OpeMed (Europe) Ltd
Clockhouse, Farnham
Surrey. GU9 7UD. United Kingdom
T: +44 (0)1252 758858
F: +44 (0)870 1619681
E: info@opemed.net

White Paper: Understanding Design and Development for Dementia 2014

INTRODUCTION

Traditionally, care for older people with dementia has been focussed on the delivery of care services and nursing, the majority of care homes and nursing across the UK operate on the basis of delivering active assistance and care to largely passive residents.

Gradually a transition is taking place which began in Northern Europe but is now spreading to the more forward thinking care organisations in the UK. This transition is moving the delivery of care away from a basis in the accepted norm of delivering care via assistance with eating, dressing, taking medication, etc to looking at the actual,

Registered in England : 6495104 VAT No: GB 928864865

individual subjective experiences of people with dementia and the individual way they cope with the consequences of their illness. This trend is referred to, inter alia, as the 'socialization of care'; the 'personalisation agenda' or simply 'person-centred care'.

In a nutshell, it is about understanding the individual and using that understanding to help stimulate, soothe, and generally interact with residents on an individual basis. Getting to know a person in detail is the first key step. In that way if the resident gets agitated or frustrated, the care giver will know what to do to help soothe to take away stress. A simple example would be playing music that the care giver knows the resident finds soothing and has happy associations with the resident's past. It would be no good playing a piece of classical music to help calm a person who cannot stand classical music for example, or playing music which has bad associations for that person. Working with the resident's family is clearly key to this process.

As dementia cannot yet be cured, the emphasis is now on **improving quality of life**, with equal attention for care, quality of life and welfare. This transition has led to important developments in health care:-

- Getting away from an institutional delivery of healthcare and getting back to basic life-affirming things such as enjoying the natural environment, enjoying the health giving benefits of natural daylight, living in safe, domestic-scale dwellings not hospital wards.

- A focus on lifestyle-related care and service: care should fit the feelings, preferences and emotional needs of individual residents, including those with dementia. It is about recognising and appreciating that residents have a unique personality which should inform how they are supported. There should be no 'one size fits all' approach.
- Seeing the world from the perspective of the person with dementia – recognising that each person's experience has its own psychological and emotional validity, that people living with dementia act from this perspective and that empathy with this perspective has its own therapeutic potential.
- Recognising that all human life, including that of people with dementia is grounded in social relationships – that people living with dementia and the people who support them need an enriched environment of social support, which compensates for any disability and fosters opportunity for personal growth.

THE ENVIRONMENT

In delivering person- centred care, there are three key elements which need to be addressed by the built environment:-

- Cognitive Ability is improved by promoting the use of familiar and recognisable surroundings and activities that respond to residents' deepest and earliest memories. This could be as simple as unloading

shopping, chopping vegetables at a kitchen table or folding washing.

- Social Ability is addressed through the design of artefacts and amenities that create opportunities for residents and staff to interact more easily in activities of daily living. Central living areas and places for everyday activities to take place are central to this.
- Physical Ability is promoted through design which unobtrusively compensates for disabilities such as mobility and limited vision which are prevalent among care home residents. Easy way-finding and visual clues to help with recollection are also important to avoid confusion leading to increased anxiety.

An important distinction or characteristic which is almost always overlooked in developing new dementia care units is the differing (normally four) stages of dementia: from early stage to end stage. This comes back to recognising the individual and their particular set of circumstances: the physical environment needs to vary for people living through these different stages of dementia.

DEMENTIA STAGE	ACTIVITY LEVEL	BUILT ENVIRONMENT
Early stage	Goal directed planned activity level	This requires many visual clues, reminders of place and time to help 'ground' a person with early stage dementia. The emphasis is on activity and stimulation of the mind and senses. Promotion of independence and choice.
Mid stage	Exploratory activity level	Requires presence of familiar activities, repetitive actions (folding washing, etc). Choices need to be limited to avoid confusion. Reminiscence is important. Memory aids useful and need to reduce distractions.
Repetitive stage	One to two step sensory activity level	Resident needs comfort at this stage. Narrow visual field, safety and security paramount. Stimulation or relaxation as mood dictates. Sensory stimulation important. Not mobile.
End stage	Reflex activity level	Subliminal or subconscious actions. Avoid over- stimulation. Daylight / warmth / sunshine / music / smells / reflex actions only. Calm tranquil environment needed.

A key aspect of designing for a cognitive impairment like dementia is to **build on the strengths that residents still have. Design should not just aim to support residents' disabilities, but utilise their remaining abilities.** There are a number of ways in which this can be done.

A person with dementia will find it easier to remember a fact or procedure when they are prompted by a reminder or a memory aid. This is generally termed recollection. What becomes more difficult is recalling information without a leading link, such as trying to recall what clothes a person wore yesterday. This is more to do with recognition. Utilising the power of recollection has many applications in dementia care.

DESIGN CONSIDERATIONS

The building layout of a care home should be based around

significant places that are held within a person's oldest and strongest memories. New environments that use unfamiliar typologies will not help a person to recollect the purpose of that space or how they should interact with it. The internal rooms are easier to manage as they will include recognisable objects such as dining tables in a dining room, or a bed in a bedroom and will, therefore, be more identifiable from a person's past. They will appeal to a person's earlier memories and in most cases evoke positive and useful associations.

Externally, however, the building will have to be designed to have memory aids / visual clues to aid recollection. Residents should be housed in small domestic scale units that will have visual clues externally. So, for example, a resident being housed in a building with a clock tower or weather vane will remember that as a visual clue / memory aid which will signify that they are at home and therefore decrease their anxiety levels. Another resident may be housed in a building with applied render or in a timber clad building which has been colour treated to aid memory in addition to having bright coloured front doors and other domestic memory triggers such as a hanging basket at the back door or a circular window rather than a rectangular one, etc.

In addition to evoking memories of home and familiar settings, these visual clues are also useful for 'wayfinding' around the building and the site as, again, the loss of recognition makes remembering the plan form of a building difficult. Pictorial representations can also be used internally

and easily identifiable signage can be used to explain the function of rooms and therefore aid wayfinding via recollection.

Critical to the ethos of this development is the sub-division of the home into small, familial, domestic scale units. Each living unit should be sub-divided into smaller units, giving a feel of being part of a household rather than a large institution.

SOCIALISATION WITHIN DESIGN

A major part of the use of socialising activities as therapeutic treatment and which stimulate and reinforce positive associations and earlier recollections are based on the natural environment, particularly gardening, growing flowers and vegetables and looking after animals. These are all powerful therapeutic tools for providing care for people with dementia.

Developments should provide both organized and informal nature-based activities from a homely building that maximizes access to dementia-friendly gardens. **The inside of the living areas should be light, and the gardens visible from as many rooms as possible. An emphasis should be on the 'edge spaces', where the inside meets the outside.**

Having dementia friendly gardens and allotments, with linkages to Social and Therapeutic Horticulture programmes and support have been shown to have a huge positive

impact on the wellbeing of dementia residents and particularly when linked to interventions aimed at recreating normal household family life.

The gardens associated with these projects must be of sufficient size to accommodate the number of residents and the requisite glass houses, potting sheds, individual plots and group gardens required for the success of the project.