

# **ENVIRONMENTAL ASSESSMENT TOOL - ACUTE CARE HANDBOOK**

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**RESOURCE 7**

**Suite of Environmental  
Design Resources**

**September 2020**



**Dementia Training Australia  
ENVIRONMENTS**

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# **EAT-ACUTE CARE HANDBOOK**

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ASHLEE OSBORNE  
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Design Resources**

September 2020



# DEMENTIA TRAINING AUSTRALIA

# ENVIRONMENTAL

# DESIGN RESOURCES

## TABLE OF CONTENTS

### Introduction

### Resource 1: Using the built environment to create comprehensible, manageable and meaningful environments for people with dementia

<b>PART 1</b>	<b>Dementia: its prevalence and impact</b> .....	1
1.1	Introduction.....	2
1.2	People with dementia in residential aged care.....	4
1.3	People with dementia in hospitals.....	5
1.4	People with dementia in the community.....	6
<b>PART 2</b>	<b>A review of the literature on environmental design for people with dementia</b> .....	9
2.1	<b>Unobtrusively reduce risks</b> .....	10
2.1.1	Falls prevention.....	12
2.1.2	Over emphasis on safety.....	13
2.2	<b>Provide a human scale</b> .....	14
2.2.1	Number of places (beds) in the facility.....	14
2.2.2	Physical size of the facility.....	17
2.2.3	Social density.....	17
2.3	<b>Allow people to see and be seen</b> .....	18
2.3.1	Wayfinding.....	19
2.3.2	Benefits for staff.....	19
2.4	<b>Reduce unhelpful stimulation</b> .....	19
2.4.1	Over-stimulating entry doors.....	20
2.4.2	Noise and temperature.....	21
2.5	<b>Optimise helpful stimulation</b> .....	21
2.5.1	Signage.....	22
2.5.2	Using familiar objects.....	23
2.5.3	Contrast.....	24
2.5.4	Good illumination.....	24
2.6	<b>Support movement and engagement</b> .....	27
2.6.1	Access to nature.....	27
2.6.2	The role of staff in facilitating the use of the garden.....	27
2.6.3	Opportunities for engagement.....	28
2.7	<b>Create a familiar place</b> .....	29
2.7.1	Technology.....	29
2.7.2	Cultural differences.....	29

<b>2.8</b>	<b>Provide a variety of places to be alone or with others in the unit</b> .....	29
2.8.1	Single rooms.....	31
2.8.2	Variety of spaces in hospitals.....	31
<b>2.9</b>	<b>Provide a variety of places to be alone or with others in the community</b> .....	31
2.9.1	Links to the community in hospitals.....	32
<b>2.10</b>	<b>Design in response to vision for way of life</b> .....	32
2.10.1	Domestic or homelike environments.....	33
<b>2.11</b>	<b>Summary</b> .....	38
<b>PART 3</b>	<b>References</b> .....	41

## Resource 2: **Applying the key design principles in environments for people with dementia**

<b>PART 1</b>	<b>Key Design Principles</b> .....	49
<b>PART 2</b>	<b>Principles not checklist</b> .....	53
<b>PART 3</b>	<b>Assessment Tools</b> .....	57
3.1	<b>Selection of an Assessment Tool</b> .....	58
3.2	<b>Available Assessment Tools</b> .....	60
<b>PART 4</b>	<b>Using the EAT family of tools</b> .....	63
4.1	<b>Consultation</b> .....	64
4.2	<b>Listening</b> .....	65
4.3	<b>Priorities</b> .....	65
<b>PART 5</b>	<b>Stepping through the conversation</b> .....	67
<b>PART 6</b>	<b>Case studies</b> .....	75
6.1	<b>Working on the plans</b> .....	76
	Murray House, Wentworth	
6.2	<b>Working on an existing building</b> .....	82
	Melaleuca Glengowrie Blue Cross	
6.3	<b>Working on an existing building</b> .....	95
	Flametree Illawarra Retirement Trust	
6.4	<b>Working on an existing building</b> .....	106
	Multi Purpose Service Oberon	
6.5	<b>Planning a culturally appropriate place</b> .....	119
	Tjilpiku Pampaku Ngura	
<b>APPENDIX 1</b>	<b>Planning Template</b> .....	127

**Resource 3: Environmental Assessment Tool (EAT) Handbook**

<b>PART 1</b>	Key Design Principles.....	131
<b>PART 2</b>	Environmental Assessment Tool.....	135
<b>PART 3</b>	Using the Spreadsheet.....	139
<b>PART 4</b>	Applying the Principles.....	145
<b>APPENDIX 1</b>	Environmental Assessment Tool.....	185
<b>APPENDIX 2</b>	Planning Template.....	193

**Resource 4: Environmental Assessment Tool - Higher Care (EAT-HC) Handbook**

<b>PART 1</b>	Key Design Principles.....	197
<b>PART 2</b>	Environmental Assessment Tool - Higher Care.....	201
<b>PART 3</b>	Using the Spreadsheet.....	205
<b>PART 4</b>	Applying the Principles.....	211
<b>APPENDIX 1</b>	Environmental Assessment Tool - Higher Care.....	257
<b>APPENDIX 2</b>	Planning Template.....	271

**Resource 5: Dementia Friendly Community - Environmental Assessment Tool (DFC-EAT) Handbook**

<b>PART 1</b>	Key Design Principles.....	275
<b>PART 2</b>	Dementia Friendly Community - Environmental Assessment Tool ..	279
<b>PART 3</b>	Using the Spreadsheet.....	283
<b>APPENDIX 1</b>	Dementia Friendly Community - Environmental Assessment Tool ..	287
<b>APPENDIX 2</b>	Planning Template.....	291

**Resource 6: Indigenous Aged Care Design Guide**

<b>PART 1</b>	INTRODUCTION AND BACKGROUND.....	295
	Who will use the Guide? .....	296
	Planning a residential aged care facility .....	297
	Creating an Enabling Environment - Accessibility.....	297
	Why this is a design guide and not an operational manual .....	297
	How the operation of the facility will influence design .....	298
	Role of staff .....	298
	Staff needs vs resident needs.....	298
	Staff areas.....	299
	Compliance.....	299

<b>PART 2</b>	<b>HOW TO USE THE GUIDE</b> .....	301
	The 10 Key Design Principles.....	301
	The Indigenous Environmental Assessment Tool .....	306
	Building Services Survey Sheets .....	311
<b>PART 3</b>	<b>THE 10 DESIGN PRINCIPLES IN DETAIL</b> .....	313
1	Unobtrusively Reducing Risk .....	313
2	Focusing on the Small Scale .....	339
3	Seeing and Being Seen .....	345
4	Hiding Unimportant Things .....	363
5	Emphasising Important Things .....	373
6	Moving About and Engaging .....	385
7	Creating a Recognisable and Meaningful Place.....	399
8	Choosing to be on Your Own or With Others.....	407
9	Being Part of the Community .....	417
10	Doing What You Want to Do .....	421
<b>APPENDIX 1</b>	<b>Indigenous Environmental Assessment Tool</b> (sheets to be copied).....	441
<b>APPENDIX 2</b>	<b>Staff and support areas</b> .....	457
<b>APPENDIX 3</b>	<b>Electrical Safety</b> .....	466
<b>Resource 7:</b>	<b>EAT-Acute Care Assessment Tool Handbook</b>	
<b>PART 1</b>	<b>Key Design Principles</b> .....	469
<b>PART 2</b>	<b>An Acute Health Care Literature Review</b> .....	473
<b>PART 3</b>	<b>Environmental Assessment Tool-Acute Care</b> .....	491
<b>PART 4</b>	<b>Using the Spreadsheet</b> .....	495
<b>PART 5</b>	<b>Applying the Principles</b> .....	501
<b>APPENDIX 1</b>	<b>Environmental Assessment Tool-Acute Care</b> .....	559
<b>APPENDIX 2</b>	<b>EAT-Acute Care Planning Template</b> .....	573

# INTRODUCTION

The Environmental Assessment Tool-Acute Care Handbook is the latest addition to Dementia Training Australia's Environmental Design Resources. It is designed to be used in acute health care settings where patients stay for up to a week. (Where patients stay longer, the EAT or EAT-HC is the more appropriate tool to use.)

The purpose of this handbook is to support those who wish to improve acute care environments for people living with dementia. As with other handbooks in this collection, it introduces the reader to a systematic way of looking at the built environment and provides tools that guide the user to an understanding of what needs to be changed, and how the change might be accomplished.

To create a supportive environment for people living with dementia, the environment and operational philosophy need to complement each other. Despite the best efforts of staff, the physical environment sets a limit on what can be achieved in the support of people living with dementia – particularly people who are mobile. A good environment can reduce confusion and agitation, improve wayfinding and encourage social interaction. On the other hand, a poor environment increases confusion and results in behaviour that causes distress to people living with dementia and others, and will eventually reduce staff to a state of helplessness in which they feel that nothing can be done. The effects of a well designed environment on people living with dementia are summarised in Table 1 below.

**Table 1: Effects of a well designed environment on people living with dementia**

Improvements in:-	Reductions in:-
<ul style="list-style-type: none"> <li>• Wayfinding</li> <li>• Eating behaviour</li> <li>• Motor functions</li> <li>• Activities of daily living</li> <li>• Self-help skills</li> <li>• Mobility</li> <li>• Pleasure</li> <li>• Use of toilet</li> <li>• Vitality</li> <li>• Interactions between staff and patients</li> <li>• Independence in dressing</li> <li>• Ease of supervision</li> <li>• Likelihood of patients making friends with one another</li> <li>• Quality of life</li> </ul>	<ul style="list-style-type: none"> <li>• Agitation</li> <li>• Anxiety</li> <li>• Conflict</li> <li>• Confusion</li> <li>• Depression</li> <li>• Dyspraxia</li> <li>• Emotional disturbance</li> <li>• Number of falls</li> <li>• Restlessness</li> <li>• Stress associated with bathing</li> <li>• Amount of physical help required</li> <li>• Time spent by staff locating and monitoring patients</li> <li>• Number of attempts to leave</li> <li>• Doses of antibiotics and psychotropic drugs</li> <li>• Going into others people's spaces</li> </ul>

There are five parts in this handbook:

- Part 1:** 'Key Design Principles' contains a description of key design principles
- Part 2:** 'An Acute Health Care Literature Review' describes the evidence that informs the principles.
- Part 3:** The 'Environmental Assessment Tool-Acute Care' introduces the tool and provides directions for its use.
- Part 4:** 'Using the spreadsheet' contains a guide to scoring the EAT-Acute Care and showing the results graphically. It includes a planning template to assist planning for change.
- Part 5:** 'Applying the principles' provides information about the questions contained in the EAT-Acute Care and outlines design considerations for each of the questions.
- Appendix 1:** Environmental Assessment Tool-Acute Care
- Appendix 2:** EAT-Acute Care Planning Template

**RESOURCE 7**

**EAT-Acute Care  
Handbook**

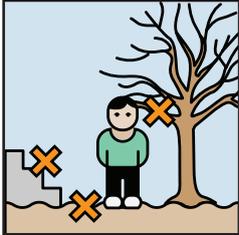


**PART 1**  
**KEY DESIGN  
PRINCIPLES**

## PART 1

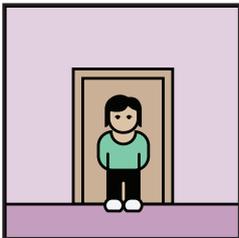
# KEY DESIGN PRINCIPLES

### 1. UNOBTUSIVELY REDUCE RISKS



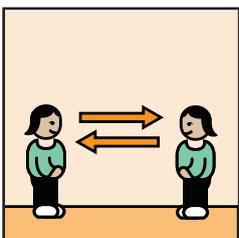
People living with dementia require an internal and external environment that is safe and easy to move around if they are to continue to pursue their way of life and make the most of their abilities. Potential risks such as steps must be removed. All safety features must be unobtrusive as obvious safety features, such as fences or locked doors, can lead to frustration, agitation and anger or apathy and depression.

### 2. PROVIDE A HUMAN SCALE



The scale of a building can affect the behaviour and feelings of a person living with dementia. The experience of scale is influenced by three key factors; the number of people that the person encounters, the overall size of the building and the size of the individual components (such as doors, rooms and corridors). A person should not be intimidated by the size of the surroundings or confronted with a multitude of interactions and choices. Rather the scale should encourage a sense of wellbeing and enhance the competence of a person.

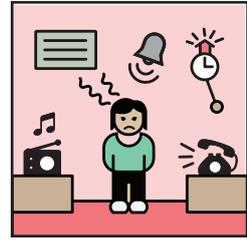
### 3. ALLOW PEOPLE TO SEE AND BE SEEN



The provision of an easily understood environment will help to minimise confusion. It is particularly important for people living with dementia to be able to recognise where they are, where they have come from and where they can go. When a person can see key places, such as their bed, a toilet, a place to sit, kitchenette and an outdoor area they are more able to make choices and see where they want to go. Buildings that provide these opportunities are said to have good visual access. Good visual access opens up opportunities for engagement and gives the person living with dementia the confidence to explore their environment. It can also enable staff to see patients. This reduces staff anxiety about the patients' welfare and reassures the patient.

## 4. REDUCE UNHELPFUL STIMULATION

Because dementia reduces the ability to filter stimulation and attend to only those things that are important, a person living with dementia becomes stressed by prolonged exposure to large amounts of stimulation. The environment should be designed to minimise exposure to stimuli that are not specifically helpful to the patient, such as unnecessary or competing noises and the sight of signs, posters, places and clutter that are of no use to the patient. The full range of senses must be considered. Too much visual stimulation is as stressful as too much auditory stimulation.



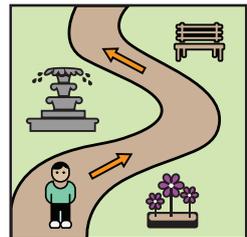
## 5. OPTIMISE HELPFUL STIMULATION

Enabling the person living with dementia to see, hear and smell things that give them cues about where they are and what they can do, can help to minimise their confusion and uncertainty. Consideration needs to be given to providing redundant cueing i.e. providing a number of cues to the same thing, recognising that what is meaningful to one person will not necessarily be meaningful to another. Using text and image in signs is a simple way to do this. Encouraging a person to recognise their bedroom through the presence of furniture, the colour of the walls, the design of a light fitting and/or the bedspread is a more complex one. Cues need to be carefully designed so that they do not add to clutter and become over stimulating.



## 6. SUPPORT MOVEMENT AND ENGAGEMENT

Purposeful movement can increase engagement and maintain a person's health and wellbeing. It is encouraged by providing a well defined pathway, free of obstacles and complex decision points, that guides people past points of interest and opportunities to engage in activities or social interaction. The pathway should be both internal and external, providing an opportunity and reason to go outside when the weather permits.

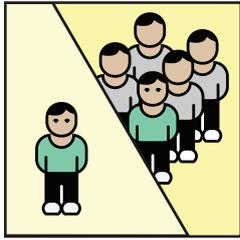


## 7. CREATE A FAMILIAR PLACE

A person living with dementia is more able to use and enjoy places and objects that are familiar to them from their early life. The environment should afford them the opportunity to maintain their competence through the use of familiar building design (internal and external), furniture, fittings and colours. The personal backgrounds of the patients need to be reflected in the environment. The involvement of the person living with dementia in personalising the environment with their familiar objects should be encouraged.

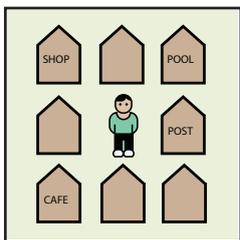


## 8. PROVIDE A VARIETY OF PLACES TO BE ALONE OR WITH OTHERS



People living with dementia need to be able to choose to be on their own or spend time with others. This requires the provision of a variety of places in the ward, some for quiet conversation and some for larger groups, as well as places where people can be by themselves. These internal and external places should have a variety of characters, e.g. a place for reading, looking out of the window or talking, to cue the person to engage in relevant activity and stimulate different emotional responses.

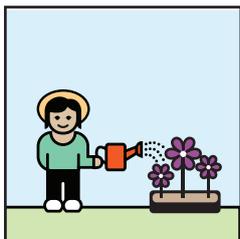
## 9. LINK TO THE COMMUNITY



Without constant reminders of who they are, a person living with dementia will lose their sense of identity. Frequent interaction with friends and relatives can help to maintain that identity and visitors should be able to drop in easily and enjoy being in places that encourage interaction.

Stigma remains a problem for people living with dementia. Where possible a 'bridge' should be built between the ward and the community by providing a place that is shared by the community and people living with dementia. A coffee shop near the ward, for example, may enable a person living with dementia to go there easily without needing assistance.

## 10. DESIGN IN RESPONSE TO VISION FOR WAY OF LIFE



While a 'vision for a way of life' may seem out of place in an acute ward because of the focus on treatment and the brevity of the stay, it should be remembered that brief disruptions to the feelings of competence and worth can have a great effect on a person living with dementia. Some hospitals have a very clearly defined vision for a way of life – those that are operated by religious orders, for example. The built environment of these hospitals clearly supports the vision in the way the architecture reflects the values and traditions of the religious order and the spaces provide opportunities for the continuation of valued experiences, e.g. contact with nature, a view of the sky, places for reflection and quiet conversation.

The core of any vision for a way of life is the maintenance of a sense of agency, the feeling that 'I can choose'. So, in its simplest form, the application of the principle of responding to a vision for a way of life involves providing the person living with dementia opportunities to live the life they want to live in the circumstances they are in. In most acute wards these choices are limited but some basic choices should always be available, e.g. to have high or low levels of illumination and the choice of being in a quiet place. If there are no choices available, or if the choices are provided in a way that is not understandable by the person living with dementia, the environment is incapable of supporting any vision for a way of life.

These principles are an extension of work first published in 1987 [1] and continued in 2003[2].

### References

1. Fleming, R. and J. Bowles, Units for the confused and disturbed elderly: Development, Design, Programming and Evaluation. Australian Journal on Ageing, 1987. 6(4): p. 25-28.
2. Fleming, R., I. Forbes, and K. Bennett, Adapting the ward for people with dementia, 2003. Sydney: NSW Department of Health.

**RESOURCE 7**

**EAT-Acute Care  
Handbook**

**PART 2**  
**AN ACUTE HEALTH  
CARE LITERATURE  
REVIEW**

## PART 2

# AN ACUTE HEALTH CARE LITERATURE REVIEW

### INTRODUCTION

There has been a substantial amount of research on the effects of aspects of the built environment on people living with dementia. It has usually been aimed at identifying how the environment can be designed or modified to reduce the difficulties experienced by a person living with dementia who is in residential aged care or in hospital.

In 2014 The Agency for Clinical Innovation (ACI) Aged Care Health Network commissioned Professor Richard Fleming and Architect Kirsty Bennett of the NSW/ACT Dementia Training Study Centre (now Dementia Training Australia), University of Wollongong to prepare the Key Principles for Improving Health Care Environments for People with Dementia [4]. It built on the publication ‘Adapting the Ward’ by Richard Fleming, Ian Forbes and Kirsty Bennett that was published in 2003 by the NSW Dept of Health<sup>5</sup>.

In 2020 a review of literature published between June 2013 and June 2019 was undertaken to

- a) identify any new research related to the 10 evidence based principles and
- b) identify any new or emerging areas of research on the impact and design of acute health care environments for people living with dementia.

This literature review focused on the 10 evidence based principles that define an appropriate physical environment for the care of people living with dementia in an acute health care setting (refer Part 1). For many people and their families, hospital is a challenging setting due to the busy, unfamiliar and stressful nature of the environment. Living with a disability, cognitive impairment or the physical, sensory or cognitive impacts of old age can make this experience even more challenging. There is an increasing awareness, supported by research, that the hospital environment has an important role to play in improving the experience of people living with a disability including dementia, those that provide support (family and friends) and those that care for them (medical, nursing, allied health and support staff).

### DEMENTIA IN ACUTE HEALTH CARE

Dementia is a major cause of ill health and death in Australia, affecting up to 436,000 Australians in 2018 and causing more than 13,700 deaths in 2017. Dementia is currently the second leading cause of death in Australia and the leading cause of death among Australian females<sup>1</sup>.

According to the Australian Institute of Health and Welfare<sup>1</sup> there were almost 95,000 hospitalisations of people with a diagnosis of dementia during 2016-2017. Of these hospitalisations, 92% involved at least one overnight stay, with an average length of stay of 13 days. This is compared to an average stay of 2.7 days during the same period (2016-17) for people who did not have a diagnosis of dementia<sup>2</sup>.

