Improving health and social care environments for people with dementia [Powerpoint presentation]

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Thinking differently about healthcare buildings: innovative infrastructure planning and design to improve the quality and safety of care
EuHPN 2014, Edinburgh

Improving Health and Social Care Environments for People with Dementia

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3rd October 2014
Aim of the presentation

Introduce the key principles of dementia friendly design, in relation to the specific aspects of this age group (i.e. senses, perceptions and cognitions) to improve quality and safety in elderly patient’s journey through the health and social care environments.
Outline of the presentation

- Aim and context Context
- Age-related considerations
- Quality and Safety considerations
- DH Dementia Capital Programme
- Key principles of dementia friendly design
- Health and Social Care environments
- Conclusions and next steps
Context: Ageing population

- Ageing population is a global issue. By 2016 the number of people over 65 will outnumber the number of children under 5.
  
  (WHO - National Institute on Aging - National Institutes of Health, Global health and ageing, 2011)

- Ageing population brings together a series of implications and co-morbidities.
  

- The current cost of dementia for the UK economy is estimated on £23 billion a year.
  
  (Alzheimer’s Society, Dementia 2012: A national challenge, 2012)
Context: NHS built assets

- The NHS is one of the largest building landlords in the UK: its assets are worth £84 bn.  
  (Baillie, Young blood vital to sector's future, Health Estate Journal of the Institute of Healthcare Engineering and Estate Management, 2013)

- In England, approximately 22% of NHS acute hospital buildings pre-date 1948 and 25% of buildings were built between 1948 and 1974.  
  (Short et al, Building resilience to overheating into 1960's UK hospital buildings within the constraint of the national carbon reduction target: Adaptive strategies, in press)

- Age of the building can be used as a proxy for critical infrastructure backlog and building condition.  
  (Mills et al., Critical Infrastructure Risk in NHS England: Predicting the impact of building portfolio age, International Journal of Strategic Property Management, in press)
In 2010, the DH set the target to save up to £20 billion by the year 2014, and reinvest them to improve quality and raise productivity through improvements in space utilisation.


The Francis Report and the Keogh Review provided evidence and validation of quality and safety issues in the national infrastructures.

(Francis, Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013)
(Keogh, Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report, 2013)
Context: DH Dementia Capital Programme

- Health and social care environments need to respond to ageing population and all its related conditions including dementia, to improve quality and safety in elderly patient’s journey.

(Loughborough University Enterprise Ltd., IFF Research, Department of Health, DH Improving the environment of care for people with dementia - Internal Project Report, 2014)

- One such response has been the Department of Health England Capital Programme “Improving the environment of care for people with dementia”, the initial findings of which are presented here.

(Loughborough University Enterprise Ltd., IFF Research, Department of Health, DH Improving the environment of care for people with dementia - Internal Project Report, 2014)
Quality and safety considerations

**COST**
Cost of design, planning, maintenance, refurbishment, upgrade, decommission and disposal of **health and social care infrastructure** and service provision.

**CHANGE**
'Planning based on the idea that **operational regimes** are permanent must fail since all health buildings change constantly.' (J. Weeks, 1973)

**TIME**
**Pace of** clinical, social, cultural, environmental, economic and technologic changes, which may vary across different countries (**timely interventions**).

**SCALE**
Scale refers equally to the scale of **service provision** (systems and operations) and to the scale of **setting** (local, regional, national and international).
This presentation draws on some aspects that are emerging from the Department of Health England National Programme: “Improving the environment of care for people with dementia”.

The DH Capital Programme has provided £50M capital funding for 116 NHS and Social Care pilot projects to develop evidence that will support the development of evidence-based design standards and guidance.
DH Dementia Capital Programme - Delivery plan

Dementia Capital Funding Programme Activity Plan

- Framework for data collection
- Knowledge sharing activities
  - Webinars
  - Tele-Workshops

Detailed case studies Activities
- Workshops
- Focus groups
- Site Visits
  - Analyse data - Develop evidence from case studies

Programme impact monitoring
- 1st quarterly data collection
- 2nd quarterly data collection
  - Analyse data - Develop evidence

Project progress monitoring
- Pilot Project self-assessment report
- Monthly data collection

Final project report
- Gardens & Outdoor spaces
- Circulation spaces & Communal areas
- Nursing stations
- Areas for carers

- Gardens & Outdoor spaces
- Circulation spaces & Communal areas
- Activity spaces
- Bedrooms
Key principles of dementia friendly design

