients, staff and family alike are enthusiastic about the care concept in most places where it has been implemented.

Hearthstone, Marlborough, USA

In Marlborough, Massachusetts (USA), one wing of a large residential elderly CCRC (Community Care Re-Housement Community) has been remodelled to make up one of seven Hearthstone Alzheimer care resources. Forty-eight residents, ranging from people with moderately severe dementia to 25 living with the last stages of the disease, live in a community that supports each to the best of their abilities. The home is spread over three floors, with common rooms and support elements on the ground floor and resident rooms on second and third levels.

The day is structured to encourage people away from their bedrooms and into communal space. Most of the time, residents are busy in groups or alone, since there is a continuous programme of activities with something for every level of capabilities and for different interests and lifestyles. Several common rooms are provided specifically for these activities. The concept is based on a need for community and purposeful activity building on 'hardwired' skills (skills that are retained even in later stage dementia, like the ability to understand and enjoy music together) – as opposed to the focus on safety and independence of the Dutch small group concept.

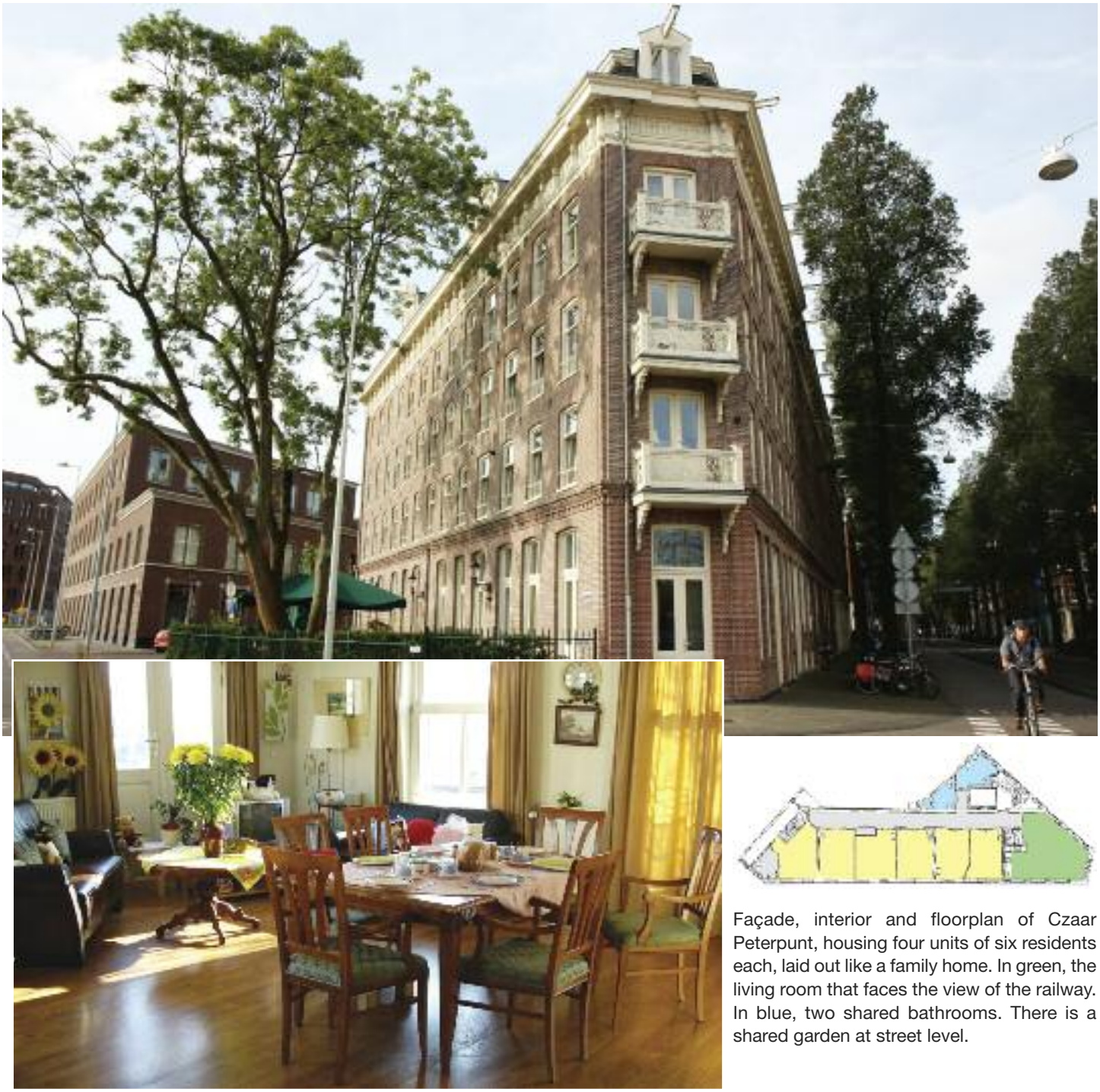
The Russets, Bristol, UK

Situated in the rural countryside outside Bristol, The Russets is a 36 resident unit split into three wings of 12 rooms each. Loosely based on Kingsway Court, a modern Australian design, it is built around an enclosed courtyard, with gardens and a summer house. Together with open plan kitchens and a mixture of quiet and more socially designed lounges, the gardens are the heart of The Russets. This is because the day centres on activities – cooking, hanging out the washing, finding the way to the permanently manned summer house in which more traditional activities are carried out. The scheme is thoughtfully designed to channel residents, visitors and staff towards engagement with one another and their environment.