Of those who came to hospital with an existing diagnosis of dementia, dementia was recorded as the principal diagnosis for about 1 in 5 (22%) of these people, and for the other 78% dementia was recorded as an additional diagnosis. Where dementia was an additional diagnosis, the most common principal diagnosis was related to injury (21%), and more than 1 in 3 (36%) of these were for a leg fracture<sup>2</sup>.

Hospital admissions were mostly for acute care (72%)—followed by geriatric evaluation and management (8%), maintenance care (7%) and rehabilitation care (6%)—and commonly began with a new admission from the community (70%)<sup>2</sup>.

In 2016-17, almost all (97%) hospitalisations with a diagnosis of dementia were assigned to the highest or second highest categories for clinical complexity\*. Further, the majority (71%) of dementia hospitalisations were of the highest clinical complexity, compared with 16% of hospitalisations of people without a diagnosis of dementia<sup>3</sup>.

*\*Clinical complexity, is based on the Australian refined diagnosis related group (AR-DRG) assigned to each hospitalisation. AR-DRGs classify units of hospital output. The classification groups inpatient stays into clinically meaningful categories of similar levels of complexity (outputs) that consume similar amounts of resources (inputs).<sup>3</sup>*

## A REVIEW OF THE LITERATURE

A review of the literature shows that there is sufficient support for the key principles of design (Refer Part 1) to be used to structure the way we understand the impact the built environment can have on people living with dementia. This is not to say that the principles provide a black or white answer, a right or wrong view. These are best seen as a starting point for a conversation, and there are a number of factors to take into account when applying them. The evidence is discussed below according to the key design principles. This will assist the reader to understand the content and structure of the EAT-Acute Care.

## PRINCIPLE 1. Unobtrusively reduce risks

**People living with dementia require an internal and external environment that is safe and easy to move around if they are to continue to pursue their way of life and make the most of their abilities. Potential risks such as steps must be removed. All safety features must be unobtrusive as obvious safety features, such as fences or locked doors, can lead to frustration, agitation and anger or apathy and depression.**

### 2.1 Evidence base

A person living with dementia will often experience confusion as their cognitive ability declines. This is likely to be heightened in an unfamiliar setting such as a hospital, and when the person is under stress. Incorporating safety measures into an environment is desirable to minimise the possibility of harm resulting from this situation.

Safety measures often include the provision of a secure perimeter<sup>6</sup> There is some evidence that there is an overemphasis on safety in British<sup>7</sup> and Australian healthcare facilities providing care to people living with dementia [8], and it is important to note that patients may respond negatively to a safety or security measure if it obviously impedes their freedom<sup>9-11</sup>. Freedom of movement (or lack of it) has been identified as an important theme in the experience of patients with dementia in hospital. Inhibiting freedom of movement can create tension and may result in constant negotiation being needed between patients and staff.<sup>12</sup> Providing any safety measures as unobtrusively as possible is the best way to avoid these negative outcomes<sup>13,14</sup>. In the case of a perimeter fence, for example, planting can be used to hide a fence that is intended to prevent someone from leaving the area when it might not be safe for them to do so. In this instance, rather than seeing a fence, a person will see a garden, an opportunity rather than a barrier.

In research where people living with dementia have been asked about their experiences in acute care settings, the provision of a place of safety was identified as a key theme. However, safety meant not only physical safety but also feeling emotionally and psychologically safe.<sup>15,16</sup>

The safety and wellbeing of all patients needs to be considered, and sometimes a purpose designed inpatient unit for people living with dementia is desirable (for them and for other patients).<sup>17</sup> These units ideally include more space (at least 30 square meters per patient),<sup>18</sup> a garden, a quiet area, a place to be away from other patients, and a place for activities. There should also be a specific model of care.<sup>17,19,20</sup>

The prevention of falls is another key safety concern although Australian data is not readily available to support this. The provision of specialised care has been shown to reduce falls.<sup>21</sup> A significant reduction in injuries associated with falls has been achieved in some settings by providing furniture that puts the person living with dementia closer to the ground through the use of bean bag chairs, futons and mattresses placed on the floor.<sup>22</sup> This approach ensures that if a fall does take place, it does not occur from a great height. There is, however, significant concern that this is still a form of restraint, as is the use of bed rails. It is also interesting to note that evidence from a study involving 2000 patients suggests that the physical restraint of cognitively impaired patients does not reduce the risk of falls.<sup>23</sup> A 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 environment).<sup>24</sup> This view is supported in a thorough review of the use of restrictive devices to minimise the risk of falling in people with dementia.<sup>25</sup>

## PRINCIPLE 2. Provide a human scale

**The scale of a building can affect the behaviour and feelings of a person living with dementia. The experience of scale is influenced by three key factors; the number of people that the person encounters, the overall size of the building and the size of the individual components (such as doors, rooms and corridors). A person should not be intimidated by the size of the surroundings or confronted with a multitude of interactions and choices. Rather the scale should encourage a sense of wellbeing and enhance the competence of a person.**

### 2.2 Evidence base

The development of special care units for people living with dementia has been influenced by the view that larger facilities increase agitation and are confusing for residents<sup>26, 27</sup> and high quality care is easier to provide in small groups.<sup>14, 28</sup> However, a small scale unit is almost always accompanied by a particular approach to the delivery of care, such as providing a homelike environment that focusses on activities of daily living.<sup>29</sup>

The variation in models of care may explain the variation in the findings on this topic. Zeisel, for example, found less social withdrawal in larger units [13], while a large study found no link between small size and low levels of neuropsychiatric symptoms.<sup>30</sup> The relative importance of the model of care as a modifier of behaviour (rather than size of unit) has also been noted in long term hospital care settings.<sup>31</sup> In aged care, the evidence tends to suggest that the best outcomes occur when the resident lives in a small unit but has access to a larger social network.

The theme of access to other areas for social interaction to reduce patient density has been picked up in the acute care literature with suggestions for providing direct access to usable outdoor space as well as providing access to open communal areas.<sup>32</sup>

A domestic scale and feel have been recommended in the acute care setting in order to make the inpatient experience more familiar and less confusing.<sup>32-34</sup> Compact units have been found to provide greater comfort, a more homelike atmosphere, better opportunities for monitoring patients.<sup>35</sup> improved orientation and prevention of alienation.<sup>36</sup>

Long corridors in acute care settings have been identified as potentially overwhelming, and recommendations have been made that circulation routes should be subdivided to create a more human scale, with clearly identifiable staff bases to aid orientation.<sup>36</sup>

### PRINCIPLE 3. Allow people to see and be seen

**The provision of an easily understood environment will help to minimise confusion. It is particularly important for people living with dementia to be able to recognise where they are, where they have come from and where they can go. When a person can see key places, such as their bed, a toilet, a place to sit, kitchenette and an outdoor area they are more able to make choices and see where they want to go. Buildings that provide these opportunities are said to have good visual access. Good visual access opens up opportunities for engagement and gives the person living with dementia the confidence to explore their environment. It can also enable staff to see patients. This reduces staff anxiety about the patients' welfare and reassures the patient.**

#### 2.3 Evidence base

Confusion may be reduced for a person living with dementia when she or he can see everywhere that she or he wants to go to from wherever they are. While acute care buildings are often large (making this difficult to achieve), if they are seen as being made up of many different components this principle which focusses on providing good visual access can be applied to each part of the building.

This principle defined the plans of the purpose designed CADE units built by the NSW Department of Health in the late 1980's. These units were shown to improve self-help, socialization and behaviour.<sup>37, 38</sup> It is also associated with improved orientation.<sup>39, 40</sup> Disorientation has been found to be less pronounced in L, H and square shaped units where the key locations such as dining and activity rooms were located together<sup>40</sup> and where the straight line layout of the circulation system (ie without any change of direction of the corridors) provided good visual access.<sup>27</sup>

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 staff anxiety. At the same time if patients can see staff this will help them feel supported. It is not surprising that staff working in facilities with good visual access spend less time locating and monitoring their patients.<sup>35</sup> The decentralisation of nurses' stations to small bays, which allow staff to readily monitor their patients and patients to see staff, has been found to reduce the use of the nurse call system.<sup>42</sup> An identified challenge for patients living with dementia within a busy, noisy hospital ward is to balance the need for ease of observation (good visual access) with the patient's need for a quieter location with less stimulation. The former is often best achieved near the busy, noisy staff base, and the latter by placing the patient in a side room or a quiet out-of-the-way area which is likely to have poorer visual access.<sup>43</sup>

## PRINCIPLE 4. Reduce unhelpful stimulation

**Because dementia reduces the ability to filter stimulation and attend to only those things that are important, a person living with dementia becomes stressed by prolonged exposure to large amounts of stimulation. The environment should be designed to minimise exposure to stimuli that are not specifically helpful to the patient, such as unnecessary or competing noises and the sight of signs, posters, places and clutter that are of no use to the patient. The full range of senses must be considered. Too much visual stimulation is as stressful as too much auditory stimulation.**

### 2.4 Evidence base

A person living with dementia experiences difficulty in coping with a large amount of stimulation.<sup>44</sup> It is important therefore, that the environment is designed to reduce the impact of unhelpful stimulation.<sup>45</sup> Hospital environments are not optimised for people living with dementia, as they are often noisy, busy and impersonal, as well as confusing and disorientating.<sup>43, 46, 47</sup>

There is strong evidence that people living with dementia are less verbally aggressive where sensory input is more understandable, and where such input is more controlled.<sup>13</sup> Many patients living with dementia are extremely sensitive to their auditory environment, and in particular, to noise levels which at times may be high within a hospital ward<sup>48, 49</sup> and may make it difficult for them to communicate their needs.<sup>43</sup> There needs to be a high degree of acoustic control in inpatient common spaces<sup>50-53</sup> as reducing noise in these areas may reduce agitation. Additionally, other potentially overstimulating environmental factors should be considered such as appropriate lighting and temperature.<sup>54</sup>

Busy entry doors pose particular problems for staff and patients as they are a constant source of over stimulation and offer patients an invitation to leave. This can be avoided by positioning doors so that they are not the main focus and destination in the unit.<sup>35</sup> and ensuring that door closing mechanisms are designed to minimise noise. Murals are sometimes used to hide doors but need to be used thoughtfully as they are not an optimal solution to a door that is causing distress.<sup>55</sup>

Hospital wards are busy environments with large amounts of equipment, people and furniture. Reducing clutter on wards can reduce sensory overstimulation for patients with dementia which may reduce apprehension, anxiety and psychological distress.<sup>15</sup>

Another issue within a hospital environment is the impact of complex technology such as the building itself, diagnostic, treatment, information and communication technology. Consideration should be given to how a patient living with dementia may be expected to interact with these technologies and how they may contribute to unhelpful stimulation during a hospital stay.<sup>56</sup>

The goal is to provide the patient living with dementia 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.

## PRINCIPLE 5. Optimise helpful stimulation

**Enabling the person living with dementia to see, hear and smell things that give them cues about where they are and what they can do, can help to minimise their confusion and uncertainty. Consideration needs to be given to providing redundant cueing i.e. providing a number of cues to the same thing, recognising that what is meaningful to one person will not necessarily be meaningful to another. Using text and image in signs is a simple way to do this. Encouraging a person to recognise their bedroom through the presence of furniture, the colour of the walls, the design of a light fitting and/or the bedspread is a more complex one. Cues need to be carefully designed so that they do not add to clutter and become over stimulating.**

### 2.5 Evidence base

As a person living with dementia experiences difficulty in coping with a large amount of stimulation,<sup>44</sup> it is important that the things in the environment that are most important to them are emphasized. As noted above, the goal is to provide the patient living with dementia with an optimum level of stimulation. This requires achieving a balance between reducing unhelpful stimulation and enhancing stimuli that aid orientation and engagement.

The available evidence suggests that signage alone has limited effectiveness in promoting wayfinding and spatial orientation for patients living with dementia.<sup>57</sup> These patients require multiple forms of environmental support to achieve mobility and independent wayfinding including direct visual access (such as a clear view to the toilet door), appropriate use of contrast to highlight key features and other visual cues, in addition to good signage. When signage and other navigational aids are used to assist in wayfinding they should be integral to the design of environments for people living with dementia.<sup>53, 58, 59</sup> and have been associated with a reduction in negative responses from the patient.<sup>60</sup> The placement and content of signs is important; signs placed low and combining pictorial elements and simple nomenclature are most effective.<sup>57, 61</sup> Signs for patients and visitors should be clear and wall mounted signage should be highlighted by a contrasting wall background, while those that are only relevant to staff should not stand out.<sup>62</sup>

Personalised signs and cues may be used to good effect.<sup>63</sup> Within a multi bed room, the use of signs and cues (such as a bedspread or photos at the patient's bedside) is important to help a person identify their place in the room.

There is some evidence that the use of colour to distinguish the doors to residents' rooms in residential aged care has a beneficial effect<sup>52</sup> and the display of personal memorabilia outside the room may be of some benefit in wayfinding.<sup>63, 64</sup> Hospital data is limited.

Contrasting the object to be seen with its background is one of the most powerful ways of enhancing helpful stimulation. However, contrast can have negative effects when it takes the form of sharp edges between floorcoverings, or geometric patterns which can be seen as steps by people living with dementia.<sup>65</sup> This should be avoided.

Contrast is useful to help patients living with dementia eat well. Appropriate lighting and temperature and greater colour contrast between the

tablecloth, place mats and dishes may result in improved nutritional intake and less agitation.<sup>66, 67</sup>

High levels of illumination are often recommended.<sup>68, 69</sup> People with dementia in institutional settings are often exposed to inadequate levels of bright light.<sup>70</sup> Increasing illumination to normal levels has been shown to regulate circadian rhythms and improved sleep patterns for people living with dementia,<sup>69, 71, 72</sup> however some studies have shown that high levels of illumination are associated with increased agitation.<sup>54, 71, 74</sup>

Consideration should be given to the position of artificial light at the bed to ensure that glare is avoided.<sup>56</sup> Adjustable task lighting for the patient, and adequate light for staff when attending to patient clinical care needs should be considered. Staff task lighting at night should minimise disturbance to patients.<sup>36</sup>

There is some evidence suggesting that sunlight in patient rooms can reduce depression, which may be relevant as depression is often found in people living with dementia.<sup>69, 75</sup>

## PRINCIPLE 6. Support movement and engagement

**Purposeful movement can increase engagement and maintain a person's health and wellbeing. It is encouraged by providing a well defined pathway, free of obstacles and complex decision points, that guides people past points of interest and opportunities to engage in activities or social interaction. The pathway should be both internal and external, providing an opportunity and reason to go outside when the weather permits.**

### 2.6 Evidence base

Poorly designed environments can contribute to the agitated mobilisation that is sometimes seen in patients living with dementia.<sup>76</sup>

Controlling movement by obvious security measures can be counterproductive, as seen when patients hover around prominently locked exit doors waiting for an opportunity to leave.

The provision of a walking path has been shown to be associated with lower levels of agitation.<sup>13</sup> It should be noted, however, that the provision of a walking path alone does not reduce neuropsychiatric symptoms<sup>30</sup>; it is necessary for someone to interact with the patients while they are outside for benefits to occur.<sup>77</sup> An innovative study of the external environment in the community provides some clear guidance on the characteristics that make the outside world friendly to people living with dementia. It should be familiar, legible, distinctive, accessible, comfortable and safe.<sup>78</sup> Access to an outside area is also associated with reduced sadness and increased pleasure.<sup>36, 79</sup> In addition, research suggests that even a view to a garden can improve a person's responses<sup>80</sup> and can have a positive impact on mood.<sup>88, 82</sup>

If patients living with dementia are offered attractive alternatives to aimless movement they are likely to take them, so it is important that a path takes them past areas of comfort and interest.<sup>36, 83</sup> Access to appropriate places to walk can provide exercise, and may contribute to better sleep at night if the person living with dementia is tired in a beneficial way from meaningful

activity during the day.<sup>84</sup> Helping a patient living with dementia to stay active can help her or him to stay motivated, increase self esteem and reduce boredom and anxiety. Meaningful, enjoyable activities can assist in staying active,<sup>85</sup> with some limited research showing maintenance or even improvement in mobility and a reduction in falls when patients living with dementia are kept engaged.<sup>86</sup> Patients living with dementia commented in one study<sup>15</sup> that while traffic in the corridors was heavy and fast paced and staff were under time pressure to get their tasks done, the patients, by contrast, sat for hours and had nothing to do. The researchers comment that “the issue of profound boredom was a consistent theme expressed by all participants”.<sup>15</sup>

## PRINCIPLE 7. Create a familiar place

**A person living with dementia is more able to use and enjoy places and objects that are familiar to them from their early life. The environment should afford them the opportunity to maintain their competence through the use of familiar building design (internal and external), furniture, fittings and colours. The personal backgrounds of the patients need to be reflected in the environment. The involvement of the person living with dementia in personalising the environment with their familiar objects should be encouraged.**

### 2.7 Evidence base

People living with dementia recall the distant past more easily than the recent past. This may explain the beneficial effects associated with them being in an environment that is familiar to them.

The opportunity for residents of aged care facilities to increase the familiarity of their surroundings by bringing in their own belongings has been associated with the maintenance of activities of daily living and reductions in aggression, anxiety and depression.<sup>87</sup>

In an acute environment, the use of personalisation cues (such as furnishings, portrait photos and shadow boxes) may not be as feasible due to shorter length of stay, frequent turnover of patients and more demanding infection control regulations.<sup>88, 89</sup> However, the use of personalised cues in acute care settings should be attempted wherever possible. Consideration should be given to differentiating bed spaces and rooms, and providing some limited capacity for personal objects such as dressing gowns and small items.<sup>88, 89</sup> Supporting patients to personalise their spaces has been shown to aid recognition and reduce anxiety.<sup>90</sup> When differentiating bed spaces/rooms, research suggests that basic design principles be considered: large format graphics, positioned at an appropriate height for good visual access, appropriate location, good lighting and use appropriate contrast.<sup>88, 90</sup> It has been noted that during research interventions these environmental cues were only effective when introduced and explained by ward staff to the patients, and the reinforcing of these cues was embedded in the daily work of staff. The wayfinding impact of these measures, however, remained limited.<sup>88</sup>

The unfamiliar hospital environment may contribute to disorientation, and may cause distress and agitation (ie negative patient responses).<sup>89, 91.</sup>

<sup>92</sup> This may also adversely impact on the completion of activities of daily

living.<sup>93</sup> Making the healthcare environment as familiar as possible has been recognised as contributing to the avoidance of agitation and disorientation,<sup>94</sup> and to improving staff morale on institutional psychiatric inpatient units.<sup>96</sup> Limiting the number of times a patient moves from ward to ward should be given priority as this avoids a patient living with dementia having to relearn their environment over and over. Literature also suggests that nutritional status may be improved and altered by a number of environmental factors, including creating a more familiar dining atmosphere.<sup>54, 92</sup>

While it is possible for people living with dementia to learn to use new technologies, this is not easy and requires a great deal of support from skilled staff.<sup>97</sup> It is much easier, more practical and, possibly, more pleasant for the person living with dementia to be provided with fittings (such as taps and switches) that they can use because their use is recorded in their long term memory, rather than teach a new response when a person is already in a new setting.

People living with dementia who come from other cultures are at particular risk of finding themselves in an unfamiliar environment. A detailed knowledge of a person's personal history, heritage, customs and beliefs is required to provide an environment that will help someone make the most of their abilities and support person centred care.<sup>85, 98</sup>

## **PRINCIPLE 8. Provide a variety of places to be alone or with others**

**People living with dementia need to be able to choose to be on their own or spend time with others. This requires the provision of a variety of places in the ward, some for quiet conversation and some for larger groups, as well as places where people can be by themselves. These internal and external places should have a variety of characters, e.g. a place for reading, looking out of the window or talking, to cue the person to engage in relevant activity and stimulate different emotional responses.**

### **2.8 Evidence base**

People living with dementia benefit from being able to seek company of others or be on their own.

