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'Home' in the aged care institution: authentic or ersatz

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Abstract

Recent health care transformations are driven by societal changes. Aged care institutions now place more emphasis on the design and management of the facility as a *home*. However, the meaning of *home* is contested. By analyzing one case study in the context of emerging ideas in the literature, this paper explores the construction of the institution as *home*. The study reveals attributes that are effective representations of *home*, but finds that the idea of *home* is often romanticized and trivialized. The paper argues that the making of *home* in an institution relies on the provision of privacy, autonomy and respect.

Keywords: dementia; residential aged care facilities; nursing *home*; *home*; constructed environment; design.

1. Introduction

In 2006-07 Australian Government expenditure on aged care was 0.7% of GDP and this is set to grow to 1.9% by 2046-47, higher than both education and defense (Productivity Commission, 2008). The number of permanent residents in RACF is predicted to rise from 170,171 in 2007 (Australian Institute of Health and Welfare, 2008) to 237,541 by 2020 (Allen Consulting Group, 2002). Over this time demand for high quality nursing care will escalate with the progressive increase in the dependency of people

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resident in RACFs (Productivity Commission, 2008). In the UK, the number of 85s will increase by one third by 2020 to a total of almost two million people, 90% having at least three diseases (Smith 2010).

Worldwide, the predicted increase in the number of people with Alzheimer's from the year 2006 to 2050 is 285% for North America, 534% for South America, 229% for Europe, 476% for Africa, 497% for Asia, and 365% for Australia (Volicer, 2009).

This massive growth over the next few decades in the number of elderly people, many of whom will have both physical and cognitive illnesses, will exert significant financial and logistical pressures on governments and the elderly in developed and developing countries. Many of those living in developed countries will have high expectations of residential care facilities. Concurrently, there is a change in care philosophy from pathogenic (dealing with disease) to salutogenic (maintaining health) and an increased emphasis on providing residential aged care facilities that are homelike and de-institutionalized both physically and in terms of care regimes. Nevertheless, the high cost of providing residential aged care facilities requires government or developers to build large institutions that allow for greater efficiencies in staffing, support facilities and services. This results in design challenges for providers that base their care philosophy on the provision of "homelike" care homes.

Following a selective literature review, a case study of a contemporary Dutch care *home* that adopted the suite of ideas associated with "homelike" design is introduced. A discussion of theories interrogating the contested notion of *home* are then tested using the case study.

2. Literature review

2.1. 'Home' as a multi-dimensional and complex phenomenon

The meaning of '*home*' is highly complex, encompassing physiological, temporal, social, political, psychological, cultural and legal dimensions (Moore, 2007; Manzo, 2003; Sommerville, 1997). The concept of *home* has been the subject of fascination for several decades from the phenomenological geography of the 1970s, focusing on the experience of *home* as an existential state, to the physical and spatial dimensions of *home* in the environmental psychology and behavior research of the 1980s (Dovey, 2005). The relative focus and relationship between the abstract and physically situated aspects of *home* continue to permeate the field (Rowles & Chaudhury, 2005). For Rapoport (2005) the shifting meanings of *home* are 'confusing and dangerous' leading to a common conflation of *home* and house. Conversely, for Dovey (2005) there is delight in the complexities of '*home* as paradox' defined as a continual interplay between security and conflict, known and unknown.

Any exploration of *home* is inevitably caught up in this complexity. It is perhaps best described by Rybczynski (1988; p.230) as like an onion appearing "simple on the outside, but …deceptive, for it has many layers."

Thus, explorations of *home* are necessarily multi-dimensional and relational. The feeling of *home*, described as a 'canniness' of living or everyday familiarity, is constructed through an interplay between bodies, emotions and objects in a framework of physiological, social and psychological associations (Schillmeier and Heinlein 2009). It is a continual process of 'making *home*' rather than a given state of being (Moore 2007).

It is important to recognize both the individual experience of *home* and the broader social forces that are fundamental to its construction (Després, 1991, Moore 2007). In particular, emphasis has been placed on the relationship between the 'real' and 'ideal' (Somerville, 1997). The *home* is generally conceived as a site of physical, psychological and emotional security and an affirming symbol of self-identity. As Cooper-Marcus (1995; p.4) argues, "A *home* fulfills many needs: a place of self-expression, a vessel of memories, a refuge from the outside world, a cocoon where we can feel nurtured and let down our guard."