1. Reduce safety risks (e.g. falls, aggressions, evacuation);
2. Provide a human non-institutional scale and environment;
3. Ensure good visual access (e.g. people, objects);
4. Promote orientation (e.g. time, day, location);
5. Support way-finding and navigation;
6. Promote respect, privacy and dignity;
7. Encourage movement and engagement;
8. Provide an optimum level of stimulation;
9. Encourage independence;
10. Support diet and nutrition;
11. Provide access to natural light;
12. Provide optimum lighting and contrast; and
13. Promote contact/communications with friends and relatives.
1. Reduce safety risks

- Use of matt, even coloured and homogeneous flooring
1. Reduce safety risks

- Use of handrails and rest areas
1. Reduce safety risks

- Use of appropriate lighting levels and de-clutter space
2. Provide a human non-institutional scale and environment

- Use of non-institutional furniture and fittings
2. Provide a human non-institutional scale and environment

- Disguise bed headboards and clinical equipment
3. Allow good visual access

- Use of glazed screens and see-through furniture
3. Allow good visual access

- Use of open plan and non-facing doors
4. Promote orientation

- Use of visual clues and memory boxes
4. Promote orientation

- Use of calendars and large face clocks
4. Promote orientation

- Use of dynamic lighting
5. Support way-finding and navigation

- Use of detectable colour-coding
5. Support way-finding and navigation

- Use of familiar pictures and images
5. Support way-finding and navigation

- Use of appropriate and legible signage
6. Promote respect, privacy and dignity

- Use of internal glazing, screens and blinds
6. Promote respect, privacy and dignity

- Allow and respect cultural differences
7. Encourage movement and engagement

- Use of legible layouts
7. Encourage movement and engagement

- Use of short corridors and resting points
7. Encourage movement and engagement

- Access/visual to gardens, patio areas and conservatories
8. Provide an optimum level of stimulation

- Use of sensory rooms and reminiscence software
8. Provide an optimum level of stimulation

- Appropriate noise and light levels
9. Encourage independence

- Toilets with contrasting colour seats and handrails
9. Encourage independence

- Bathrooms and wet rooms with ceiling mounted hoists
9. Encourage independence

- Safety devices (e.g. acceleration detectors, alarms) and personal files/diagnosis (e.g. passport with level, needs)
10. Support diet and nutrition

- Allow choice for dining areas
10. Support diet and nutrition

- Use of coloured contrasting crockery and adjustable cutlery
11. Provide access to natural light

- Use of large and low windows
12. Provide optimum lighting and contrast

- Use of roof-windows and artificial lighting
12. Provide optimum lighting and contrast

- Use of adjustable lighting levels

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13. Promote contact/communications with friends & relatives

- Access to areas & elements for interaction
13. Promote contact/communications with friends & relatives

- Easy access to outdoor areas
Conclusions: Environmental impact

- Interventions in **different types of settings** (e.g. acute hospitals, care homes, sheltered houses, day centres).

- Opportunity to transform built environments and increase the **value of space** towards a better use of resources.

- **Staff empowerment** and consequent reduction of tension in the working environment.

- Use of the built environment to **change care delivery** (e.g. improved use of supportive technologies and focus on integrated care pathways).

- **Greater understanding** of how age-related issues impact on the perception of the built environment.
Conclusions: Economic impact

- Most of the principles can be achieved at relatively low cost and can be applied to health and social care environments (e.g. transferred, repeated and integrated).

- Opportunity to capitalise organisation assets through additional and long-term investments.

- Generated Value for Money in a variety of elements: triggered further investments; decreased staff turnaround; introduced new working roles; reduced the stigma of dementia; boosted local and regional economies.

- Long-term implications on people with dementia: reduced Length of Stay; reduced need of hospitalisation; smoother care pathway; reduced need of carers; improved safety.
Conclusions: Social impact

- Improved **Quality of Life** of people with dementia and carers.

- Great **enthusiasm and engagement** of: clinical staff, contractors, charity organisations, volunteers, education sector and local communities.

- Extensive and valuable **knowledge sharing** among each individual involved in any project stage (i.e. impact on their dementia awareness, within the participant organisations and among the local communities).

- Broad **empowerment of community-based settings**.

- Opportunity to put in action a long-term process to enhance a **Culture Change** at national scale.
Next steps

- Most of the Pilot Projects are willing to take this Programme one step further and embed dementia friendly design principles into their organisational and operational processes.

- An Expert Panel was set up during the Stage 2 and will be involved to validate the design principles identified through the Programme in Stage 3.

- The next stage will be to analyse the evidence gathered to support the development of DH evidence-based design standards and guidance for dementia friendly environments in Health and Social Care settings (March 2015 - Stage 3).
Thank you for your kind attention

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