The provision of rooms for different functions has been shown to be a hallmark of dementia specific units in a survey involving 436 Minnesota nursing homes.<sup>58</sup> The strongest evidence for its importance comes from Zeisel's well controlled study<sup>13</sup> which indicated that residents with the opportunity to enjoy privacy were less anxious and aggressive, and those who had access to a variety of common spaces with varying ambiance were less socially withdrawn and depressed. The time residents of aged care homes spend in active behaviour has been shown to be associated with the provision of a variety of spaces,<sup>99</sup> and patients in special care units have been described as enjoying the opportunity to be alone and in social spaces.<sup>35</sup> In an acute care setting, the provision of social spaces away from the bed provides opportunities for privacy and for socialisation.<sup>36</sup> These spaces should be easy to access, welcoming and integral to the ward.<sup>36</sup>

Single rooms are important for most people living with dementia as they provide them with an opportunity to withdraw when they feel threatened

or uncomfortable.<sup>100, 101</sup> Single rooms have been associated with a reduction in the need for intervention, including medications, and improvements in sleeping.<sup>56, 102</sup> The opportunity for patients to spend time elsewhere contributes to privacy and choice.<sup>103</sup> However, single rooms result in a reduction in social interaction and reduced staff observation capacity and so the provision of these for people living with dementia should be carefully considered, with some research supporting the idea of low occupancy, single sex, shared rooms.<sup>36</sup> Greater patient safety and social interactions were identified as benefits of shared rooms.<sup>56, 104</sup> Based on current research the issue remains a topic for debate for patients living with dementia.

Specific recommendations for providing a variety of spaces within an inpatient unit have been identified<sup>105</sup> and they include 'dedicating space for social interaction, clearly indicating a room's intended use, making areas visually distinct so that the intended use of different parts can be delineated from their appearance, using colours to enhance activities and spaces, using various materials to provide different tactile and visual experiences, using lighting to help define space, and finally, making the spaces that have special meaning to patients stand out.'<sup>105</sup>

## PRINCIPLE 9. Link to the community

**Without constant reminders of who they are, a person living with dementia will lose their sense of identity. Frequent interaction with friends and relatives can help to maintain that identity and visitors should be able to drop in easily and enjoy being in places that encourage interaction.**

**Stigma remains a problem for people living with dementia. Where possible a 'bridge' should be built between the ward and the community by providing a place that is shared by the community and people with dementia. A coffee shop near the ward, for example, may enable a person living with dementia to go there easily without needing assistance.**

### 2.9 Evidence base

A person living with dementia will benefit from remaining connected to their family, friends and neighbourhood. Avoiding isolation which can lead to a person's withdrawal is important.

Having a hospital situated within the community can support not only ease of access for the patient living with dementia, but also for those accompanying them to hospital, family, friends and the wider community. Age and dementia friendly communities can help support equality and equity of access and maintenance of these community relationships for patients with dementia.<sup>56</sup>

Family members as 'competent collaborative partners in care' or 'expert advocates' can make an important contribution to care within the acute health care environment.<sup>85, 106</sup> Providing an environment that can support an appropriate family member to stay overnight with the patient living with dementia may help them feel safe and secure and provide dignified care.<sup>85, 107</sup> Providing a comfortable space for families to visit can increase social support for the patient.<sup>82</sup>

The provision of links to the community in a healthcare context involves encouraging visitors. This has been picked up by some architects as described by Poulter<sup>108</sup> “The idea is to include in the design a welcoming, caring environment for the patient, the visitor, and the neighbourhood.”. This is achieved by creating spaces that are sensitive to the patient and family experience, welcome visitors, minimise patient confusion and anxiety, offer positive diversion to patients and families, provide features that are visually and audibly soothing (eg water features) and encourage wonder and playfulness.<sup>56</sup>

## PRINCIPLE 10. Design in response to vision for way of life

**While a ‘vision for a way of life’ may seem out of place in an acute ward because of the focus on treatment and the brevity of the stay, it should be remembered that brief disruptions to the feelings of competence and worth can have a great effect on a person living with dementia. Some hospitals have a very clearly defined vision for a way of life – those that are operated by religious orders, for example. The built environment of these hospitals clearly supports the vision in the way the architecture reflects the values and traditions of the religious order and the spaces provide opportunities for the continuation of valued experiences, e.g. contact with nature, a view of the sky, places for reflection and quiet conversation.**

**The core of any vision for a way of life is the maintenance of a sense of agency, the feeling that ‘I can choose’. So, in its simplest form, the application of the principle of responding to a vision for a way of life involves providing the person living with dementia opportunities to live the life they want to live in the circumstances they are in. In most acute wards these choices are limited but some basic choices should always be available, e.g. to have high or low levels of illumination and the choice of being in a quiet place. If there are no choices available, or if the choices are provided in a way that is not understandable by the person living with dementia, the environment is incapable of supporting any vision for a way of life.**

### 2.10 Evidence base

The environment plays a vital role in enabling the care that takes place within it. Having a clearly articulated model of care is essential if an environment is to be supportive of people living with dementia.

Over the last twenty five years there has been extensive interest in providing ‘homelike’ environments for people living with dementia.<sup>109</sup> 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 writes:

*“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."<sup>108</sup>*

The advantages of going beyond a simple medical model aimed at the efficient delivery of medical services is becoming apparent<sup>53</sup> and in Australia can be seen in the design of the Royal Children's Hospital in Melbourne, for example. The application of this approach to the development of appropriate models of care for people living 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 healthcare<sup>110</sup> 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."<sup>92</sup>*

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

There has also been recognition of the importance of a supportive 'culture of care' within health care organisations to support staff to provide good care for a patient living with dementia and to legitimise practices so that they are valued by staff.<sup>111</sup> Staff education may be required to ensure staff understand their interaction with the environment and the impact on the person living with dementia (for example, the benefits of access to outdoor spaces)<sup>84, 92</sup>

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 to live their lives as independently 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 patients have access to all of the normal household facilities and encouragement to use their abilities.<sup>112</sup> 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 seeking<sup>113</sup> and improved social interaction and eating behaviour.<sup>114</sup>

## PART 2

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**RESOURCE 7**

**EAT-Acute Care  
Handbook**



**PART 3**

**ENVIRONMENTAL  
ASSESSMENT TOOL  
- ACUTE CARE**

## PART 3

# ENVIRONMENTAL ASSESSMENT TOOL -ACUTE CARE

### INTRODUCTION TO THE EAT-ACUTE CARE

The Environmental Assessment Tool-Acute Care (EAT-Acute Care) provides a systematic framework for reviewing an acute environment for people living with dementia and identifying areas for improvement. It is organised around key design principles and contains questions that respond to each principle. These principles are evidence based (refer to Part 2 of this handbook for more information).

A copy of the Environmental Assessment Tool-Acute Care can be found in Appendix 1 at the back of this handbook.

### BACKGROUND TO THE EAT-ACUTE CARE

The EAT-Acute Care is intended to complement the original Environmental Assessment Tool (EAT) and the EAT-Higher Care (refer Resources 3 and 4 respectively).

The EAT was first published by NSW Health in a book 'Adapting the Ward' (R Fleming, I. Forbes and K. Bennett 2003). It was intended to assist in the modification of wards in rural New South Wales hospitals where people living with dementia tended to be admitted for prolonged periods.

The EAT-Higher Care was published in February 2017 and is intended for use in facilities where people with dementia are living. It is designed to be used where people are mobile or non ambulant.

### USING THE EAT-ACUTE CARE

The EAT-Acute Care is designed to be used in acute health care settings where patients stay for up to a week.

Some key steps have been identified as valuable when using the EAT-Acute Care:

1. Be familiar with the key design principles
 

It is important that the person completing the EAT-Acute Care is familiar with the key design principles underpinning the assessment tool (refer to Part 1 of this handbook). While the tool is designed to be used by a non-design professional and can be completed by a member of staff or a person visiting the ward, attending a presentation by a person who is experienced in using the principles is a good way of gaining an understanding of them.
2. Be familiar with the EAT-Acute Care
 

Prior to starting the assessment, users should familiarise themselves with the EAT-Acute Care by reading it thoroughly. If a group of people is completing the EAT-Acute Care there are two ways to approach this:

  - a. The group completes the assessment together and the answers are determined by consensus.

- b. A number of people complete the assessment independently and they meet afterwards to discuss their results and agree on the best answers.

When more than one person completes the tool it encourages discussion, familiarises more people with the design principles and facilitates ownership of the results of the assessment, all of which are beneficial.

### 3. Undertaking the assessment

Before using the EAT-Acute Care, it is important to clearly define the area that is to be assessed i.e. the extent of the ward and what features are included in it. Is the courtyard garden, for example, part of the ward being assessed, another ward or both? In a large health care facility, it may be helpful to assess wards separately as this will allow for more accurate responses to questions. Ask someone who knows the ward well about the boundaries of the ward so that the area that is to be assessed is accurately defined.

It is important to ensure that the questions are answered as accurately as possible. Spending time in the ward and observing daily life will help generate a feel for the place. This will also create opportunities for interaction with patients so that they can enjoy the visit, rather than feeling the subject of scrutiny. While patient input is not required during use of the tool, observing the way patients interact with the environment can provide additional information during the assessment process.

The EAT-Acute Care questions typically require a 'yes' or 'no' answer.

Some questions are best answered by sitting in a central position and others by moving around. If the correct answer is not obvious, ask a staff member who works in that part of the ward. It may be that there is a difference of opinion between the staff and the person completing the EAT-Acute Care, for example regarding the amount of visual clutter in the ward. In this case the person completing the EAT-Acute Care will need to determine the correct response. If in doubt as to the intent or aim of the question, refer to Part 5 of this handbook where information about each question is provided.

It may be that on the day of the visit something is observed that is unusual and not representative of a typical day. Speaking to the nurse unit manager (or the liaison person) before leaving the ward can be a good way to double check the significance of such observations.

## RESULTS OF THE EAT-ACUTE CARE

The results of the EAT-Acute Care can be entered on an Excel spreadsheet that allows the data to be shown graphically, and enables the creation of a Room for Improvement (RFI) report as discussed in Part 4 of this handbook. Contact the DTA-Environments team to discuss this process further.

It is important to remember that the purpose of the EAT-Acute Care is to provide a framework for reviewing the environment and identifying areas for improvement.



## RESOURCE 7

### EAT-Acute Care Handbook



## PART 4 USING THE SPREADSHEET

## PART 4 USING THE SPREADSHEET

### WHAT DO THE EAT-ACUTE CARE SCORES MEAN?

It is important to remember that the purpose of the EAT-Acute Care is not to achieve a particular score. There is no perfect design. Even the best wards can do things better. The purpose of the EAT-Acute Care is to provide a systematic framework for reviewing the environment and identifying areas for improvement.

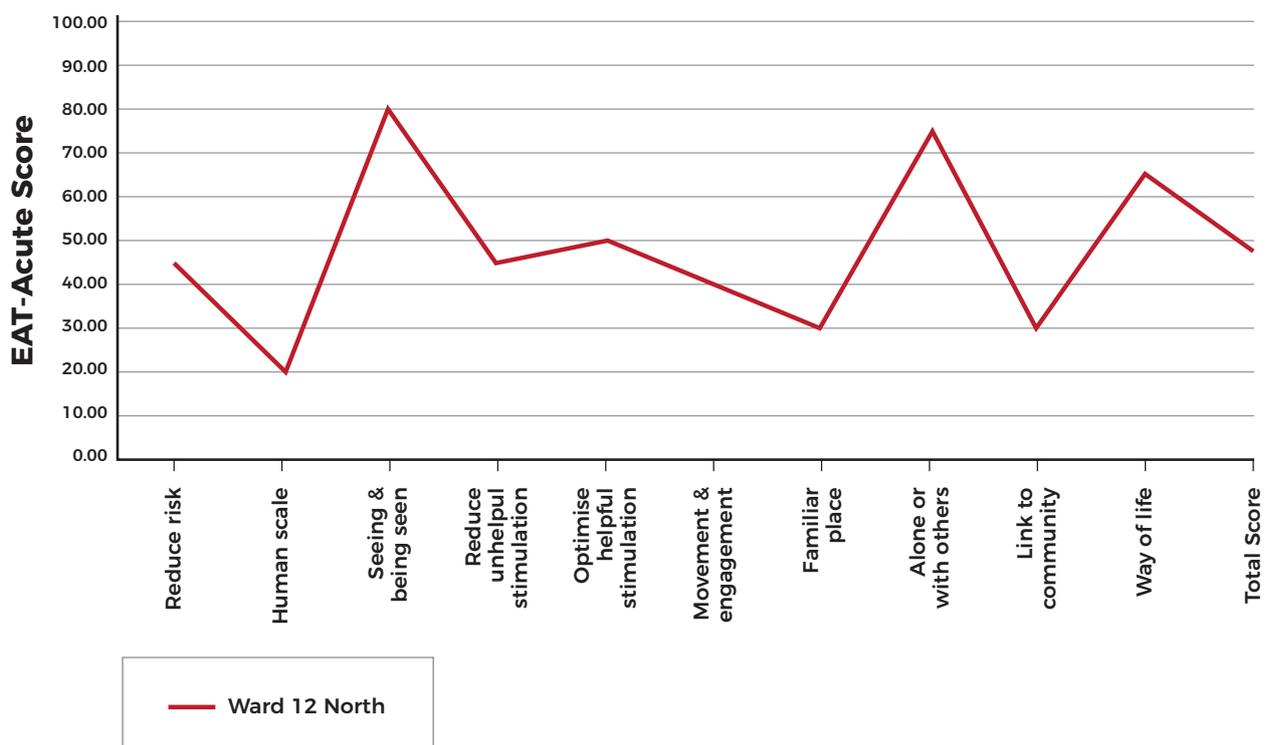
It is important to recognise that principles are not a set of rules that are to be applied in the same way every time. There are many ways in which the EAT-Acute Care questions can be responded to. How the design principles are best interpreted will depend on the particular context of the acute care setting. Geographic location, climate, site, culture, socio economic background and lifestyle of the patients are just some of the things that will influence the responses to the principles. They will be applied differently in different settings and in response to a range of needs.

### DISCUSSION OF RESULTS

**a.** Showing the results graphically

Figure 1 shows how the response to the principles can be shown graphically. This is a quick way of showing potential areas of most and least concern. In this example, the most obvious area of concern is the principle of 'Provide a human scale'. 'Create a familiar place' and 'Link to the community' also do not score well. On the other hand, the ward responds well to the principles 'Seeing and being seen' and 'Provide a variety of places to be alone or with others'.

**Figure 1: EAT-Acute Care results shown graphically**



**b.** Using a 'Room for Improvement' (RFI) report

The spreadsheet provides the means of generating a 'Room for Improvement' (RFI) report for the EAT Acute-Care. This is a table which ranks the EAT-Acute Care items according to the amount of room for improvement that is available, i.e. the possible maximum score minus the actual score.

The RFI table can be used to structure the discussion. Start at the top and discuss the items one by one until the point where there is little room for improvement (because the item is scored at the maximum). This will ensure that all of the main points are discussed.

The Not Applicable items (N/A) have been placed at the top of the list to encourage consideration of the possibility that they may be relevant. In the example in Table 1, a number of items regarding the outside area and place to sit have been scored N/A. Putting these at the top of the RFI report provides an opportunity to discuss whether the provision of an outside area and place to sit is important in the ward.

**Table 1: Abbreviated EAT 'Room for Improvement' report**

<b>EAT-ACUTE CARE ITEM</b>	<b>Actual score</b>	<b>Maximum possible score</b>	<b>RFI score</b>	<b>Principle</b>
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*Look at the items below that have been scored as Not Applicable (N/A). Would the ward be improved if they were considered to be applicable?*

Toilet door is seen from the most used place to sit	N/A	1	N/A	Allow people to see and be seen
Door to ward is seen from an outside area	N/A	1	N/A	Allow people to see and be seen
Place to sit is seen from where staff spend time	N/A	1	N/A	Allow people to see and be seen
Exit to outside area is seen from corridor	N/A	1	N/A	Allow people to see and be seen
Door back into ward is seen from outside area	N/A	1	N/A	Allow people to see and be seen

*Discuss the following items in turn. These are ordered according to where there is the most room for improvement.*

Place to sit is seen as soon as patient leaves room	1	3	2	Allow people to see and be seen
Patients can see toilet pan, door or commode from bed	1	3	2	Allow people to see and be seen
Patients have familiar items near their bed	0	2	2	Create a familiar place
Side doors can be secured	0	2	2	Unobtrusively reduce risks
Places where person can be on their own	0	2	2	Variety of places to be alone or with others

EAT-ACUTE CARE ITEM	Actual score	Maximum possible score	RFI score	Principle
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*The items below (RFI = 0) do not need as much discussion (but may still have room for improvement).*

Length of corridor allows person to feel comfortable	1	1	0	Provide a human scale
Corridor is free of trip hazards and obstructions	1	1	0	Unobtrusively reduce risks
Place to sit is used to store items	1	1	0	Create a familiar place

**c.** Using a 'Planning Template'

A Planning Template can be used to guide the discussion and to record proposed actions to improve the environment for people living with dementia. (Refer Table 2)

The discussion should begin by asking the question 'Can we improve this situation by using our existing resources differently?' 'How can we re-use what is there?' There might be some chairs available, for example, that can be relocated to furnish a small area for conversation.

If this isn't the case then the next question is 'What can we do in the short term?', which may mean 'What can we do with the money in the petty cash?' or 'What can we do as part of our planned maintenance works?'

If this isn't sufficient to improve the situation the next question is 'What can we do in the medium term?', eg 'What can we do if we receive a donation/bequest? Can we allocate some money in next year's budget to achieve this change? Can we apply for a grant or contact the local service organisation?'

The final question is 'What can we do in the long term?' or 'Does this item need to be put into the capital works budget? Does it need to be the subject of ongoing strategic planning and fundraising?'

When action items have been agreed, add the response to the appropriate cell of the table according to the relevant principle(s) and the time frame that is proposed. In the example shown in Table 2, the use of the EAT-Acute Care identified that there was not a familiar place for private conversation. Discussion focussed on how this could be addressed, and it was agreed that the first step was to rearrange the existing furniture to encourage small group and privacy. While not a long term response, staff felt this was something that could be done quickly and easily, re-using what is already there. Some cushions or throws would help to make the existing furniture less institutional and as these were likely to be sourced relatively easily, this was a short term action item. Replacing furniture will take some time and so this was seen as a medium and long term solution. Finally, some building works to alter the scale of the room and create private areas was seen as ideal, but a long term goal.

It is important to recognise that making changes can take time. Some changes, such as altering the layout of the building, will be possible but very expensive. Others, such as moving a piece of furniture will be relatively easy to implement. Don't lose heart! The advantage of systematically considering

environmental changes is that it is possible to identify a schedule of priorities and then work through them as opportunities arise and as part of a regular maintenance program.

Table 2: EAT-Acute Care Planning Template (full scale version in Appendix 2)

KEY DESIGN PRINCIPLES											
		Unobtrusively reduce risks	Provide a human scale	Allow people to see and be seen	Reduce unhelpful stimulation	Optimise helpful stimulation	Support movement & engagement	Create a familiar place	Provide a variety of places to be alone or with others	Link to the community	Design in response to vision for way of life
<b>ACTIONS</b>	<b>ISSUE</b>							furniture in place to sit is not familiar to majority of patients	Nowhere to have private conversation away from bed		
	How can we re-use what is there?								Rearrange existing furniture to allow for small (private) interactions within larger space		
	What can we do in the short term?							Provide cushions/throws to change appearance			
	What can we do in the medium term?							Replace some furniture			
	What can we do in the long term?							Replace remaining furniture	Lower ceiling and insert bay window to delineate part of room		



**RESOURCE 7**

**EAT-Acute Care  
Handbook**



**PART 5**  
**APPLYING THE  
PRINCIPLES**

## PART 5

# APPLYING THE PRINCIPLES

This section is organised around the key design principles contained in the EAT-Acute Care and the questions that relate to each principle (refer to Part 1 and Appendix 1 of this handbook).

Each question in the assessment tool is discussed. Under each question there is a brief statement of what is important and why, and some key design considerations. For most (but not all) items three categories follow: Ensure, Avoid and Consider. These give suggestions and examples of design responses, problem areas to avoid, and items that may be considered depending on the particulars of a project and the people who will be patients there.

Some questions are found under more than one principle and some information is duplicated. This section has been designed so that each question stands alone, allowing the reader to use it as a reference document rather than being required to read it from beginning to end.

### 1. Unobtrusively reduce risks

#### Inside

#### 1.1 Can the entry to the ward be secured?

It may be necessary to be able to prevent some patients leaving the ward to maintain their safety. Being able to secure the front entry to the ward when required can help provide this security. The location of the ward entry within the ward, and the type of security mechanism selected will be important to allow for ease of use by staff, visitors and other patients.

It is important that measures to create a secure ward entrance are as unobtrusive as possible to avoid frustration, agitation and anger.