Diversity and core values

These are just three examples of dementia homes designed in the 21st century. Though they have clear and important differences, there are underlying similarities. Internationally (notably in Europe, North America and Australasia), the modern models of design for dementia care that have come to fruition over the past twenty years have a lot in common. An important core premise is that dementia care should not be centred on the convenience of the caregiver, but focused on the person living with dementia.

Peter Heijmen is a researcher of healthcare buildings at TNO, the Dutch institute for applied scientific research. Christopher Manthorp is an independent consultant working for Barchester Healthcare.



Façade, interior and floorplan of Czaar Peterpunt, housing four units of six residents each, laid out like a family home. In green, the living room that faces the view of the railway. In blue, two shared bathrooms. There is a shared garden at street level.

A second premise is that people with dementia should be treated first and foremost as individuals with choices and expectations, needing a safe, comfortable homely home – not as patients to be warehoused in efficiently designed quasi-clinical institutions. The third and equally important premise is that good design for people living with dementia can and must embody, support and enhance such a philosophy of care – otherwise it will produce buildings without soul or real purpose.

These philosophies and the care models that have grown from them have not been developed by architects. They were initiated by care professionals, working with residents and families and reflect an urgent sense of a need to change the way they did their work in order to address the reasonable expectations of older people and their families. Starting from very different institutional approaches as points of departure, care professionals found themselves working towards similar goals and principles despite markedly diverse cultural, financial and legislative circumstances.

What the best engaged and thinking architects contribute to the most successful of these projects is entering into dialogues and producing designs that facilitate models of care that enrich the lives of the residents and the caregivers. A dementia home then is more than a shell around an efficient care process, but rather a safe, cheerful and harmonious living environment for people in an active phase of their lives. Space, light, connections with people and with the surroundings are as essential to people with dementia in need of care environments as they are to healthy people.

Of course cultural differences also mean philosophical and architectural differences expressed in modern residential care designs. A good example of these differences would be attitudes to privacy and relationships with staff. At Czaar Peter residents have a basin in their rooms but share toilets and bathrooms. The cultural assumption is that most residents need help in using the facilities and will feel no embarrassment in asking for this help in a friendly, family style environment. Having a private

Left: plan of The Russetts, Bristol, a 36 resident unit split into three wings of 12 rooms each, built around an enclosed courtyard with gardens and a permanently-manned summer house where more organised activities take place. Right, top and bottom: Hearthstone, Marlborough, USA, where the day is structured to encourage people away from their bedrooms and into communal space.

bathroom, then, is more of a burden than an asset – and not just economically. This is not an assumption that translates well: legislation in the UK demands en suite bathrooms, which The Russets reflects. Although this is not just a UK phenomenon this emphasis also reflects the extent to which the British will retreat to their rooms, valuing shared time in communal spaces but placing a premium on privacy. Hearthstone strikes a balance but most US care environments have bedrooms that open directly onto communal spaces. This means that all visitors will have to walk through the living room before meeting their loved one in private. Every movement in the house is noticed by everyone in the house, and when doors are left open, the private room effectively becomes part of the communal space.

The balance of privacy and communal living is one of a number of issues that stand out as candidates for a constructive debate. The mixing or separation of residents living with different stages of illness is another. Group size and team organisation, of course, will always be a part of these debates, as will the balance between 'normalising' environments that concentrate on avoiding the institutional as against environments designed to provide people living with dementia with plentiful visual cues to where they are and to help with orientation through activities. Debates on these issues are vital and healthy. What is really disappointing about current approaches to design for dementia care is the extent to which they take place in isolation. There is a certain amount of discussion and exchange between architects and care providers within their own countries, but almost none on a cross cultural level. There are notable exceptions, of course: Damian Utton's excellent book (Utton 2007), which includes 50 examples of environments from around the world or Garuth Chalfont's work on integrating gardens and activities (Chalfont 2007), but they are few and far between. Real opportunities for learning from one another are being missed.

This is not to say that we should be aiming for standardisation. The current diversity of environments reflects cultural differences and the needs of individuals as it should. Unfortunately, governments, inspectors and private care organisations trying to guarantee a minimum of quality of care (and control costs at the same time) have a tendency to arrive at a standard through historical or cultural accident and then to make it hard to deviate from that. In the Netherlands, design for dementia care is not as diverse as it could be, because there is one preferred model. This is the international norm. At the same time, the differences between those preferred models are such that it should not be too hard to learn from each other. A process of exchange would enrich all parties and make for transferrable gains.

It is not difficult to imagine a model taking elements from all three of the environments discussed at the beginning of this article. Transferring a concept to a different cultural setting will mean it working just a bit differently. In a time when cultural backgrounds are becoming more diverse everywhere, let us use our diverse experience and combined creativity and further enrich the lives of people with dementia.

References

Chalfont GE (2008) *Design for nature in dementia care*. London: Jessica Kingsley Publishers.

Utton D (2007) *Designing homes for people with dementia*. London: Hawker Publications.