

Aged Care:
Designing for
Demential Units

an Insight by Sue Kenny
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Good design for dementia is usually good design for all aged care, with some additional hidden security measures built in. It's not rocket science, but there are a few small "rules" we use.

Designing for dementia is about creating an environment that an elderly person can enjoy and feel comfortable in. Clearly, staff and the care programme are larger determinants of wellbeing for residents. However, a well-designed home for people suffering from dementia will significantly assist in reducing levels of aggression, minimising agitated wandering behaviour, preventing injury from absconding, and increasing the wellness of residents. Therefore, it will give staff more time for that special extra care.

Rule I

It is primarily a home we are designing, and secondarily a workplace.

All the icons of a home, and their relationships to each other must be incorporated – front door, lounge, bedroom, bathroom, dining room, kitchen, back door, back yard. The front door must open into an entry hall or the lounge room, not into a waiting area outside a staff office. The back door should open from the kitchen, laundry or another

sitting/family room. There must be a clarity in the layout of the unit, providing direct and clear routes to all areas of daily living.

Rule II

Always present a destination.

As a resident comes out of bedroom and looks along the corridor an activity or destination point should be clearly visible, such as: the bench and overhead shelving of a kitchenette popping out into the corridor; a wall with a large open "window" into the dining room; a sitting niche with chairs and a library bookshelf; access to a courtyard garden. This gives the resident a focus of direction. Put as much natural light into the corridor as possible through communal rooms that open to the outside, glazed panels between rooms along the corridor, skylights with diffusers. Direct sunlight through a skylight is not good as it can produce both glare and bright/dark shadow patterns on the floor.

Rule III

What NOT to locate at the end of a corridor.

Anything we do not want residents to focus their attention on: a fire escape exit door; the locked front entry door to the unit; door to staff office / linen cupboard / pan room / clinical room; one resident's bedroom door; staff access to an adjacent accommodation unit.



Rule IV

It's not a prison!

The security that is necessary to ensure the safety of wandering residents must be unobtrusive. As many doors to the outdoors as possible should be freely accessible, with an electronic lock that comes on only at night. Being unable to get through a locked door is a typical trigger for aggression. The solution is to provide a series of unlocked doors that the residents can open, passing through uncontrolled to another space, or into a secure courtyard or garden. It is critical that the building plan form disguises the "real" security door beyond which there is escape to danger, such that the resident is unaware of the barrier.

Rule V

Disguise the presence of locked doors.

Where there are doors that need to be locked – to staff areas, or to the visitor entry, or an adjacent accommodation unit – they should be located somewhere unobtrusive, and especially not in a focal point such as at the end of a corridor. Locking release mechanisms (i.e. keypads) should not be located at the door itself, but a small distance away. Never use locks that have a keypad built into the door hardware itself. Doors and architraves should be painted out to match the wall, and if possible, hardware powdercoated to match. The door might be panelled to match a wall panel, or – very kitsch but effective – brick wallpaper applied over the wall and door.

Rule VI

Loud unfamiliar noises can cause distress and aggression.

Noises that residents have been used to throughout their lives such as traffic noises from a nearby road are unlikely to be problematic in city areas, but tap-tapping shoes or a metal trolley clanking down a corridor is not familiar. Throw out the vinyl in circulation spaces and install a good quality, low-maintenance health care carpet,

on a concrete floor that has been sealed against moisture ingress. Incontinence accidents can be dealt with provided a reasonable cleaning programme is adhered to. A little extra care in cleaning has far-reaching effects in the increased sense of dignity residents have in their lives. And looking at basic occupational health and safety issues, you don't slip over on wet carpet!

Rule VII

Design to assist in continence control.

Bedrooms should have an ensuite with the toilet directly visible from the bed, and a permanent low-level night light over the toilet. A black toilet seat can assist some residents in recognition. A resident toilet should be located close to large gathering spaces, especially dining rooms, and pictogram signage used. For dementia units with severe sufferers, we use fibre cement walls and epoxy sealants behind and under the skirting to prevent the smell of urine getting into the walls and building trims. In this level of unit, even the best low-maintenance health care carpet cannot be used, and one of the many low-maintenance vinyls is the only real option.

Rule VIII

Have a great secure garden.

It must incorporate activity points, not just be for aimless wandering. Seating under cover is important. It's good to have a path leading out of one communal space (eg sitting room) and leading to another (eg dining room). The wandering then has a destination. Other activities in the garden could be a potting shed, raised planters, gardening area, bird aviary, bus stop, old car / lawnmower for tinkering, clothes line, with an indoor area close by for clothes sorting and folding. The fencing must be non-climbable. Don't think of what a frail little old lady can climb, but what an active 18 yr old can climb. Often dementia sufferers are very mobile, strong and agile. Fencing might be pool fencing style, or a paling fence with all the rails to the outside, or a solid wall with no toeholds, to at least

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1800mm high. Gates must be disguised – do not have a path leading to the gate, but have access to the gate through a mulched garden bed.

Rule IX

Bedrooms.

Often people who suffer from dementia have a rummaging habit, and items going missing from wardrobes is a common problem. To resolve this, we use wardrobes with three hinged doors: two that are lockable for staff access to residents' clothes only, and one freely accessible door for a "rummage" cupboard for the resident. Make this door obvious with colour and a large D-Pull handle. Make the other two doors (and architraves) the same colour as the wall, with the lock at a low level, not in direct eye line-of-sight. The door to the ensuite should be a highlight colour, but different to the front entry to the room, and the wardrobe. It can be surreptitiously lockable by staff during the day – an easy way is with a cabin hook and eye at about 1800mm AFL.

Rule X

Use normal, everyday fixtures and fittings.

Stay away from new technology tap handles, door handles and locks, dual flush toilet cisterns, overly "heavy duty" configurations of grab rails and mobility aids. Every second phone call or email contact to our office is someone wanting to sell us a new product with some you-beaut technological features. Residents need the familiarity of what they have always used in the past. One "new technology" fitting that I am quite opposed to is that of the light in the ensuite that turns on automatically when a resident gets out of bed – a standard option now for most dementia-monitoring systems. To my way of thinking, what could be more confusing (and possibly frightening) in the middle of the night when you get out of bed, and FLASH, the bathroom light turns itself on, oh-so-mysteriously. Who's there? Who turned the light on? This can be potentially quite disturbing,

and I am aware of one large dementia unit where this system was installed, and it has caused all sorts of behavioural problems.

As well as "rules" there are many little design "tricks" that can be played, such as deepening the floor covering colour at staff doorways to prevent residents crossing over, recessed "identification" cabinets next to the bedroom door to assist in room identification, panelling to non-access doors to match the adjacent wall, running a handrail across the face of a door, fixing a mirror to a door. If one particular "trick" works for one resident in the unit, then it is worthwhile.

Rules, of course, are made to be broken, and there are always specific circumstances where the rules I have mentioned may not be applicable. It is, however the general concepts that will always remain applicable in designing for dementia: the provision of unobtrusive security and to make a resident feel comfortable within their environment by designing the familiar, such that behaviours such as aggression and the desire to escape are minimised.

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