#### ENSURE:

- entrance to ward is clearly recognisable from outside
- entrance door can be secured if required

#### AVOID:

- entrance to ward that is unwelcoming and uninviting upon approach
- treating the entry as a destination within the ward

#### CONSIDER:

- where ward entrance is located within the ward (to limit its prominence)
- the type of security mechanism selected. This needs to allow for ease of use by staff, visitors and other patients while still limiting access for some people when required.
- making the entry to the ward unobtrusive from inside the ward to prevent patients living with dementia being continually confronted by a door that may be secured
- designing so individual wards can be made secure at different times to suit different groups of patients' needs

## 1.2 Can all side doors leading out of the ward be secured?

It may be important that all side doors leading out of the ward can be secured to prevent some patients leaving the ward (e.g. when this may compromise their safety). Side doors should be able to be secured but allow for controlled coming and going. The type of security mechanism selected will be important to allow for ease of use by staff, visitors and other patients. Any measures should be unobtrusive to avoid patients being confronted by locked doors.

NB Side doors that do not lead out of the ward (but, for example, lead to a secure garden) are not the subject of this question.

### ENSURE:

- side doors can be secured if required

### AVOID:

- patients being confronted by locked doors

### CONSIDER:

- making side doors inside the ward unobtrusive to prevent patients being continually confronted by a door which may be locked

## 1.3 Can people be prevented from climbing in or out of windows when they are open?

The extent to which ward windows can be opened is another component of reducing risk. Limiting the opening of windows can prevent patients leaving the ward if they shouldn't and people coming in through the window and creating security issues.

Climbing out of windows is dangerous. Awning, double hung and sliding windows can all be unobtrusively modified to ensure that they cannot be opened wide enough to allow a person to pass through.

### ENSURE:

- extent of window opening is controlled

### AVOID:

- windows that can be opened and allow for climbing in or out

### CONSIDER

- having some opening windows to allow access to fresh air and natural ventilation

#### 1.4 Is lighting at the patient's bed adjustable (e.g. choice of light source, adjustable direction or dimmable)?

Lighting plays a key role in making a place easy to navigate and pleasant to be in. There should be sufficient natural and artificial lighting to ensure that patients are able to see rooms and what is in them at all times. Glare must be avoided.

##### ENSURE:

- sufficient natural (and artificial) lighting for daytime and night-time use

##### AVOID:

- glare
- lighting that shines directly into patient's eyes

##### CONSIDER:

- lighting that includes night lighting and/or dimmers
- task lighting for staff activities and patient reading
- placement and identification of switches for patient light sources
- the design of window furnishings (as this can reduce glare)

#### 1.5 Is there dimmable or night lighting in the patient's ensuite/toilet?

Lighting also plays a key role in assisting patients to navigate their way around the ward at night. There should be sufficient lighting at night to ensure that patients are able to locate and navigate their way to the ensuites/toilet. Night lighting should not be so bright as to interfere with sleep. Night lighting should also assist staff to attend to basic patient care without unduly disturbing the patient.

##### ENSURE:

- sufficient, even lighting for night-time use

##### AVOID:

- glare
- up-lighting or overbright night-lighting
- uneven lighting that does not provide a continuous light path to the ensuites/toilet

##### CONSIDER:

- location and visibility of ensuite/toilet light switch when patient reaches ensuites/toilet at night (i.e. use of contrast, logical location, in-switch indicator light)
- consistent use of recognisable plates for light switches
- switch to enable night-lighting to be used as required, dependent on patient needs

### 1.6 Does the lighting in a typical patient's ensuite provide bright, even lighting when using the toilet, shower and/or basin?

Lighting plays a key role in making a place easy to navigate and pleasant to be in. There should be sufficient natural and/or artificial lighting to ensure that patients are able to see when using the toilet, shower and basin and are able to see what is in the room upon approach. Glare must be avoided.

#### ENSURE:

- sufficient even natural (and artificial) lighting for daytime and night-time use

#### AVOID:

- glare
- lighting that creates strong shadows
- uneven lighting within the toilet/ensuite

#### CONSIDER:

- placement and identification of switches for patient use (lights, nurse call)
- consistent use of recognisable plates for similar types of switches
- lighting that uses night lighting and/or dimmers
- task lighting above the basin
- the design of window furnishings

### 1.7 Does the lighting in the shared bathroom provide bright, even lighting when using the toilet, shower and/or basin?

Lighting plays a key role in making a place easy to navigate and pleasant to be in. There should be sufficient natural and/or artificial lighting to ensure that patients are able to see when using the toilet and be able to see what is in the room. Glare must be avoided.

#### ENSURE:

- sufficient even natural (and artificial) lighting for daytime and night-time use

#### AVOID:

- glare
- lighting that creates strong shadows
- uneven lighting within the toilet/ensuites (especially between cubicles)

#### CONSIDER:

- placement and identification of switches for patient use (lights, nurse call)
- consistent use of recognisable plates for similar types of switches
- lighting that uses night lighting and/or dimmers
- task lighting above the basin
- the design of window furnishings

## 1.8 Are corridors free of trip hazards and obstructions?

Most patients living with dementia will also be elderly and may be at greater risk of trips and falls. Maintaining or increasing mobility in hospital patients delivers better health outcomes. To support mobility and minimise trip hazards and obstructions, corridors should be kept tidy and free of stored furniture and equipment.

### ENSURE:

- corridors are free of trip hazards and obstructions

### AVOID:

- storage of furniture along corridors
- storage of equipment and supplies in patient corridors

### CONSIDER:

- using designated storage areas for equipment, supplies and excess furniture
- maintaining one side of corridor clear of obstruction to facilitate patient movement if corridor storage is necessary
- in the absence of adequate nearby storage, restricting the placement of equipment in patient corridors to times when it is most needed (e.g., storing hoists in corridor only when a number of patients are having showers)

## 1.9 Are patient rooms free of clutter, trip hazards and obstructions?

Providing a patient room that is free of clutter, trip hazards and obstructions can maximise the patient's ability to mobilise safely and perform activities of daily living independently. To support mobility and minimise trip hazards and obstructions, patient rooms should be kept tidy and free of trip hazards and obstructions.

### ENSURE:

- patient rooms are free of clutter
- trip hazards and obstructions are removed
- separate lockers/cupboards are provided near each patient bed for patient and staff use

### AVOID:

- storage of furniture in patient rooms
- storage of excess equipment and supplies in patient rooms

### CONSIDER:

- using designated storage areas for equipment, supplies and excess furniture

### 1.10 Inside, is contrast *between* floor surfaces at the thresholds of rooms avoided?

A person living with dementia may perceive two floor surfaces that have a high level of contrast between them as one floor surface which is adjacent to a hole or step or barrier. A resident may not wish to leave their bedroom, for example, as he/she perceives the corridor floor (which has a high level of contrast with the adjacent bedroom floor) is a danger to them. This can lead to falls, anxiety and limit a person's ability to move about freely and be independent.

#### ENSURE:

- contrast between different floor finishes is minimised
- where contrast is used, it is used intentionally to guide a person (e.g. by using a contrasting border in front of a cleaner's cupboard to deter a person living with dementia from entering)
- clear differentiation between horizontal and vertical surfaces

#### AVOID:

- strong contrast between changes in floor surfaces as these can result in the floor being perceived as a step or hole

#### CONSIDER:

- using floor finishes to guide and direct patients to places of interest and importance

### 1.11 Inside, is contrast *within* floor surfaces (e.g. patterns and/or features) avoided?

A person living with dementia may perceive two floor surfaces that have a high level of contrast between them as one floor surface which is adjacent to a hole or step or barrier. A patient may not wish to leave their bedroom, for example, as he/she perceives the corridor floor (which has a high level of contrast with the adjacent bedroom floor) is a danger to them. This can lead to falls, anxiety and limit a person's ability to move about freely and be independent. Patterns within floor finishes can have the same effect as patients try to step over or around patterns or pick up objects from the floor surface.

#### ENSURE:

- contrast within floor finishes is minimised

#### AVOID:

- strong contrast within floor surfaces as these can result in the floor being perceived as a step or hole
- unnecessary features in floor finishes such as vinyl or carpet
- strongly contrasting or complex patterns in floor finishes

#### CONSIDER:

- clear differentiation between horizontal and vertical surfaces

**1.12 Inside, is glare from artificial lighting minimised?**

As people age their eyes react more slowly to changes in light, meaning they require more time to transition between different light levels and issues with glare become more significant. Glare can be an irritant and can actually decrease visual performance.

**ENSURE:**

- patient areas are not over-lit but have appropriate lighting levels, ideally that can be varied according to time of day and patient/staff needs

**AVOID:**

- the use of spotlights
- lights that shine into patients' eyes
- lights that shine upwards from below eye level
- shiny surfaces that reflect light

**CONSIDER:**

- the height and angle of lights so they don't shine directly into the patient's eyes
- the use of dimmers and complementary light fittings to allow lighting levels to be varied to meet patient and staff needs
- using window treatments to manage internal glare

**Outside****1.13 Is glare from natural and artificial lighting minimised?**

In **outdoor** areas, and particularly in the transition zone when a patient is moving for an internal to an external spaces, the age related slowing of the eyes reaction to changes in light levels must also be considered. Glare should be minimised and older eyes given time to adjust to external light levels.

**ENSURE:**

- transition zone at exit to outdoor space to create similar lighting conditions between inside and outside
- shaded areas within outdoor areas

**AVOID:**

- the creation of dark shadows across paths and in sitting areas
- white paving/ground surfaces
- shiny surfaces that reflect light
- the use of spotlights
- lights that shine upwards from below eye level (e.g., lights set into pavements)

**CONSIDER:**

- the use of pergolas and planting to screen direct sunlight
- the height and angle of lights so they don't shine directly into the patient's eyes

- providing a transition zone inside entrance from outdoor space to allow time for eyes to adjust between indoor and outdoor lighting levels
- consider providing seating within these transition zones

#### 1.14 Is there step free access to all areas?

As many patients use mobility aids, step free access is important so that patients can easily move about outside and access all areas. Step free access means that no changes of level must be negotiated by the patient along a path, or between outside features (such as a shelter and a raised garden bed). It does not mean that only step free access must be provided, rather that there must be at least one means of step free access available to all areas. (In some situations a ramp may lead to an area from one direction and a couple of steps from another which is acceptable.) In all cases, steps with risers of varying heights and small changes of level are unacceptable.

##### ENSURE:

- no uneven surfaces outside
- steps are minimised and an alternative step free access is provided
- step free route is clearly identifiable
- any change of level is clearly identified (e.g., between grass and paving)

##### AVOID:

- any small changes in levels (for example ridges, hobs, small steps)
- risers of varying heights
- any barrier that prevents step free access to all areas

##### CONSIDER:

- providing a ramp of suitable gradient to replace or complement existing steps

#### 1.15 Is contrast between path surfaces avoided?

A person living with dementia may perceive two ground surfaces that have a high level of contrast between them as one floor surface which is adjacent to a hole or step or barrier. For example, a patient may not wish to access an outside sitting space if there is a high level of contrast between it and the path, as it is likely to present as a danger to her/him. This can lead to falls, anxiety and limit a person's ability to move about freely and be independent. Patterns in ground surfaces can have the same effect as patients try to step over or around patterns or pick up objects from the ground surface.

##### ENSURE:

- contrast between different outdoor ground finishes is minimised
- where contrast is used, it is used intentionally to guide a person (e.g. by using a contrasting border in front of a garden bed)
- clear differentiation between horizontal and vertical surfaces

**AVOID:**

- strong contrast between changes in ground surfaces as these can result in the ground being perceived as a step or hole
- unnecessary features in outside ground surfaces
- strong contrast complex patterns in ground finishes

**CONSIDER:**

- using ground surfaces to guide and direct patients to places of interest and importance

**1.16 Are path surfaces even?**

An even path surface will reduce the likelihood of patients tripping as they walk outside. Paths should be free from undulations, holes and ragged edges, as well as seasonal changes such as falling leaves.

**ENSURE:**

- path surfaces are even and well maintained
- continuous materials, such as concrete, are used for path surfaces

**AVOID:**

- slippery surfaces
- bedding paving bricks in sand which may move over time
- uneven and undefined path edges
- planting trees in close proximity to paths (to avoid tree roots raising paths and fruit, blossom and leaves falling on paths)
- glare from night lighting on paths

**CONSIDER:**

- path design so that the surface is well drained and ponding is avoided
- selecting a surface that is most familiar to older patients and their visitors
- protecting paths from driving rain and wind

**1.17 Are paths clear of obstacles (e.g. trees, thorny plants) along and over the path?**

Obstacles along a path present a great hazard to patients. Trees, plants and bushes can project onto paths (reducing their width) and creating tripping hazards. Twigs and leaves falling from trees can also be dangerous for patients. Branches which hang over the path can also be a hazard if they hang near head height.

**ENSURE:**

- plants close to paths are well maintained
- overhanging branches are regularly pruned

**AVOID:**

- thorny plants
- plants which grow too large near paths

**CONSIDER:**

- replacing inappropriate plants near pathway

### 1.18 Can patients be prevented from leaving the *outside* area by getting over/under the perimeter?

It may be important that the environment is secure to prevent patients leaving the ward if it is not safe for them to do so. Having a fence that is sturdy and difficult to climb (or go under) is vital in this regard.

The fence needs to be high enough to make it difficult for patients to climb over when it is important that the ward is secure. The fence should be 1.8m high if this is the case. It should also be continuous and well maintained, and the fence design must not allow for climbing (in or out).

It is important that measures to create a secure garden are as unobtrusive as possible to avoid frustration, agitation and anger.

**ENSURE:**

- fence is continuous and well maintained
- fence is 1.8m high where the perimeter is needed to be secure
- fence design does not allow for climbing (in or out)
- gates are able to be secured but allow for controlled coming and going

**AVOID:**

- fences and gates with openings or horizontal members which can be used as foot holds
- planting near the fence which can be used for climbing
- latch on outside of the gate

**CONSIDER:**

- designing the fence so that it blends into the landscape
- using vegetation to hide the fence so it is not foreboding or institutional

### 1.19 Can patients be prevented from leaving the *outside* area through a gate (e.g. could the gate be locked if required?)

It may be important that the environment is secure to prevent patients leaving the ward if it is not safe for them to do so. Having a gate that is sturdy and difficult to climb (or go under) is vital in this regard.

The gate needs to be able to be locked while allowing for exit in an emergency (if this is part of an emergency evacuation route). Mechanical keypads or keypads which are linked to a staff call system can be installed on gates. (If keypads are linked to a staff call system, they will release automatically in the event of a fire). It is important that measures to create a secure garden are as unobtrusive as possible to avoid frustration, agitation and anger.

Double handles/latches and handles which open in an anti-clockwise direction may also be effective to prevent easy opening by patients from within the grounds. It is also important that patients cannot reach over a gate and open it from the outside while inside the grounds.

#### ENSURE:

- gate design does not allow for climbing (in or out)
- gates are secured but allow for controlled coming and going
- fence is continuous and well maintained
- fence is 1.8m high where the perimeter is needed to be secure
- fence design does not allow for climbing (in or out)

#### AVOID:

- fences and gates with openings or horizontal members which can be used as foot holds
- latch on outside of the gate

#### CONSIDER:

- designing the gate so that it blends into the fence
- double handles/latches, handles which open in an anti-clockwise direction, keypads to secure exit
- designing the fence so that it blends into the landscape
- using vegetation to hide the fence so it is not foreboding or institutional

## 2. Provide a human scale

### 2.1 Does the length of the corridor(s) allow a person to feel comfortable (and not uneasy because it is/they are too long)?

Corridors on wards are also important in creating a human scale. Long corridors in hospitals can be overwhelming for patients living with dementia. Patient circulation routes should be subdivided into a more human scale with clearly identifiable staff bases to aid orientation.

#### ENSURE:

- patient corridors are divided into zones to create a more human scale (colour, finishes, materials)
- staff bases are clearly identifiable to enable easy recognition by patients (colour, details and materials)

#### AVOID:

- long corridors with repetition of colours, materials and details
- institutional finishes

#### CONSIDER:

- use of redundant cueing to differentiate corridor zones (i.e., use colour, theme, materials, graphics, signage that complement each other, and are familiar and appropriate to hospital location and context)

### 2.2 Is furniture in place to sit arranged so people can sit on their own or in small groups?

Furniture should be arranged so that a person would feel comfortable spending time there. The way furniture is placed can affect the scale of the space. Furniture could be grouped to create a comfortable space for small groups, or a single chair could be placed in a location that provides a pleasant view that is not in the way of others.

#### ENSURE:

- places to sit are designed and detailed to create a human scale setting
- small areas for quiet conversation/interaction are provided
- large lounge or dining rooms are edged with nooks and smaller areas for small groups and individuals
- nooks and the smaller edge rooms have a good view of ward activities and/or outside
- corridors, especially long corridors, are broken up by the provision of a space and furniture that enables people to have a conversation

#### AVOID:

- large undifferentiated places
- rows of chairs located in busy corridors with no view
- institutional multi-use places to sit
- using storage spaces or excess corridor area as sitting spaces

**CONSIDER:**

- varying corridor and hall widths to accommodate small sitting places
- regularly arranging furniture in designated sitting spaces to encourage a range of interactions
- a variety of furniture selection so that not all rooms look the same
- domestic decoration (pictures, etc)

### 2.3 Are a variety of colours, finishes and materials used in the ward?

Using a variety of colours, finishes and materials can be used to help reduce the ward to a more human scale. Through these design tools, spaces can appear larger or smaller, ceilings higher or lower and corridors shorter or longer. The use of colours, finishes and materials can also help create an environment that is easier to understand, navigate and can facilitate wayfinding.

**ENSURE:**

- use of colour, finishes and materials to break a ward into zones
- the ward entrance is designed and detailed to emphasise a human scale (rather an institutional or corporate one)
- the ward entrance is friendly, and says 'welcome' (rather than being cold and impersonal)

**AVOID:**

- long corridors
- institutional finishes
- repetition of colours, materials and finishes throughout ward

**CONSIDER:**

- hospital wide design scheme to ensure standardised, logical and integrated approach (e.g., toilet doors finished in a common colour)
- small scale shared spaces (i.e., for small groups)
- a variety of furniture selection so that not all rooms look the same
- domestic decoration (pictures, etc)

### 3. Allow people to see and be seen

#### 3.1 What proportion of patients can see the toilet pan, toilet door, or a commode from their bed?

A toilet is a room that needs to be used often and therefore needs to be easy to find and get to. For a confused patient in an unfamiliar environment, being able to easily identify the toilet from their bed can be helpful for both the patient and for staff.

##### ENSURE:

- contrast is used to highlight location of toilet door (in room and in toilet)
- appropriate signage (size, clear text, graphics, location, matt finish)

##### AVOID:

- non-standardised approach to toilet signage (i.e. variety of signage throughout ward and/or hospital)

##### CONSIDER:

- hospital wide approach to toilet door finish and standardised signage to ensure standardised, logical and integrated approach
- night lighting to support easy location of toilet at night
- location of toilet door and bed placement to maximise visual access to toilet when designing or renovating patient bedrooms

#### 3.2 What proportion of patients can see a staff base as soon as they leave their room?

If patients can easily see a staff base it can help them to feel supported while in hospital. At the same time, if staff can more easily observe patients, this can reduce their anxiety and make it easier to monitor their patients.

##### ENSURE:

- staff bases can be easily seen from the corridor (through the use of location, colour, finishes, appropriate signage, lighting)

##### AVOID:

- corridor clutter that obscures the view of the staff base when a patient leaves their room

##### CONSIDER:

- hospital wide approach to staff bases and standardised signage to ensure standardised, logical and integrated approach
- establishing clear lines of sight from patient room thresholds to staff base (or way to staff base)

### 3.3 What proportion of patients can see the entry to their room from the corridor?

Patient rooms are the places where patients will spend the majority of time during their hospital stay. When a patient leaves their room, for example to use a toilet or to spend time away from their bed, the entry to their room needs to be easy to see to ensure they can return easily.

Entrances to patient rooms offer patients an important way to recognise their room, and consideration should be given to the finish and decoration of room entrances and signage around the door and/or at the room threshold. The placement of a landmark (such as a piece of artwork) near the entrance can also be important in highlighting the entry to a patient room. These measures will help patients locate their room.

#### ENSURE:

- patient rooms can be clearly distinguished from one another
- patient room entrances can be clearly distinguished from one another
- patient room entrances or doors are positioned so they can be easily seen from the corridor
- where room entrances or doors cannot be easily seen, features are placed near adjacent walls to identify rooms

#### AVOID:

- repetition of finishes and features, as this makes all patient room doors and approaches to rooms appear to be the same

#### CONSIDER:

- how clear lines of sight can be provided to patient room entrances or doors
- the use of redundant cueing, i.e. providing more than one cue to the same thing (for example, through the use of colour, texture, finish, names, numbers, images, artwork) recognising that different things can be meaningful to different patients and at different times.

### 3.4 What proportion of patients can see their bed from the entry to their room?

As many patients will be in a shared room, individual beds should be easily seen and recognised from the entrance to the shared patient room. Good visual access will make the identification of an individual's bed space easier and reduce stress and anxiety.

#### ENSURE:

- bed curtains are pushed back when not in use
- furniture and equipment is minimised to maximise visual access to beds

**AVOID:**

- curtains, partitions or other barriers that obstruct views to the beds from room entry

**CONSIDER:**

- how clear lines of sight can be provided to patient beds from the room entry during design
- differentiation of each bed space to make identification of individual bed easier for patients (such as use of colour, materials, artwork, and provision of a place to display personal items)

### 3.5 What proportion of patients can see a place to sit as soon as they leave their room?

A place to sit on a hospital ward provides patients with an opportunity to spend time relaxing and socialising with others or on their own away from their bed. A place to sit may be a designated patient lounge, a nook along a corridor or even a seat placed along a corridor. However, a place to sit should be comfortable, have a pleasant or interesting view, and be in a location that does not get in the way of other ward activities. It needs to be easy to find and recognise. If patients can see the way to a place to sit when they leave their room this will help them know where they are heading and give them a hint of what they will find when they get there.

**ENSURE:**

- a place to sit is provided for patients
- the place to sit is located in a prominent position on the ward
- the place to sit is identifiable when leaving the bedroom (e.g. by furniture, furnishings and/or colour)

**CONSIDER:**

- how clear lines of sight between patient rooms and a place to sit can be created

### 3.6 Can a toilet door be clearly seen from the most used place to sit?

A toilet is a room which needs to be used often and therefore needs to be easily located. If it is in close proximity to a place to sit and can be seen from the place to sit, it can act as an important prompt for patients.

**ENSURE:**

- door (ie toilet door) is visible but still offers patient privacy
- clear path between the toilet and the place to sit
- contrast is used to highlight location of toilet door
- appropriate signage (size, clear text, graphics, location, matt finish)

**AVOID:**

- locating the door (ie toilet door) so that it dominates the view from the place to sit
- locating the toilet pan so that if the door is left open patient's privacy is compromised
- obstructing the view between the place to sit and the toilet
- obstructing the path between the place to sit and the toilet
- the spread of toilet odours into the place to sit

**CONSIDER:**

- the location of screens and the placement of fixtures in the toilet
- use of appropriately adjusted door closer so that the toilet door closes but patients can easily open the door
- hospital wide approach to toilet door finish and standardised signage to ensure standardised, logical and integrated approach
- night lighting to support easy location of toilets at night

### **3.7 Can the exit to an *outside area* be clearly seen from the most used place to sit?**

Spending time outside is important and some hospital wards have direct access to an outside space (verandahs, courtyards, roof top gardens or garden spaces). It is important that patients on these wards are able to see the way to go outside, especially from the most used place to sit within the ward.

**ENSURE:**

- that the door to outside is clearly recognisable as a door
- that it is clear this door leads to an outside space
- clear lines of sight to outside areas especially to places where activities may be occurring
- easy (step free) access to outside area

**AVOID:**

- obstructing the view of the door to outside
- obstructing the view out of any places to sit
- designing doors that could be mistaken for windows (and visa versa)

**CONSIDER:**

- using sidelights to doors if the door is solid so people can see their destination
- ways to distinguish between windows and doors (e.g., design of mullions and transoms, size of glazing panels, sill heights, door furniture)

### 3.8 Can the place to sit be clearly seen from where staff spend most of their time (such as the staff base)?

Patients are likely to be reassured if they know staff are around and so good visual access between the point(s) where staff spend most of their time and places to sit is important. As patients become more mobile they may spend a lot of time out of their rooms and in places to sit on the ward. It will be an advantage if staff can easily see patients and assist them if required.

#### ENSURE:

- good visual access to places to sit from staff areas, circulation routes and patient rooms

#### AVOID:

- a dominating central staff base

#### CONSIDER:

- the general transparency of building (planning, the placement of windows, windowsill height and glazed doors). Perforated screens, small inside windows and low walls may increase the transparency between rooms, whereas solid walls and furniture may decrease the transparency.

### 3.9 Can an *outside area* be clearly seen from where staff spend most of their time?

It is important that patients spend time outside if possible. Patients are likely to be reassured if they can see where staff are and so good visual access between the point(s) where staff spend most of their time and any outside areas is important. It will also be an advantage if staff can easily see patients and can assist them if required.

#### ENSURE:

- good visual access to outside from staff areas and circulation routes

#### AVOID:

- a dominating central staff base

#### CONSIDER:

- the general transparency of building (planning, the placement of windows, window sill height and glazed doors)
- decentralised staff bases

### 3.10 Can the door back into the ward be clearly seen from an outside area?

It is important that patients spend time outside if possible. It is, however, vital that they can easily return inside from an outside area (verandahs, courtyards, roof top gardens or garden spaces). The door back into the ward should be easy to find and recognise.

#### ENSURE:

- door to inside is clearly recognisable as a door
- door to inside can be clearly seen from outside area
- where door to inside cannot be easily seen, features are placed near the door location to draw attention to it (such as colour, garden features, artworks, landmark plants)

#### AVOID:

- repetition of finishes and features across building exterior in outside area, as this makes entry door difficult to identify

#### CONSIDER:

- positioning door to inside so it can be easily seen from anywhere in the outside area
- how clear lines of sight can be maintained to door to inside from the outside space
- the use of redundant cueing, i.e., providing more than one cue to the same thing (for example, through the use of colour, texture, finish, signage, images, artwork) recognising that different things can be meaningful to different patients and at different times.

### 3.11 Can the exit to an outside area be clearly seen from a corridor?

Ward corridors provide the main circulation space for patients once they are able to move beyond their bed. The corridors are likely to be an important place in the life of the ward. As it is important that patients spend time outside if possible, it is important that patients are able to see the way to go outside from the ward corridor/s.

#### ENSURE:

- that the door to outside is clearly recognisable as a door
- that it is clear this door leads to an outside space
- clear lines of sight to outside areas especially to places where activities may be occurring
- easy (step free) access to outside area
- if signage is required that it is appropriate (size, clear text, graphics, location, matt finish)

**AVOID:**

- obstructing the view of the door to outside
- obstructing the view out of the corridor
- designing doors that could be mistaken for windows (and visa versa)

**CONSIDER:**

- using sidelights to doors if the door is solid so people can see their destination
- ways to distinguish between windows and doors (e.g., design of mullions and transoms, size of glazing panels, sill heights, door furniture)

**3.12 Can a kitchenette be clearly seen from a corridor?**

If patients are able to move beyond their bed and move around the ward, access to a kitchenette can provide independence, choice and the ability to engage in a meaningful activity. It may also be an important part in facilitating a patient's return to home. (It is recognised, however, that for some patients this may not be appropriate for a variety of reasons). If a kitchenette is provided for use by patients it needs to be easy to find and recognise. If patients can see the kitchenette from the corridor it will help them know where they are heading and what they will find when they get there. Seeing inside the kitchenette (rather than just the outside of the room) will give them added information and inspiration as to what they may be able to do in this space (e.g. make a cup of tea/coffee, access a microwave, refill a water bottle).

**ENSURE:**

- the kitchenette is located in a prominent position in the ward
- the kitchenette is identifiable from the corridor by, for example, form, colour, appropriate signage (size, clear text, graphics, location, matt finish)
- entry doors to the kitchenette are glazed to allow people to look inside
- it is clear that this is a space for patients and families (rather than a staff only area)

**AVOID:**

- repetition of building form, scale and colour which doesn't distinguish the kitchenette from other areas
- obstructing the view in or out of the kitchenette, for example by closing curtains, using solid doors

**CONSIDER:**

- how clear lines of sight between the kitchenette and the corridor can be achieved
- sidelights to doors to allow people to see inside the kitchenette (if the door is solid)

### 3.13 Can a toilet be clearly seen from a corridor?

A toilet is a room which needs to be used often and therefore needs to be easily located. If it can be clearly seen from the corridor it can be readily used and can act as an important prompt for patients.

#### ENSURE:

- toilet is visible but still offers patient privacy
- clear path between the toilet and the corridor
- contrast used to highlight location of toilet door
- appropriate signage (size, clear text, graphics, location, matt finish)

#### AVOID:

- locating the toilet pan so that if the door is left open patients' privacy is compromised
- obstructing the view between the corridor and the toilet
- obstructing the path between the corridor and the toilet
- the spread of toilet odours into the corridor
- non-standardised approach to toilet signage (i.e., variety of signage throughout ward and/or hospital)

#### CONSIDER:

- the location of screens and the placement of fixtures in the toilet
- use of appropriately adjusted door closer so that the toilet door closes but patients can easily open the door
- hospital wide approach to toilet door finish and standardised signage to ensure standardised, logical and integrated approach
- night lighting to support easy location of toilets at night

## 4. Reduce unhelpful stimulation

4.1

### Is there a public address, staff paging or call system with bells, audible medical equipment, loud speakers or flashing lights in use?

Within an acute care environment patients may require equipment that often has audible alarms or sounds. It is important to recognise that these can be distressing to a patient living with dementia, as she/he is more likely to have difficulty filtering out unnecessary noise.

The noise from public address and staff paging systems can also be disturbing. Bells, lights and public announcements can interrupt patients' daily life and cause distraction and confusion. They often give information which is not directed to patients, and so provide an unnecessary interruption for them.

A staff call system plays an important role in a hospital as it assists patients to contact staff and enables staff to respond to patients' needs. There are many types of staff call systems which are available. All have advantages and disadvantages and can be tailored to varying degrees to fit particular circumstances and settings. It is important to do research to determine which is the most appropriate system in a particular location, remembering that these systems can be a source of distress to patients living with dementia if they are noisy and difficult to use. There are also a number of additional items which are available and can be linked to a staff call system (such as a bed sensor). These can significantly enhance the ability of the staff to do their work and play an important role in meeting patients' needs.

#### ENSURE:

- staff paging systems sound only as needed, rather than throughout the ward
- the staff call system can be adapted and additional items used to meet a particular patient's needs
- Audible alarms, sounds and flashing lights on medical equipment at the patient bedside is turned off or minimised

#### AVOID:

- loud bells, flashing lights and public announcements

#### CONSIDER:

- ability to reduce volume of public address system and call bells in patient rooms to minimum acceptable level

#### **4.2 Does the noise from closing doors disturb patients (e.g. flapping doors, noisy automatic doors)?**

The sound of doors closing in a ward can be very distracting for a patient. It is important that doors can be closed quietly and door closers are adjusted to close doors quietly.

##### **ENSURE:**

- doors close quietly

##### **AVOID:**

- door closers that are poorly adjusted

##### **CONSIDER:**

- installing cushioning seals around doors

#### **4.3 Is the impact of noise limited in patient areas (e.g. deliveries, lifts, plant, door entry systems are not heard)?**

A hospital ward requires many deliveries. These are 'back of house' functions and need to remain that way. The introduction of unnecessary noise and the visual distraction of trolleys and new people making deliveries may interrupt patients and compromises their ability to focus on their recovery.

##### **ENSURE:**

- there are separate entrances and circulation routes for deliveries

##### **AVOID:**

- deliveries through patient areas

##### **CONSIDER:**

- zoning activities within the ward to ensure service areas (such as laundry washing and drying, food preparation and bulk supplies and cleaning stores) do not conflict with patient areas

## 4.4

**Are unnecessary sources of noise such as TV's, radios and audible medical equipment turned off or minimised?**

Unnecessary sources of noise can be very distracting for a patient. It is important that unnecessary sources of noise such as TVs, radios, audible medical equipment are turned off or minimised to reduce the impact on other patients. Such noise can significantly add to the amount of unhelpful stimulation the patient is exposed to.

**ENSURE:**

- unnecessary sources of noise such as TVs, radios and audible medical equipment is turned off or minimised
- patients utilise headphones if possible, particularly in shared rooms

**AVOID:**

- patient entertainment systems with individual speakers that are audible to other patients
- patient entertainment systems that combine a number of functions in one device

**CONSIDER:**

- type of patient entertainment system that is provided. It needs to be simple to use, with recognisable components and clear instructions.

## 4.5

**Are there designated quiet times (which staff as well as visitors must observe?)**

Hospitals are a challenging setting due to the busy, unfamiliar and stressful nature of the environment. For a patient with dementia the experience can be even more challenging with prolonged exposure to large amounts of stimulation which is confusing and disorientating for her/him. Providing a designated quiet time allows time for rest and recovery so a patient can better cope with the demands of the day.

**ENSURE:**

- designated quiet times on the ward
- quiet times are observed by all staff, patients and visitors

**AVOID:**

- unregulated access by visitors
- deliveries during designated quiet times

**CONSIDER:**

- using the environment to emphasise that this is a quiet time e.g., dimming lights, closing blinds

#### 4.6 Can the transfer of sound from one room to another be managed (e.g. by closing doors)?

Many patients are extremely sensitive to their auditory environment and in particular to noise levels, which at times may be very high in a hospital environment. Reducing noise levels and transmission of noise between ward areas may reduce stress and agitation.

##### ENSURE:

- noise levels are minimised on the ward
- doors are used when appropriate to help reduce transmission of noise between rooms

##### AVOID:

- socially isolating patients by leaving doors shut at all times

##### CONSIDER:

- selection of finishes to provide for absorption of noise (floor, wall, ceiling, doors)
- identifying a designated route through the ward is used for the delivery of supplies and removal of waste
- separating noisy and quiet functions within the ward
- placing patients with sensitivity to noise in quieter rooms on the ward

#### 4.7 Are single rooms available that have little exposure to staff operational noise?

Some patients may become distressed and may disrupt or intrude on other patients if in a shared patient room, or if subjected to high levels of noise. Placing a patient in a quieter part of the ward may provide her/him with a less stimulating environment, which is likely to result in better sleep and lower levels of anxiety and stress. It will, however, also mean that there is less capacity for staff supervision and observation.

There is often a balance between having a patient who requires higher levels of supervision near the staff base, and the awareness that patients with dementia have greater sensitivity to noise. Each patient should be assessed to provide the best option for them. Wards should have some quieter, single rooms available to provide the required flexibility.

##### ENSURE:

- single rooms with little exposure to staff operational noise are available
- staff operational noise is minimised (particularly during designated quiet times)

##### AVOID:

- routinely placing all patients with dementia in rooms near staff bases without considering individual needs

**CONSIDER:**

- installing features to allow for observation/supervision while minimising exposure to operational noise (i.e. closed doors with glass panels for unobtrusive observation, use of technology such as pressure mats and remote patient sensing to allow for remote observation)

**4.8****Is there a lot of visual clutter in the ward (i.e. staff notices, signage, objects, furniture that are either irrelevant to patients &/or make it hard for them to interpret their environment)?**

Too much visual stimulation in a ward can be very distracting and/or distressing for patients living with dementia. People can feel overwhelmed when faced with information which they are not able to process and understand.

Signs can become visual clutter when there are many of them, as they no longer stand out and catch people's attention. Notices and signs in patient areas need to be patient focused. Signage which is directed primarily at staff needs to be minimised in wards and instead placed in staff areas. Signage placement needs to be carefully considered, recognising that signs can have a negative impact if poorly located. Signs next to an artwork, for example, diminish the impact and ambience of the artwork.

A room full of furniture or equipment can also be visual clutter when it is difficult for someone living with dementia to see what they are looking for. Furniture that is left inadvertently in a room can create an impression of a store room, rather than a shared space or place to sit.

**ENSURE:**

- patients are able to focus on the most important objects in the room
- signs are only used when other environmental cues or means of communication are inadequate
- all signs and notices are current

**AVOID:**

- storing objects, equipment and furniture in rooms that are not store rooms
- clutter resulting from clinical information and objects
- placing information for staff only in patient rooms

**CONSIDER:**

- regularly reviewing the environment for visual clutter

#### 4.9 Is the entry to the ward easily visible to patients?

Activity at the ward entry can be disturbing for patients if they are not able to come and go as they wish. It is important that such activity is screened so that patients are not constantly prompted to think about trying to leave or faced with unnecessary distractions.

##### ENSURE:

- design allows for a discreet entry that is not easily observed from the main public areas of the ward

##### AVOID:

- direct entry into place to sit for patients

##### CONSIDER:

- making an obvious entry less obvious from the ward side by painting it the same colour as the wall or disguising it in another way, e.g. with a mural. (It is important to carefully consider the content of any mural so that it is relevant, age appropriate and not confusing.)

#### 4.10 Are doors to staff only areas easily seen (e.g. storerooms, clean and soiled utility rooms)?

Patients have no need to enter staff only areas or open doors to cleaners' cupboards. More importantly, these spaces may contain materials or equipment that could be harmful. It is important that patients' attention is drawn only to those doors which they can open and may lead to somewhere of interest, rather than to those which may be locked, are irrelevant, or present a potential danger to the patient or visitor.

##### ENSURE:

- doors to staff only rooms and cleaners' cupboards are unobtrusive
- doors to staff only rooms and cleaners' cupboards, and doors to patients' areas are not the same

##### AVOID:

- doors to staff only areas and cleaners' cupboards in patients' areas

##### CONSIDER:

- planning/location of staff only areas and cleaners cupboards
- locating staff only areas and cleaners' cupboards in staff zones

#### 4.11 Is the service entry (where food, linen etc is delivered) easily visible to patients?

As with activity at the ward entry, seeing activity at the service entry is unhelpful for patients. These functions relate to the 'back of house' services of a ward and should be carried out unobtrusively. The service entry should be screened and hidden so that it is not a focus for patients. Instead, their attention should be drawn to other more fulfilling areas of the ward. For staff, this separation will make their job easier as the likelihood of inappropriate involvement in these functions by patients is minimised.

##### ENSURE:

- separate unobtrusive service entry

##### AVOID:

- deliveries through the main ward entrance used by patients and visitors
- noise from service entry interrupting patients

##### CONSIDER:

- timing of deliveries to minimise patient interruption (i.e. avoid deliveries during designated quiet times)
- if no separate service entry, using side entrances for deliveries
- if no separate service entry, managing the use of main entry to minimise impact on patients and visitors

#### 4.12 Inside, can glare from natural light be managed by using curtains and blinds?

Natural and artificial lighting should be designed to avoid glare to ensure that patients can see easily within a room and to outside. The use of curtains and blinds can assist in managing glare at key times of day. The type of lamp and light fitting that are selected, the selection of surfaces and finishes, and the use of glass (which can reflect the light) should also be considered.

##### ENSURE:

- ability to control glare from windows using window furnishings
- light fittings and shades that protect from glare

##### AVOID:

- highly reflective surfaces and finishes

##### CONSIDER:

- light paint colours around windows to reduce contrast around windows as this can reduce glare
- orientation of windows
- using adjustable internal window shading treatment such as curtains or blinds
- outside awnings

### 4.13 Is the wardrobe (or cupboard) that the patient uses full of a confusing number of clothes and/or irrelevant objects?

It is important that patients have the opportunity to put their clothes or possessions away. Sometimes, however, too many choices aren't helpful and can leave a person feeling frustrated and confused. Limiting the number of things that can be easily accessed in a wardrobe/cupboard is a good way of minimizing this. Providing a less obvious wardrobe/cupboard, where the majority of clothes are stored, and a more obvious wardrobe with only limited, appropriate clothing (preferably chosen by the resident) is one approach.

#### ENSURE:

- patients have access to a wardrobe/cupboard containing only a small number of items
- simple layout of wardrobes/cupboard

#### AVOID:

- large wardrobes/cupboards with many doors/drawers
- locking all wardrobe/cupboard doors
- overcrowding wardrobe/cupboard with a lot of contents
- storing hospital supplies and equipment in patient storage

#### CONSIDER:

- making some wardrobe/cupboard doors less obvious
- reducing the number of wardrobe/cupboards

### 4.14 Are light fittings positioned so that they shine directly into a patient's eyes when they are lying on the bed?

As people age their eyes react more slowly to changes in light, meaning they require more time to transition between different light levels and issues with glare become more significant. Glare can be an irritant and can actually decrease visual performance. Lights that shine directly into a patient's eyes can be uncomfortable, confusing and distressing.

#### ENSURE:

- light fittings at the patient's bed do not shine directly into the patient's eyes when she/he is lying on the bed
- appropriate task lighting to enable staff to perform clinical tasks

#### AVOID:

- the use of downlights or spotlights
- shiny surfaces that reflect light

#### CONSIDER:

- the height and angle of lights so they don't shine directly into the patient's eyes
- providing adjustable lights at the patient's bed

## 4.15

**At night, is task lighting provided which enables staff to see to perform tasks without a) increasing overall lighting level in patient room & b) light shining directly into patient's eyes?**

At night, the change in light levels when a bright light is switched on to enable staff to perform tasks requiring high levels of illumination is more marked. This can cause great distress for a patient, particularly if she/he has been asleep and is awakened by a bright light. The discomfort and distress of sudden exposure to bright light in an ageing, slow to react eye, is greater than for a younger person. A well considered lighting plan can provide appropriate task lighting for staff at night without increasing the overall light level in a room or shining light directly into the patient's eyes. This is particularly important in a shared patient room where a number of patients can be unnecessarily impacted upon by poor lighting design.

**ENSURE:**

- light fittings at the patient's bed do not shine directly into the patient's eyes when she/he is lying on the bed
- appropriate task lighting to enable staff to perform clinical tasks at night

**AVOID:**

- the use of spotlights
- only providing lighting options that increase general illumination in the room
- shiny surfaces that reflect light

**CONSIDER:**

- the height and angle of lights so they don't shine directly into the patient's eyes
- providing adjustable lights at the patient's bed

## 4.16

**At night, can light from the corridor be prevented from entering a patient's room?**

As a person living with dementia experiences difficulties in coping with a large amount of stimulation, the environment should be designed to reduce the impact of stimulation that could impact on their wellbeing. This includes providing appropriate levels of darkness at night to promote sleep. Stray light from corridors can delay or disturb sleep. It may also suppress melatonin production, further disrupting sleep.

**ENSURE:**

- light from the corridor can be prevented from entering the patient's room through the use of shut doors, blinds or curtains
- corridor lighting is reduced at night

**AVOID:**

- leaving doors, blinds or curtains open to facilitate observations at expense of patient sleep

**CONSIDER:**

- night lighting of corridors

## 5. Optimise helpful stimulation

### Inside

#### 5.1 Are signs easy to see, read and understand?

Signage is integral to the design and function of hospitals, however, there is a risk of overstimulation and confusion when there is excessive and inappropriate use of signage. It must be remembered that not all signage is helpful or necessary. The content and placement of signs needs to be carefully considered. If signs are not effective, they are not providing helpful stimulation.

#### ENSURE:

- signage has a distinct and consistent identity
- signage is located in critical locations such as key decision points and locations
- appropriate signage (size, clear text, graphics, matt finish)
- signs are carefully positioned so they can be easily seen (height, location)

#### AVOID:

- unnecessary replication of signage

#### CONSIDER:

- a consistent, hospital wide signage strategy
- the use of redundant cueing to aid in wayfinding, i.e. providing more than one cue to the same thing (for example, through the use of colour, texture, finish, signage, images, artwork) recognising that different things can be meaningful to different patients and at different times
- regular review of signage on ward to remove unnecessary, out of date or damaged signs

#### 5.2 What percentage of patients have a clearly defined path from their room to a place to sit (e.g. by using colour, objects and/or signage)?

A place to sit can be a key destination for patients once they are able to leave their beds. Therefore it is important that patients can make their way there with little assistance. While it is desirable for patients to see a place to sit as they step away from their rooms, this may not always be possible and so attention needs to be paid to the design of the route to the place to sit.

#### ENSURE:

- patients can either see a place to sit, or the way to a place to sit, from the doorway of their room
- the way to a place to sit is clearly recognisable e.g. through the use of colour, furniture, artwork or appropriate signage

**AVOID:**

- corridors which do not have a clear indication of where they lead (e.g., to a place to sit)
- corridors that look like each other (refer 5.4)

**CONSIDER:**

- the transparency of the place to sit if it is a separate room. (Perforated screens, glass, small inside windows and low walls may increase the transparency between rooms, whereas curtains, solid walls and furniture may decrease the transparency)
- the use of multiples cues such as visual, auditory and olfactory (e.g. the smell of coffee brewing or toast being made)

**5.3 Is a place to sit clearly recognisable from the corridor?**

A place to sit can be a key destination for patients once they are able to leave their beds. It is important that it can be easily recognised upon entering the corridor, and upon approaching the space. The use of colour, artwork and/or appropriate signs or symbols will assist patients in this regard. An indication from outside the room as to what is inside is also valuable, rather than relying upon someone to open a closed door to see what is inside.

**ENSURE:**

- the place to sit is recognisable (whether it is a room, a nook, part of a larger space or an area along a corridor)
- the use of multiples cues to assist recognition and wayfinding (visual, auditory and olfactory)

**AVOID:**

- barring entry to the place to sit through a locked door
- closing the door and turning off lights when the room could be used
- using 'left over' furniture in these areas which does not clearly indicate the use and purpose of the space
- using these areas as storage areas
- using curtains, solid walls and furniture in a way that decreases the transparency of the place to sit

**CONSIDER:**

- the transparency of the place to sit (for example, using perforated screens, glass, small inside windows and low walls to increase the transparency).
- furniture selection so that the purpose of the place is highlighted
- introducing images near the approach such as a painting of people sitting relaxing, lounge chairs etc
- promoting music, song and chatter

#### 5.4 Are different corridors clearly recognisable so patients can identify where they are (e.g. variety of materials, appropriate signage, colour)?

There can be many corridors within a ward and each corridor can be quite long if it leads to a number of rooms. It is therefore important that the corridors do not all appear the same, and that each corridor is broken up into different parts, to highlight, for example, a group of patient rooms, a sitting alcove, a view, or a door leading to outside. This can be done in many ways, for example, by using lighting (both natural and artificial), colour, artwork, a change in ceiling height or treatment, varied placement of windows, framing of a view or by varying the width of the corridor.

##### ENSURE:

- corridors have identifiable parts
- a range of finishes and features are included in a corridor

##### AVOID:

- repetitive corridors
- repetitive finishes
- using the same features in different corridors

##### CONSIDER:

- introducing features such as lighting (both natural and artificial), colour, artwork, a change in ceiling height or treatment, sitting alcove, skylight, views, paintings, framing of a view, varying the width of the corridor, varying the placement of windows

#### 5.5 Is colour, artwork or appropriate signage used to differentiate patient rooms?

It is important to be able to identify the room before a door is opened and when a person looks into a room. This will enable patients to find their room, feel confident it is theirs, and (ideally) only enter their room. The finish on patient room doors can be varied (in detailing or colour) to assist this. Patient name, photos, art work and memory or shadow boxes (which allow a person to display some of their favourite things outside their room) can also be used effectively to identify patient rooms as belonging to a particular person prior to entry.

It is also important to be able to differentiate between the inside of patient rooms as well. This will reassure patients that they are in the correct place, and also promote some sense of wellbeing when inside the room.

##### ENSURE:

- patients have the opportunity to identify their room from outside the entry
- patients can personalise their rooms in some way

**AVOID:**

- repetition (for example of door finish, colour, furniture, layout)

**CONSIDER:**

- colour, photos, art work and memory or shadow boxes (inside and outside the patient room)
- a standardised signage system to identify individual patient rooms with names as appropriate that can also allow for variety and personalisation (e.g., clipframe on door to provide easy and clear patient name signage with the possibility of finish in colour and decoration)

### **5.6 Is colour, artwork or appropriate signage used to differentiate patient bed bays?**

In shared rooms it will be important for a patient to not only find their room, but to be able to identify which bed bay is theirs.

**ENSURE:**

- each bed bay is differentiated (colour, finishes, artwork, clear signage, furniture, personal items)
- patients can personalise their bed bay
- some personal space is provided at the bed bay

**AVOID:**

- repetition (for example of colour, furniture, artworks)

**CONSIDER:**

- colour, photos, art work and shelf for personal items
- providing standard furniture in a variety of colours or finishes to allow for variety within a patient room

### **5.7 Can patients see their personal items (e.g. photos, pictures, objects) when in bed?**

Having some personal items with them in hospital can provide a unique and familiar reminder to a person that this is their room or bed. This can help reduce anxiety in an otherwise very unfamiliar environment. These items (such as photos, pictures and objects) need to be placed so that the patient can see these items when in bed if they are to be of benefit to them.

In an acute care environment, extensive personalization cues may not always be appropriate due to short length of stay, frequent turnover of patients and infection control regulations. However, consideration should be given to limited personalisation of spaces and provision of cues, especially for patients living with dementia.

**ENSURE:**

- items are displayed where patient can see them while in bed

**AVOID:**

- placing items above bed head or in visually obscured location in room

**CONSIDER:**

- dedicated space for displaying patient personalisation items (such as a shelf or Velcro 'pin' board located on wall at foot of bed)

**5.8 Can most patients see out of a window from their bed?**

Patients may spend more time in their bed if they are less mobile, for example because they have difficulty moving about or are ill. It is particularly important that patients are not removed from contact with nature just because it is difficult for them to go outside. Having a view to outside gives patients the opportunity to connect with nature, to be aware of the time of day, the season, and the changes that take place in any day. An attractive view can provide an important source of stimulation and provide a good conversation point.

**ENSURE:**

- each patient room has a view to outside
- curtains and other obstructions in shared rooms are opened/removed when possible to ensure all patients have a view to outside

**AVOID:**

- rooms which have a poor view to outside e.g. of a plain brick wall

**CONSIDER:**

- designing layout of rooms to enable all patients to have a view to outside
- how attractive outside views can be created

**5.9 Are ensuite/shared bathroom/toilet doors clearly marked with an appropriate sign and contrast?**

Shared ensuites, bathrooms and toilets need to be clearly recognisable. These rooms will be used frequently, and if they can be easily found when they are needed it will reduce the stress and anxiety in older people. The finish to doors to shared ensuites, bathrooms and toilets should be clearly different from bedroom doors. Any signage should be meaningful and appropriate in size, language, contrast and colour. Signs should combine words and symbols, be placed at eye level or lower and contrast with the background.

**ENSURE:**

- ensuite/bathroom/toilet doors are recognisable

**AVOID:**

- ensuite/bathroom/toilet doors being the same colour and finish as bedroom doors

**CONSIDER:**

- colour, contrast, plates, sign, symbol, lighting
- hospital wide design scheme to ensure standardisation, logical and integrated approach (e.g., a toilet door is always the same shade of blue with consistent signage)

### **5.10 In a typical patient room can most patients see the toilet pan, toilet door, or a commode from their bed when lying down?**

If patients are able to see the toilet door it will assist them to locate and use the toilet.

If the toilet pan can be seen as soon as the ensuite door is opened, it will assist patients to recognise and use this room. Placing the toilet pan in a prominent position in a room will reduce the chance of the confusion and distress that can occur if patients fail to recognise the room and so continue to look for a toilet. In particular at night, the visibility of an ensuite door and a toilet pan will help a patient to maintain independence. This can reduce inappropriate use of other parts of a room and minimise discomfort and embarrassment for the patient, their family and staff. If commodes are used, they also need to be clearly visible from the patient's bed to encourage their use and reduce the anxiety caused by the patient needing to find a toilet.

**ENSURE:**

- toilet door or toilet pan can be visible from the bed
- contrast between the toilet pan, floor and walls
- contrasting toilet seat is used

**AVOID:**

- obscuring the toilet pan
- using white fittings in a room with white finishes

**CONSIDER:**

- artificial lighting over the toilet (to ensure it is not in shadow)
- a low level of night lighting to the toilet and ensuite area
- skylight over toilet
- positioning of pan in the room so it is clearly visible upon opening the door

### **5.11 Is contrast used to help people see key features in shared bathrooms (including taps, basin, rails and toilet)?**

If a patient is unable to see an object such as a toilet, it is unlikely that they will be able to use it. Contrast is often of far more importance than the colour of an object. (It is possible for objects to be of different colours but have little contrast between them and so appear the same. In these cases the objects will blend into one another.) It is important that there is contrast between horizontal surfaces, e.g. toilet seat and floor, basin and vanity bench top, taps and basin so that object that is to be used stands out. Contrast between vertical surfaces is also necessary, for example so that doors can be easily seen, handles stand out against cupboard doors etc.

#### **ENSURE:**

- contrast is used so that objects can be seen easily

#### **AVOID:**

- bland environments where there is little contrast
- contrasting floor finishes (refer 1.10 & 1.11)

#### **CONSIDER:**

- the use of contrast when selecting colours, finishes, fittings and furniture

### **5.12 Is contrast used to help people see key features in the ensuite (including taps, basin, rails and toilet)?**

As with 5.11 if a patient is unable to see an object such as a toilet, it is unlikely that they will be able to use it. It is important that there is contrast between horizontal surfaces, e.g. toilet seat and floor, basin and vanity bench top, taps and basin so that object that is to be used stands out. Contrast between vertical surfaces is also necessary, for example so that doors can be easily seen, handles stand out against cupboard doors etc.

#### **ENSURE:**

- contrast is used so that objects can be seen easily

#### **AVOID:**

- bland environments where there is little contrast
- contrasting floor finishes (refer 1.10 & 1.11)

#### **CONSIDER:**

- the use of contrast when selecting colours, finishes, fittings and furniture

### 5.13 Do the toilet seats (commode/over toilet seats) contrast with the floor and/or wall?

It is vital that toilet seats contrast with the background so that they can be easily seen and identified by the patient. This is necessary for commodes and over toilet seats too.

#### ENSURE:

- contrasting toilet seats
- contrast between the toilet pan, floor and walls
- toilet pan is visible from doorway of shared ensuite, bathroom or toilet

#### AVOID:

- white toilet seats with white pans and white tiling
- obscuring the toilet pan

#### CONSIDER:

- lighting directly over the toilet
- positioning of pan in the room so it can be easily seen

### 5.14 Are olfactory cues (such as food smells and familiar toiletry products) used to provide a variety of experiences for a patient?

It is important that all of the senses are considered when providing cues that can be helpful to a person living with dementia, and the sense of smell has an important role to play. The smell of coffee brewing or toast being prepared can stimulate memories and orientate someone to time of day. The smell of food can help people feel ready to eat, and to find their way toward a kitchen or dining room if that is the goal. These cues need to be used carefully so that they do not compete with each other or become overwhelming and confusing. It should also be recognised that patients may have positive or negative associations with certain aromas and these need to be considered when using olfactory cues. Allergies will also need to be taken into account.

#### ENSURE:

- olfactory cues are considered and regularly reviewed to meet patients' needs

#### AVOID:

- multiple concurrent olfactory cues as this can be confusing
- contradictory messages being given by olfactory cues e.g., the smell of food and cleaning products. Is it lunch time or time to clean the ensuite?

#### CONSIDER:

- how to change olfactory cues to reflect different times of day and seasons

### 5.15 Are there auditory cues to provide a variety of experiences for a patient?

It is important that all of the senses are considered when providing cues that can be helpful to a person living with dementia, and the sense of sound has an important role to play. Music can stimulate memories, alter moods and give patients a variety of experiences. Auditory cues need to be used carefully so that they do not compete with each other or become overwhelming and confusing. Patients may have positive or negative associations with certain sounds, and this also needs to be taken into account when using auditory cues.

#### ENSURE:

- auditory cues are considered and regularly reviewed to meet patients' needs

#### AVOID:

- multiple concurrent auditory cues as this can be confusing

#### CONSIDER:

- how to change auditory cues to reflect different times of day and seasons

### 5.16 Is there an attractive view to outside from the place to sit for a person when seated or lying down? (does not include patient's room)

When patients may spend time lying down, perhaps because they are ill. This should not, however, mean that they need to remain in their rooms, just because they are not able to sit up. Where possible a place to sit should allow for patients to both sit and lie down. Having an attractive view when sitting or lying down gives patients the opportunity to connect with outdoors, to be aware of the time of day, the season and the changes that take place in any day. An attractive view can provide an important source of stimulation and provide a good conversation point.

#### ENSURE:

- low sill height e.g. 600mm to allow a view outside when sitting or lying down
- place to sit has an attractive view to outside
- when a bed is used in the place to sit or other common space it can be located to take advantage of the view

#### AVOID:

- windows with high sill height
- providing only small places to sit where patients' beds cannot be accommodated

#### CONSIDER:

- how furniture can be arranged flexibly to meet different sitting/lying positions

### 5.17 Is the ward reception/staff base easily identifiable?

If patients (and visitors) can easily see a staff base it can help them to feel supported whilst in hospital.

#### ENSURE:

- staff bases can be easily seen from the corridor (colour, finishes, appropriate signage, lighting)

#### AVOID:

- corridor clutter that obscures the view of the staff base

#### CONSIDER:

- location(s) of staff bases(s) within the ward so they can be easily seen and their purpose identified
- hospital wide approach to staff bases and standardised signage to ensure standardised, logical and integrated approach
- establishing clear lines of sight from patient room thresholds to staff base during design phase

### 5.18 In a typical patient room, can you (the observer) read this easily without the use of artificial light from each bed location?

Lighting plays a key role in making a place easy to navigate and pleasant to be in. There should be sufficient natural lighting in a patient's room so that artificial lighting is not required during the daytime. This will increase the usability of the room and ensure that patients are able to see the room and what is in it at all times, rather than being reliant on someone turning on the light for them. Natural (and artificial) lighting should be designed to avoid glare to ensure that patients can see easily within the room and to the outside.

#### ENSURE:

- sufficient natural lighting for daytime use

#### AVOID:

- glare
- reflective surfaces

#### CONSIDER:

- the positioning of beds in relation to windows
- the location of the entry to the patient room to avoid glare or backlighting
- the design of window furnishings

### **5.19 In a typical corridor, can you (the observer) read this easily without the use of artificial light?**

Lighting plays a key role in making a place easy to navigate and pleasant to be in. There should be sufficient natural lighting in ward corridors so that artificial lighting is not required during the daytime. This will increase the usability of the space and ensure that patients are able to see the corridor and what is in it at all times, rather than being reliant on someone turning on the light for them. Natural (and artificial) lighting should be designed to avoid glare to ensure that patients can see easily within the room and to the outside.

#### **ENSURE:**

- sufficient natural lighting for daytime use

#### **AVOID:**

- glare
- reflective surfaces

#### **CONSIDER:**

- location of windows in the corridor
- the design of window furnishings

### **5.20 In the most used place to sit, can you (the observer) read this easily without the use of artificial light?**

Lighting plays a key role in making a place easy to navigate and pleasant to be in. There should be sufficient natural lighting in the place to sit so that artificial lighting is not required during the daytime. This will increase the usability of the place to sit and ensure that patients are able to see the space and what is in it at all times, rather than being reliant on someone turning on the light for them. It is important that a person looking into the room can see who and what is there. Natural (and artificial) lighting should be designed to avoid glare to ensure that patients can see easily into the room, within the room and to the outside.

#### **ENSURE:**

- sufficient natural lighting for daytime use

#### **AVOID:**

- glare
- reflective surfaces

#### **CONSIDER:**

- the location of the entry to the place to sit
- positioning of furniture in relation to windows
- the design of window furnishings

### 5.21 Are a variety of materials and finishes used to create an interesting and varied environment for a patient?

When a variety of materials is used important stimuli can be emphasised, scale can be reduced (by avoiding repetition and making areas appear more intimate) and a more familiar environment can be created. Materials and finishes can also be used to make places more memorable, and the experience of being in them more memorable. The feel of different materials and surfaces can stimulate memories and give patients varied and rewarding experiences. Walking on tiles feels different to walking on carpet or timber. Materials need to be used carefully so that they do not compete with each other or become overwhelming and confusing.

The environment can also give us a strong indication of how we are to behave, and what we are to do in a certain place. If a person is no longer able to initiate an action or remember what a certain room is for, it is especially important that he/she is able to receive this information from the environment and receive a cue as to the room's purpose. Each room should have its own distinctive characteristics so that its use is clearly identifiable, for example as a patient lounge, or place to sit. This also means that patients and staff are offered a variety of experiences.

#### ENSURE:

- that the purpose and identity of rooms are easily recognisable
- the use of multiples cues including furniture, room arrangement, furnishings and finishes

#### AVOID:

- using common colour schemes and furniture throughout a hospital

#### CONSIDER:

- how identity can be created, e.g. by the use of different wall colours, artwork, fabrics in a variety of areas

## Outside

### 5.22 Are contrasting materials used so that the edges of surfaces and objects can be easily seen (e.g. clear distinction of path edge, between seats and paving)?

If a patient is unable to see the edge of a path it is less likely she/he will remain on it. If a patient cannot see an object such as a chair, it is unlikely that she/he will be able to sit down. It is important that there is contrast between horizontal surfaces, e.g. chair seat and path, table top and seat, table top and floor so that object stands out. Contrast between vertical surfaces is also necessary.

#### ENSURE:

- contrast is used so that objects can be seen easily

#### AVOID:

- bland environments where there is little contrast

#### CONSIDER:

- contrasting path surfaces (refer 1.10 & 1.11)
- ways to integrate contrast into finishes and furniture (as well as colour)

### 5.23 Are olfactory cues (such as perfumed plants) used to provide a variety of experiences for a patient?

There are many cues that can be helpful to a person with dementia. It is important that all of the senses are considered when providing cues and the sense of smell has an important role to play. The smell of lavender or basil can stimulate memories and help people find their way to a pergola or entry to the ward. These cues need to be used carefully so that they do not compete with each other or become overwhelming and confusing. Patients may have positive or negative associations with certain aromas and so this to be taken into account when using olfactory cues. Allergies will also need to be taken into account.

#### ENSURE:

- olfactory cues are considered and regularly reviewed to meet patients' needs

#### AVOID:

- multiple concurrent olfactory cues as this can be confusing

#### CONSIDER:

- how to use olfactory cues to reflect different seasons

### 5.24 Are there auditory cues to provide a variety of experiences for a patient?

There are many cues that can be helpful to a person with dementia. It is important that all of the senses are considered when providing cues and the sense of sound has an important role to play. The sound of wind chimes, for example, can draw people to that part of the garden. Auditory cues need to be used carefully so that they do not compete with each other or become overwhelming and confusing. Patients may have positive or negative associations with certain sounds and so this needs to be taken into account when using auditory cues.

#### ENSURE:

- auditory cues are considered and regularly reviewed to meet patients' needs

#### AVOID:

- multiple concurrent auditory cues as this can be confusing

#### CONSIDER:

- how to change auditory cues to reflect different times of day and seasons

### 5.25 Are a variety of materials and finishes used to create an interesting and varied external environment for a patient?

When a variety of materials is used, important stimuli can be emphasised, scale can be reduced (by avoiding repetition and making areas appear more intimate) and a more familiar environment can be created. Materials and finishes can also be used to make places more memorable, and the experience of being in them more memorable. The feel of different materials and surfaces can stimulate memories and give patients varied and rewarding experiences. Walking on tiles feels different to walking on carpet or timber. Materials need to be used carefully so that they do not compete with each other or become overwhelming and confusing.

#### ENSURE:

- a variety of materials and finishes are used to create an interesting and varied environment

#### AVOID:

- the repetitive use of materials and finishes
- contrasting path surfaces (refer 1.10 & 1.11)

#### CONSIDER:

- how to use a variety of materials and finishes to offer a range of experiences and reinforce a sense of place

## 6. Support movement and engagement

### Inside

#### 6.1 Is there a clearly defined and easily accessible path that guides the patient back to their starting point without taking them into a blind alley or to a locked door?

It is important that patients are able to move freely and continuously when moving around the ward and reach destinations that are meaningful. They should not end up at a dead end where they can go no further and cannot easily see how to go back. If the environment supports patients in this way it will also give them more confidence to explore the ward, providing a greater level of comfort and reducing stress.

Another aspect of encouraging patients to move about freely is to ensure that not only the ward layout, but the ward corridors themselves are well designed. Attention needs to be given to sight lines, the selection of flooring and minimising obstacles.

#### ENSURE:

- pathways around the ward are continuous
- pathways do not contain hazards such as stored furniture, equipment and supplies

#### AVOID:

- dead ends, pathways that lead to nowhere
- multiple decision points

#### CONSIDER:

- widening corridors occasionally to provide sitting areas and places off the main route but without dead ends
- how relevant destinations can be made obvious to patients

#### 6.2 Can patients clearly see opportunities for meaningful engagement (either actively or passively)?

When patients are well enough to leave their bed, it is important that they are able to see opportunities for meaningful engagement. Patients may not have a clear idea of what they would like to do, or what they are looking for. They may also have forgotten where the place they are looking for is. The goal of designing the circulation within a building is not to keep patients moving, but rather to help them find places of interest and give them a rewarding experience once they are able to move beyond their bed and explore the ward. If destinations are easy to see, and there are clear landmarks along the way, the journey will be more interesting. This journey could offer patients opportunities to engage with others, to sit quietly, to take in a view and to engage in some activities, e.g., look at a newspaper, look at some artwork or reminisce about some old photos. In this way patients will be offered an experience that it is interesting and engaging.

**ENSURE:**

- the internal path is clearly defined and opportunities for participation are highlighted

**AVOID:**

- corridors with no view to other areas
- dead ends/corridors that lead to nowhere

**CONSIDER:**

- familiar landmarks along the way to important areas of the ward

## Outside

### 6.3 Is there a clearly defined and easily accessible path that guides the patient back to their starting point without taking them into a blind alley or to a locked door?

The goal of designing the **external path** layout is also to not to keep patients moving, but rather to give them a rewarding experience. Patients may not have a clear idea of what they would like to do or what they are looking for. They may also have forgotten where the place they are looking for is located. If the path takes a patient past places of interest which are easy to see, it can give patients an idea of what they might like to do.

This journey should offer patients opportunities to engage with others, engage with activities, a range of stimuli and other people or to sit quietly, for example to take in a view. In this way patients are offered experiences that are interesting and rewarding.

**ENSURE:**

- the path guides patients to points of interest and participation, such as raised garden beds, fragrant plants or artworks

**AVOID:**

- paths that lead to nowhere
- dead ends

**CONSIDER:**

- changing landscaping to create a varied outside environment
- at some point along important paths ensuring there is a close view (e.g., of patients and activities) and a medium view (e.g., of possible destinations within the ward). Where patients are used to having a long view (e.g., view to the paddocks), this may also be appropriate.

## 6.4 Can patients clearly see opportunities for meaningful engagement (either actively or passively)?

Patients should be offered opportunities to engage with others, to sit quietly by themselves, to take in a view or engage in activities while outside. Patients may not have a clear idea of what they would like to do or what they are looking for. They may also have forgotten where the place they are looking for is located. If opportunities for meaningful engagement are easily visible, patients will be able to choose what they wish to do and enjoy a variety of experiences.

### ENSURE:

- places of interest are easy to see
- paths guide patients to places of interest

### AVOID:

- paths that lead to nowhere

### CONSIDER:

- what will be interesting and engaging for patients (based on context, life experience etc)
- changing landscaping to create a varied outside environment
- a range of things for patients (their visitors and staff) to do (recognizing people's preferences can vary enormously)

## 6.5 Are there chairs or benches at frequent intervals so people can sit and enjoy the fresh air?

A patient can become tired while walking and may need a place to rest to prevent falls and injury, or to simply enjoy being outside. The provision of seats and benches at frequent intervals around the path is important.

### ENSURE:

- seating is provided at regular intervals
- seating is clearly recognisable as a place to sit (and not a garden object)

### AVOID:

- seating with sharp edges and rough surfaces

### CONSIDER:

- a variety of different seats (heights, materials and locations)
- allowing for wheelchair stopping points near seating

## 6.6 Are there both sunny and shady areas along the path?

There will be times when sunshine is sought after and others when shade is required. Patients can become hot and dehydrate if they are outside in summer, or cold if they are outside in winter. Opportunities to be in the shade or in the sun are therefore important if patients are to enjoy being outside.

### ENSURE:

- places along the path offer patients shade and sun

### AVOID:

- making outside sitting areas in places that are windy
- large surfaces that reflect the heat of the sun onto patients walking on the path

### CONSIDER:

- where and when the sun will shine in winter and summer in relation to the building, outside structures and verandahs

## 6.7 Are there verandahs or shaded seating areas in close proximity to the building?

It is important that patients are encouraged to spend time outdoors, and that it is easy for them to do so. Verandahs and shaded seating areas provide a great opportunity for patients to enjoy fresh air, without being unduly exposed to the weather, be it rain, sunshine or heat.

### ENSURE:

- there is good view from the building to outside verandah areas and shelters
- the exit to the outside verandah and seating areas is easily identified
- the path to the sitting areas is clearly defined

### AVOID:

- placing sheltered seating areas out of sight and
- placing sheltered seating areas not within easy reach of the building

### CONSIDER:

- direction of sun and wind to ensure that different areas can be used in different weather conditions and seasons
- furniture is inviting and ready to use (e.g. chairs not stacked in a corner)

## 7. Create a familiar place

### 7.1 How many of the patients have familiar items (e.g. photos, pictures, objects) near their bed?

If patients' rooms are to be familiar to them, it will help if they are able to bring some favorite and/or recognisable items into hospital with them. For some people, a cushion or blanket, or perhaps a dressing gown will be best, for others photos of family and friends will be important. The form of this decoration will depend on the patients' life experiences, hobbies, likes and dislikes. In a shared room, it is essential that patients are able to personalise a part of the room if they wish.

#### ENSURE:

- opportunity to display personal items so they can be seen from a patient's bed
- hooks and rails on walls to hang photos and other objects

#### AVOID:

- decorating rooms in a way that leaves no opportunity for personalisation by patients
- placing familiar items out of the patient's line of sight

#### CONSIDER:

- areas of pin board or fabric covered materials that will allow an easily maintained surface for pinning (or velcroing) photos and pictures onto the walls

### 7.2 Does the most used place to sit contain pieces of furniture that would be seen as domestic by the majority of patients?

Patients are likely to spend a large amount of time in the place to sit. It is therefore important that these rooms are familiar to patients, as this can contribute to a sense of wellbeing and calm. The presence of domestic furniture will not only help to create a warm and inviting atmosphere in the room but will encourage patients to use the places and enjoy them. Materials and finishes need to be selected to allow for cleaning.

#### ENSURE:

- there is a variety of furniture types i.e. several styles of chairs
- a variety of furniture heights
- a variety of familiar furniture coverings
- finishes are selected to allow for cleaning of surfaces and fabrics

#### AVOID:

- commercial or institutional furniture selection
- repetitive use of furniture

**CONSIDER:**  
.....

- the domestic lounge room as the model for furniture selection
- how familiar furniture can encourage people to find their favourite place
- furniture that is appropriate for inside and outside and can be easily moved from one to another

**7.3****Is the most used place to sit used to store items such as linen trolleys, medical equipment, wheelchairs, hoists and furniture?**

Making the space to sit welcoming and comfortable is essential if it is to be used by patients and their visitors. Using this space as a storage area for ward equipment and furniture means that the use of the space may be unclear to patients and as a result the space may be unused.

**ENSURE:**  
.....

- the space is maintained as a place to sit
- the space is recognisable as a place to sit

**AVOID:**  
.....

- storing ward equipment and furniture in this area

**CONSIDER:**  
.....

- regular review and tidying of this space

## 8. Provide a variety of places to be alone or with others

### 8.1 Are there places where a person can sit on their own or in private conversation away from their bed?

All wards need to have a number of places where patients, friends, staff and families can sit, either on their own or with others. Small areas or nooks are an important way to give people many choices. They can be an area to the side of a corridor, a space at the end of a corridor, a bay window in a larger room, or a little room off a larger room. The more of these small areas or nooks there are in a ward, the greater the opportunity for patients to enjoy privacy or community.

#### ENSURE:

- small areas for quiet conversation/interaction are provided away from a patient's bed
- large common areas are edged with nooks and smaller areas for small groups and individuals
- nooks and the smaller edge rooms have a view or something to look at
- corridors, especially long corridors, are broken up by the provision of a space and furniture that enables people to have a conversation

#### AVOID:

- large undifferentiated places
- creating spaces to sit in dark, unfriendly or uninteresting spaces on the ward
- creating spaces to sit in places where patients may feel they are in the way of ward activity

#### CONSIDER:

- varying corridor and hall widths to accommodate small sitting places

### 8.2 Are there places (not in a patient's room) where a small group of people can gather?

People can do different things and feel different emotions when they gather in a small group. For example, in a small group people may have a private conversation, listen to music or play cards. It is important that small groups of people can gather away from the patient's bed without needing to rearrange the furniture, or bring seats from one room to another. (If the furniture has to be rearranged for people to gather in this way, it is less likely to happen and so opportunities for patients to experience a more private gathering will be lost.)

#### ENSURE:

- furniture layouts accommodate small groups

**AVOID:**

- undifferentiated furniture arrangements that cater only for large groups
- furniture arrangements that require everyone to be together

**CONSIDER:**

- the varied use of common areas for different group sizes
- flexible furniture design and layout to suit different group sizes

**8.3****Can a family member/support person sit with the patient at their bedside?**

Family members and support people can make an important contribution to care within the acute care environment, especially for people living with dementia. Providing a comfortable space for visitors can increase social support for the patient.

**ENSURE:**

- comfortable furniture is available at the bedside for use by visitors

**AVOID:**

- making access to visitor furniture difficult

**CONSIDER:**

- providing adequate space for visitor furniture at the bedside so the visitor is not required to move out of the way when staff are in attendance

**Outside****8.4****Are there places where a person can be on their own and/or in private conversation?**

Patients should be able to choose to socialise in different ways. Sometimes people may choose to spend time on their own or in a small group. Certain activities are better suited to a more private setting, such as having a conversation. The **outdoor** environment needs to allow patients opportunities to gather in small groups in public and private so that patients can choose what is best for them at a particular time.

**ENSURE:**

- outdoor furniture arrangement encourages conversation
- the widths of verandah areas can accommodate small groups and still allow safe circulation past the group
- there are seasonal outside places where people can be on their own or in private conversation (shaded summer places and sunny winter places)

**AVOID:**

- wind and sun exposed seating and tables outside
- installing fixed furniture which does not allow for private conversations

**CONSIDER:**

- how the selection of outside furniture can support people to be on their own or in private conversation

### 8.5 Are there places where a small group of people can gather?

People can do different things and feel different emotions when they gather in a small group. For example, in a small group people may have a private conversation, listen to music or play cards. It is important that small groups of people can comfortably gather outside without rearranging the furniture. If the furniture has to be rearranged for people to gather in this way, it is less likely to happen and so opportunities for patients to experience a more private gathering will be lost.

**ENSURE:**

- furniture layouts accommodate small groups

**AVOID:**

- undifferentiated furniture arrangements that cater only for large groups
- furniture arrangements that require everyone to be together

**CONSIDER:**

- a variety of different external settings which are designed for different group sizes
- flexible furniture design and layout to suit different group sizes

## 9. Link to the community

### 9.1 Is it possible for a family member/support person to stay with a patient during the night?

Providing an environment that can support an appropriate family member/support person to stay overnight with the patient living with dementia may help the patient feel safe and secure. It may also assist staff to provide dignified care. Ideally this space should be comfortable for the family member/support person and help them to feel welcome, as well as get some rest. Staff should be able to attend the patient without disturbing the family member/support person.

#### ENSURE:

- a comfortable bed or appropriate reclining chair is available for overnight stays by an appropriate family member/support person

#### AVOID:

- providing unsuitable seating for overnight stays

#### CONSIDER:

- providing space at the bedside that will accommodate an overnight stay without obstructing staff when delivering patient care

### 9.2 Is there a place where families and friends can share meals and/or celebrations with their relatives/friends who are patients (e.g. café, garden)?

A person living with dementia can become isolated and less engaged as they become frailer. Engagement with family and friends (as well as the wider community) is vital to reinforce a person's identity, encourage interaction with other people and maintain the skills and interests of the person living with dementia. This also plays an important role in reducing the stigma that can be associated with dementia.

Sharing a meal together is a pleasure for many people. Community spaces in the hospital may provide opportunities to gather in a public and social space. However, it is important that patients and their families also have the opportunity to gather in a more private setting to eat and relax if they want to. The inclusion of such places is likely to encourage family and friends to visit a hospital as they feel welcome and are able to interact with their loved one in the way they are used to in the community.

#### ENSURE:

- one or more areas or rooms which can be used by families to dine with a patient
- area is attractive and comfortable
- places are included in the hospital where the person with dementia can engage with the wider community (e.g. café's and gardens)
- places are included in the hospital which encourage the wider community to come to the hospital

#### AVOID:

- distractions near the area such as main circulation pathways
- signage with lots of rules and instructions
- isolating the ward so it is difficult for patients to gain access to other parts of the hospital

**CONSIDER:**

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- flexible furnishings, flexible screening to accommodate small or large group
- location of cafés, gardens and other community spaces for ease of access by frail or less mobile patients and visitors
- location of meeting rooms and gathering places so they are easily accessed by the wider community
- providing internal and external places for the community to use

## 10. Design in response to vision for way of life

### 10.1 What is the vision of the ward? To provide:

- a) a homelike environment
- b) a hotel like environment with hotel like services
- c) a medical care hospital
- d) a salutogenic\* environment
- e) other . . .

*\*A 'salutogenic' approach is one that focuses on factors that support health and wellbeing, beyond a more traditional, 'pathogenic' focus on risk and problems.*

The development of a clear vision for a way of life in the hospital is vital.

The vision will influence the design of the ward, for example a kitchen may be essential if the vision is one of taking part in ordinary activities of daily life. However, if the focus is instead on social activities, the kitchen may be replaced with a patient common room or a place for playing bowls or bocce.

The vision will influence the priorities of a ward and how patients will spend their time within the ward and in the wider community. It will give the staff direction and help patients and their families understand what kind of care they can expect. Patients are not all the same. They come to hospital with a variety of life experiences and preferences. They enjoy doing different things and will look to continue these as far as they are able whilst in hospital. This is important to make the hospital stay as short and pleasant as possible, and to retain these skills for the patient's return home. It may not be possible for a hospital ward to meet the needs of every potential patient, but articulating a vision will assist both the hospital and the patient (and their families and friends) to know what is possible.

#### **ENSURE:**

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- there is a clearly articulated vision for how patients are to live while in the hospital, what they can do etc

#### **AVOID:**

---

- assuming all patients enjoy the same lifestyle and have the same needs

#### **CONSIDER:**

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- ways in which the environment can enable the vision to be realised

**10.2 How well does the built environment enable this to happen?****1 = not at all well****5 = extremely well**

The term 'built environment' refers to aspects of our surroundings that are built by humans (i.e., buildings and gardens), rather than the natural environment (air, water etc). Sometimes the built environment of the ward (and perhaps the wider hospital environment) supports staff to implement the vision, and sometimes it hinders its realization. The vision has been identified in question 10.1. Consider how well the built environment of your ward CURRENTLY supports staff to implement the vision when answering this question.

**10.3 How well could the built environment enable this to happen?****1 = not at all well****5 = extremely well**

Now consider how well the built environment of your ward (and perhaps the wider hospital environment) COULD support staff to implement the vision as identified in question 10.1? Does the built environment have potential or is it currently under-utilised (for example is there an unattractive or inaccessible outside spaces that COULD allow access to outside spaces for patients even if this is currently not possible due to other issues (e.g. hospital policy, maintenance issues, staffing, etc). Consider what could happen if current barriers or limitations were removed.

Or it may be that the built environment is so poor that despite all the resources and best intentions in the world, the vision could not be fully realised (for example, no possibility of access to outside spaces, no single rooms and no places to sit away from the patient's bedside may prevent the full implementation of a salutogenic vision).

## RESOURCE 7

### EAT-Acute Care Handbook



## APPENDIX 1

# ENVIRONMENTAL ASSESSMENT TOOL - ACUTE CARE

# INTRODUCTION TO THE EAT-ACUTE CARE TOOL

## PURPOSE OF THE TOOL

- To identify strengths and weaknesses of the acute care environment
- To enable a systematic conversation about ways the environment can support people living with dementia

## WHERE TO ASSESS?

- Before you start, please be clear about the extent of the ward ie what is in and what is out

## ANSWERING THE QUESTIONS

You will need to ask the manager to

- Identify where is the *most used* place to sit
- Identify where is the *most used* outdoor area
- Respond to the questions under principle 10 'Design in response to vision for way of life'

Answer questions based on how the environment is when you are there – not what it might be like at another time. (This is recorded on the cover sheet so we know).

## TERMINOLOGY

<i>Place to sit:</i>	a room, alcove, nook or part of a corridor where a patient can sit
<i>Ensuite:</i>	a toilet and/or shower directly accessed from a patient room. It may be used by one or more patients
<i>Shared bathroom:</i>	a shower or bathroom directly accessed from a corridor
<i>Shared toilet:</i>	a toilet directly accessed from a corridor

## FINAL QUESTION UNDER EACH PRINCIPLE

At the end of each principle you will be asked to rate how well the ward responds to the principle. This gives you an opportunity to record your overall impression of the ward.

# EAT-ACUTE CARE

Date: ..... Time: ..... Hospital: .....

Ward (name and type): ..... No. of patients: .....

Unusual circumstances at time of visit: .....

.....

Observer: .....

1	UNOBTRUSIVELY REDUCE RISKS	N/A	NO	YES	ADD 1 IF UNOBTRUSIVE	SCORE
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## Inside

1.1	Can the entry to the ward be secured?	0	0	1	1	
1.2	Can all side doors leading out of the ward be secured? (This does not refer to side doors leading to a secure outside area. <i>(N/A = no side doors)</i> )	0	0	1	1	
1.3	Can people be prevented from climbing in or out of windows when they are open? <i>(N/A = windows non-openable)</i>	0	0	1	1	
1.4	Is lighting at the patient's bed adjustable (e.g. choice of light source, adjustable direction or dimmable)?	0	0	1	1	
1.5	Is there dimmable or night lighting in the patient's ensuite/toilet?	0	0	1	1	
1.6	Does the lighting in a typical patient's ensuite provide bright, even lighting when using the toilet, shower and/or basin? <i>(N/A = no ensuite)</i>	0	0	1	1	
1.7	Does the lighting in the shared bathroom provide bright, even lighting when using the toilet, shower and/or basin? <i>(N/A = no shared bathroom)</i>	0	0	1	1	
1.8	Are corridors free of trip hazards and obstructions?	0	0	1	1	
1.9	Are patient rooms free of clutter, trip hazards and obstructions?	0	0	1	1	
1.10	Inside, is contrast <b>between</b> floor surfaces at the thresholds of rooms avoided?	0	0	1	1	
1.11	Inside, is contrast <b>within</b> floor surfaces (eg patterns and/or features) avoided?	0	0	1	1	
1.12	Inside, is glare from artificial lighting minimised?	0	0	1	1	

<b>1 UNOBTRUSIVELY REDUCE RISKS</b>		<b>N/A</b>	<b>NO</b>	<b>YES</b>	<b>ADD 1 IF UNOBTRUSIVE</b>	<b>SCORE</b>
<b>Outside</b> (Answer with reference to the most used outside area)						
<b>1.13</b>	Is glare from natural and artificial lighting minimised? (N/A = no outside area)	0	0	1		
<b>1.14</b>	Is there step free access to all areas? (N/A = no outside area)	0	0	1		
<b>1.15</b>	Is contrast between path surfaces avoided? (N/A = no outside area)	0	0	1		
<b>1.16</b>	Are path surfaces even? (N/A = no outside area)	0	0	1		
<b>1.17</b>	Are paths clear of obstacles (e.g. trees, thorny plants) along and over the path? (N/A = no outside area)	0	0	1		
<b>1.18</b>	Can patients be prevented from leaving the outside area by getting over/under the perimeter? (N/A = no outside area)	0	0	1	1	
<b>1.19</b>	Can patients be prevented from leaving the outside area through a gate (e.g. could the gate be locked if required)? (N/A = no outside area)	0	0	1	1	
<b>1.20</b>	On the whole, how well do you think this ward responds to the principle of 'Unobtrusively reduce risks'? 1 = not at all well, 5 = extremely well	Circle one option 1 2 3 4 5				
						<b>SCORE</b>

<b>2 PROVIDE A HUMAN SCALE</b>		<b>N/A</b>	<b>NO</b>	<b>YES</b>	<b>SCORE</b>	
<b>Scale of the ward</b>						
<b>2.1</b>	Does the length of the corridor(s) allow a person to feel comfortable (and not uneasy because it is/they are too long)? (Answer with reference to typical ward corridor)		0	1		
<b>2.2</b>	Is furniture in place to sit arranged so people can sit on their own or in small groups? (Answer with reference to place to sit most used by patients) (N/A = no place to sit)	0	0	1		
<b>2.3</b>	Are a variety of colours, finishes and materials used in the ward?		0	1		
<b>2.4</b>	On the whole, how well do you think this ward responds to the principle of 'Provide a human scale'? 1 = not at all well 5 = extremely well	Circle one option 1 2 3 4 5				
						<b>SCORE</b>

<b>3 ALLOW PEOPLE TO SEE AND BE SEEN</b>		<b>0-25%</b>	<b>26-50%</b>	<b>51-75%</b>	<b>76-100%</b>	<b>SCORE</b>
<b>3.1</b>	What proportion of patients can see the toilet pan, toilet door, or a commode from their bed?	0	1	2	3	
<b>3.2</b>	What proportion of patients can see a staff base as soon as they leave their room?	0	1	2	3	
<b>3.3</b>	What proportion of patients can see the entry to their room from the corridor? <i>(Entry includes door, architrave or other feature specific to a particular patient's room)</i>	0	1	2	3	
<b>3.4</b>	What proportion of patients can see their bed from the entry to their room? <i>(Assume curtains at bed bays are open)</i>	0	1	2	3	
<b>3.5</b>	What proportion of patients can see a place to sit as soon as they leave their room? <i>(A place to sit may not be a separate room)</i>	0	1	2	3	
		<b>N/A</b>	<b>NO</b>	<b>YES</b>	<b>SCORE</b>	
<b>3.6</b>	Can a toilet door be clearly seen from the most used place to sit? <i>(N/A = no place to sit)</i>	0	0	1		
<b>3.7</b>	Can the exit to an outside area be clearly seen from the most used place to sit? <i>(Answer with reference to the most used outside area)</i> <i>(N/A = no place to sit or no outside area)</i>	0	0	1		
<b>3.8</b>	Can the place to sit be clearly seen from where staff spend most of their time (such as the staff base)? <i>(Answer with reference to the most used place to sit)</i> <i>(N/A = no place to sit)</i>	0	0	1		
<b>3.9</b>	Can an outside area be clearly seen from where staff spend most of their time? <i>(Answer with reference to the most used outside area)</i> <i>(N/A = no outside area)</i>	0	0	1		
<b>3.10</b>	Can the door back into the ward be clearly seen from an outside area? <i>(Answer with reference to the most used outside area)</i> <i>(N/A= no outside area)</i>	0	0	1		
<b>3.11</b>	Can the exit to an outside area be clearly seen from a corridor? <i>(Answer with reference to the most used outside area)</i> <i>(N/A= no outside area)</i>	0	0	1		
<b>3.12</b>	Can a kitchenette be clearly seen from a corridor? <i>(N/A= no kitchenette)</i>	0	0	1		
<b>3.13</b>	Can a toilet be clearly seen from a corridor?		0	1		
<b>3.14</b>	On the whole, how well do you think this ward responds to the principle of 'Allow people to see and be seen'? <i>1 = not at all well, 5 = extremely well</i>	Circle one option 1 2 3 4 5				
					<b>SCORE</b>	

4	REDUCE UNHELPFUL STIMULATION	N/A	NO	YES	SCORE
4.1	Is there a public address, staff paging or call system with bells, audible medical equipment, loud speakers or flashing lights in use?		1	0	
4.2	Does the noise from closing doors disturb patients (e.g. flapping doors, noisy automatic doors)?		1	0	
4.3	Is the impact of noise limited in patient areas (e.g. deliveries, lifts, plant, door entry systems are not heard)?		0	1	
4.4	Are unnecessary sources of noise such as TV's radios, audible medical equipment turned off or minimised?		0	1	
4.5	Are there designated quiet times (which staff as well as visitors must observe?)		0	1	
4.6	Can the transfer of sound from one room to another be managed (eg by closing doors)?		0	1	
4.7	Are single rooms available that have little exposure to staff operational noise?		0	1	
4.8	Is there a lot of visual clutter in the ward (ie staff notices, signage, objects, furniture that are either irrelevant to patients &/or make it hard for them to interpret their environment)?		1	0	
4.9	Is the entry to the ward easily visible to patients?		1	0	
4.10	Are doors to staff only areas easily seen (e.g. storerooms, clean and soiled utility rooms)?		1	0	
4.11	Inside, can glare from natural light be managed by using curtains and blinds?		0	1	
4.12	Are light fittings positioned so that they shine directly into a patient's eyes when they are lying on the bed?		1	0	
4.13	At night, is task lighting provided which enables staff to see to perform tasks without a) increasing overall lighting level in patient room & b) light shining directly into patient's eyes?		0	1	
4.14	At night, can light from the corridor be prevented from entering a patient's room?		0	1	
4.15	On the whole, how well do you think this ward responds to the principle of 'Managing levels of stimulation - reduce unhelpful stimulation? 1 = not at all well 5 = extremely well	Circle one option 1 2 3 4 5			
<b>SCORE</b>					

<b>5 OPTIMISE HELPFUL STIMULATION</b>		<b>N/A</b>	<b>NO</b>	<b>YES</b>	<b>SCORE</b>	
<b>Inside</b>						
<b>5.1</b>	Are signs easy to see, read and understand?		No 0	Yes 1		
<b>5.2</b>	What percentage of patients have a clearly defined path from their room to a place to sit (e.g. by using colour, objects and/or signage)? (N/A= no place to sit)	0	0-25% 0	26-50% 1	51-75% 2	76-100% 3
<b>5.3</b>	Is a place to sit clearly recognisable from the corridor? (N/A = no place to sit)	0	No 0	Yes 1		
<b>5.4</b>	Are different corridors clearly recognisable so patients can identify where they are (eg variety of materials, appropriate signage, colour)? (NA - only one corridor)	0	No 0	Yes 1		
<b>5.5</b>	Is colour, artwork or appropriate signage used to differentiate patient rooms?		No 0	Yes 1		
<b>5.6</b>	Is colour, artworks or appropriate signage used to differentiate patient bed bays?		No 0	Yes 1		
<b>5.7</b>	Can patients see their personal items (eg photos, pictures, objects) when in bed? (N/A = no personal items)	0	No 0	Yes 1		
<b>5.8</b>	Can most patients see out of a window from their bed? (Assume curtains at bed bays are open)		No 0	Yes 1		
<b>5.9</b>	Are ensuite/shared bathroom/toilet doors clearly marked with an appropriate sign and contrast? (N/A = no ensuite, shared bathroom or toilet)	0	No 0	Yes 1		
<b>5.10</b>	In a typical patient room can most patients see the toilet pan, toilet door, or a commode from their bed when lying down?		No 0	Yes 1		
<b>5.11</b>	Is contrast used to help people see key features in shared bathrooms (including taps, basin, rails and toilet)? (N/A = no shared bathroom)	0	No 0	Yes 1		
<b>5.12</b>	Is contrast used to help people see key features in the ensuite (including taps, basin, rails and toilet)? (N/A = no ensuite)	0	No 0	Yes 1		
<b>5.13</b>	Do the toilet seats (commode/over toilet seats) contrast with the floor and/or wall?		No 0	Yes 1		
<b>5.14</b>	Are olfactory cues (such as food smells and familiar toiletry products) used to provide a variety of experiences for a patient?		No 0	Yes 1		
<b>5.15</b>	Are there auditory cues to provide a variety of experiences for a patient?		No 0	Yes 1		
<b>5.16</b>	Is there an attractive view to outside from the place to sit for a person when seated or lying down? (does not include patient's room) (N/A = no place to sit)	0	No 0	Yes 1		

5	OPTIMISE HELPFUL STIMULATION	N/A	NO	YES	SCORE
5.17	Is the ward reception/staff base easily identifiable?		No 0	Yes 1	
5.18	In a typical patient room, can you (the observer) read this easily without the use of artificial light from each bed location?		No 0	Yes 1	
5.19	In a typical corridor, can you (the observer) read this easily without the use of artificial light?		No 0	Yes 1	
5.20	In the most used place to sit, can you (the observer) read this easily without the use of artificial light? <i>(N/A = no place to sit)</i>	0	No 0	Yes 1	
5.21	Are a variety of materials and finishes used to create an interesting and varied environment for a patient?		No 0	Yes 1	
<b>Outside</b> <i>(Answer with reference to the most used outside area)</i>					
5.22	Are contrasting materials used so that the edges of surfaces and objects can be easily seen (e.g clear distinction of path edge, between seats and paving)? <i>(N/A = no outside area)</i>	0	No 0	Yes 1	
5.23	Are olfactory cues (such as perfumed plants) used to provide a variety of experiences for a patient? <i>(N/A = no outside area)</i>	0	No 0	Yes 1	
5.24	Are there auditory cues to provide a variety of experiences for a patient? <i>(N/A = no outside area)</i>	0	No 0	Yes 1	
5.25	Are a variety of materials and finishes used to create an interesting and varied external environment for a patient? <i>(N/A = no outside area)</i>	0	No 0	Yes 1	
5.26	On the whole, how well do you think this ward responds to the principle of 'Managing levels of stimulation – optimise helpful stimulation?' <i>1 = not at all well, 5 = extremely well</i>	Circle one option 1 2 3 4 5			
<b>SCORE</b>					

6	SUPPORT MOVEMENT AND ENGAGEMENT	N/A	NO	YES	SCORE
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**Inside**

<b>6.1</b>	Is there a clearly defined and easily accessible path that guides the patient back to their starting point without taking them into a blind alley or to a locked door?		0	1	
<b>6.2</b>	Can patients clearly see opportunities for meaningful engagement (either actively or passively)?		0	1	

**Outside** *(Answer with reference to the most used outside area)*

<b>6.3</b>	Is there a clearly defined and easily accessible path that guides the patient back to their starting point without taking them into a blind alley or to a locked door? <i>(N/A = no outside area)</i>	0	0	1	
<b>6.4</b>	Can patients clearly see opportunities for meaningful engagement (either actively or passively)? <i>(N/A = no outside area)</i>	0	0	1	
<b>6.5</b>	Are there chairs or benches at frequent intervals so people can sit and enjoy the fresh air? <i>(N/A = no outside area)</i>	0	0	1	
<b>6.6</b>	Are there both sunny and shady areas along the path? <i>(N/A = no outside area)</i>	0	0	1	
<b>6.7</b>	Are there verandahs or shaded seating areas in close proximity to the building? <i>(N/A = no outside area)</i>	0	0	1	
<b>6.8</b>	On the whole, how well do you think this ward responds to the principle of 'Support movement and engagement'? <i>1 = not at all well, 5 = extremely well</i>	Circle one option 1 2 3 4 5			
<b>SCORE</b>					

<b>7 CREATE A FAMILIAR PLACE</b>		<b>N/A</b>	<b>NONE</b>	<b>A FEW</b>	<b>MANY</b>	<b>SCORE</b>
<b>7.1</b>	How many of the patients have familiar items (e.g. photos, pictures, objects) near their bed?		0	1	2	
<b>7.2</b>	Does the most used place to sit contain pieces of furniture that would be seen as domestic by the majority of patients? (N/A = no place to sit)	0	No 0	Yes 1		
<b>7.3</b>	Is the most used place to sit used to store items such as linen trolleys, medical equipment, wheelchairs, hoists and furniture? (N/A = no place to sit)	0	No 1	Yes 0		
<b>7.4</b>	On the whole, how well do you think this ward responds to the principle of 'Create a familiar place'? 1 = not at all well 5 = extremely well	Circle one option 1 2 3 4 5				
<b>SCORE</b>						

## **8 PROVIDE A VARIETY OF PLACES TO BE ALONE OR WITH OTHERS**

### Inside

<b>8.1</b>	Are there places where a person can sit on their own or in private conversation away from their bed?	NO Score 0	1 Score 1	2 or more Score 2		
<b>8.2</b>	Are there places (not in a patient's room) where a small group of people can gather?	NO Score 0	1 Score 1	2 Score 2	3 or more Score 3	
<b>8.3</b>	Can a family member/support person sit with the patient at their bedside?		NO Score 0	YES Score 1		

### Outside (Answer with reference to the most used outside area)

<b>8.4</b>	Are there places where a person can be on their own and/or in private conversation? (N/A = no outside area)	0	NO Score 0	1 Score 1	2 or more Score 2	
<b>8.5</b>	Are there places where a small group of people can gather? (N/A = no outside area)	0	NO Score 0	1 Score 1	2 or more Score 2	
<b>8.6</b>	On the whole, how well do you think this ward responds to the principle of 'Provide a variety of places to be alone or with others - in the ward'? 1 = not at all well 5 = extremely well	Circle one option 1 2 3 4 5				
<b>SCORE</b>						

9 LINK TO THE COMMUNITY			SCORE
9.1	Is it possible for a family member/support person to stay with a patient during the night? <i>(Answer with reference to typical patient room)</i>	NO Score 0	YES Score 1
9.2	Is there a place where families and friends can share meals and/or celebrations with their relatives/friends who are patients (e.g. café, garden)?	NO Score 0	YES Score 1
9.3	On the whole, how well do you think this ward responds to the principle of 'Provide a variety of places to be alone or with others - in the hospital?' <i>1 = not at all well</i> <i>5 = extremely well</i>	Circle one option 1 2 3 4 5	
			<b>SCORE</b>

10 DESIGN IN RESPONSE TO VISION FOR WAY OF LIFE			SCORE
10.1	What is the vision of the ward? To provide: a. a homelike environment b. a hotel like environment with hotel like services c. a medical care facility d. a salutogenic environment e. other .... <i>(Ask the manager or their representative for their view)</i>	Circle one option a b c d e	
10.2	How well does the built environment enable this to happen? <i>(Ask the manager or their representative for their view)</i> <i>1 = not at all well</i> <i>5 = extremely well</i>	Circle one option 1 2 3 4 5	
10.3	How well could the built environment enable this to happen? <i>(Ask the manager or their representative for their view)</i> <i>1 = not at all well</i> <i>5 = extremely well</i>	Circle one option 1 2 3 4 5	
			<b>SCORE</b>

## EAT-ACUTE CARE – SUPPLEMENTARY QUESTIONS

Here are some additional questions you may wish to consider.

These are questions that did not meet measurement requirements for inclusion in the EAT-Acute Care, but may nonetheless be useful for consultation purposes.

<b>2 PROVIDE A HUMAN SCALE</b>		<b>N/A</b>	<b>NO</b>	<b>YES</b>	<b>SCORE</b>	
	<b>Scale of building</b>					
<b>2.a</b>	Does the entry to the ward allow a person to feel comfortable (and not uneasy because the spaces are too big or too small)?		0	1		
<b>2.b</b>	Do places to sit allow a person to feel comfortable (and not uneasy because the spaces are too big or too small)? <i>(Answer with reference to place to sit most used by patients. This does not include the patient's bedside.)</i> <i>(N/A = no place to sit)</i>	0	0	1		
<b>4 REDUCE UNHELPFUL STIMULATION</b>		<b>N/A</b>	<b>NO</b>	<b>YES</b>	<b>SCORE</b>	
<b>4.a</b>	Is the service entry (where food, linen etc is delivered) easily visible to patients? <i>(N/A = no service entry)</i>	1	1	0		
<b>4.b</b>	Is the wardrobe (or cupboard) that the patient uses full of a confusing number of clothes and/or irrelevant objects? <i>(N/A = no wardrobe)</i>	1	1	0		
<b>7 CREATE A FAMILIAR PLACE</b>		<b>N/A</b>	<b>NONE</b>	<b>A FEW</b>	<b>MANY</b>	<b>SCORE</b>
<b>7.a</b>	Are the colours or decorations in the patient's room warm and welcoming? <i>(Answer with reference to a typical room)</i>		0	1	2	
<b>7.b</b>	Do the colours or decorations in the most used place to sit provide a warm and welcoming space to sit? <i>(N/A = no place to sit)</i>	0	0	1	2	

9	LINK TO THE COMMUNITY	N/A	NO	YES	SCORE
9.a	Is there easy access to places which encourage interaction and engagement with the wider community (e.g. cafes, gardens)?		0	1	
9.b	Is there an easily accessible place where families and friends can feel comfortable while taking a break from visiting (eg when visiting a very sick person)?		0	1	
<b>MAXIMUM SCORE</b>					



**RESOURCE 7**

**EAT-Acute Care  
Handbook**



**APPENDIX 2**  
**EAT-ACUTE  
CARE PLANNING  
TEMPLATE**

# EAT-ACUTE CARE PLANNING TEMPLATE

KEY DESIGN PRINCIPLES						
		Unobtrusively reduce risks	Provide a human scale	Allow people to see and be seen	Reduce unhelpful stimulation	Optimise helpful stimulation
ACTIONS	ISSUES					
	How can we <b>re-use</b> what is there?					
	What can we do in the <b>short</b> term?					
	What can we do in the <b>medium</b> term?					
	What can we do in the <b>long</b> term?					

KEY DESIGN PRINCIPLES						
		Support movement & engagement	Create a familiar place	Provide a variety of places to be alone or with others	Link to the community	Design in response to vision for way of life
ACTIONS	ISSUES					
	How can we <b>re-use</b> what is there?					
	What can we do in the <b>short</b> term?					
	What can we do in the <b>medium</b> term?					
	What can we do in the <b>long</b> term?					