Without denying the construction of identity as 'authentic', it is inevitably mediated by social norms and expectations. While the positive experience of *home* is undeniable for many, it is not universal and it is important to challenge the dominant myth of domestic bliss (Moore 2000, Manzo 2003). Critiques of this idealized notion of *home* have emerged from the contexts of domestic violence (Wardhaugh 1999), divorce (Anthony 1997), *home*lessness (Moore 2007), *home* care (Yantzi & Rosenberg, 2008) and bodily impairment (Imrie 2004, Schillmeier and Heinlein 2009).

2.2. 'Home' in the institution

There is also a significant body of literature examining the relationship between idealized conceptions of *home* and the lived reality in the context of aged care institutions. There is some suggestion that the institution and *home* are incompatible (Willcocks *et al* 1987). Nevertheless, the notion that the institution can and should be conceived in this way has a relatively long history since it was first introduced in the 1960s (van der Horst 2004, p.37).

One of the strongest criticisms of aged care homes is the tendency towards romantic and stereotyped ideals of the meaning of *home* for elderly people (Oldman and Quilgars 1999). In particular, the designers of these institutions are singled out for their narrowly defined assumptions and the conflation of the meaning of *home* with space, physical form and aesthetics (Lundgren 2000, Fairhurst 2000). The 'decorative dimension' is even more pervasive and, as Lundgren (2000, p.110) argues, imposes social norms and ideals as an "expression of assumptions, associations with and conventional concepts of a "good" home." Even more damningly, this aesthetic dimension of *home* is criticized as a thinly veiled façade (Lundgren 2000, Willcocks *et al* 1987). As van der Horst argues (2004, p.41), "the material alterations create a shield for the fact that not much has actually changed. The outward appearance is that the right to home of the residents is incorporated. However, the most important things are not altered."

Two of the most 'important things' that emerge from the literature around *home* in the context of aged care are privacy and autonomy (van der Horst 2004; Hauge and Heggen 2007). The issue of privacy is generally focused around the provision of private bedrooms and bathrooms, as well as limiting the perceived size of the institution to 'clusters' of between 4-6 (Northern Europe) and 10-15 (US) residents (Regnier 2002). Although arguably desirable, the effectiveness of these idealized 'family' social units has been challenged. For example, Hauge and Heggen (2007, p.465) question whether, "staff, relatives and even elderly residents are trapped by the idea that older people have so much in common that they should be glad to spend time together." In a study of small residential homes, Peace and Holland (2001, p.404) found that residents did not communicate with each other as part of a family; while strong relationships were built with staff, when left alone in the common space "residents usually sat alongside each other while watching TV or reading". In this way the common rooms come to represent waiting rooms, blurring the boundaries between public and private, eroding the sense of *home* and leading Hauge and Heggen (2007, p.466) to question the value of 'home-like design' in these spaces as a means to "seduce the resident, relatives and staff into accepting the living room as the primary room for the residents."

The 'home-like' décor of the common rooms is also questioned in relation to autonomy since residents are unable to exert personal control over these spaces, with decisions remaining firmly in the hands of architects and owners (Lundgren 2000; Peace and Holland 2001; Hauge and Heggen 2007). For Percival (2002), this exertion of personal control over the design of the environment is seen to be particularly important for older people as part of the practice of 'making' a home.

The freedom of personal taste in the collective space of the institution is inevitably limited. Nevertheless, institutional care can also result in greater autonomy, for example with the possibility of greater mobility, increased social connections and autonomy from the support of relatives (Oldman and Quilgars 1999; Peace and Holland 2001). In a study of moving between family house and nursing home,

through one detail case study, Schillmeier and Heinlein (2009) demonstrate how the sense of *home* was lost within the family dwelling following a stroke leading to bodily impairment, then gained again through rehabilitation and a move into another independent dwelling better suited to the aging body, then lost again following a further stroke, then regained in the move to a nursing home and lost once more as practices of care and particularly technology come to erode personal autonomy. Thus, a "double process of transfer of loss" (*ibid*, p. 219) arises through a separation from feeling at *home* within the family home and the move to another *home* away from *home*.

Any move 'away' from the familiar locus of dwelling inevitably results in the transformation of *home*. Meanings adhere in things over time and this serves to anchor us by connecting past, present and future (Varley 2008, p.59). Research has shown how the importance of 'cherished objects' intensifies for older adults, especially when moving between residential settings (Sherman and Dacher 2005). Nevertheless, it is tempting to over-invest in the ability of these objects to stand in for the complex, relational and situated personal narratives of *home*.

2.3. 'Home' and dementia

The capacity to re-construct a sense of *home* in the move to an institution is further complicated in the context of dementia. The progressive neurological impairment caused by Alzheimer's disease and other forms of dementia results in a transformation of identity and the loss of the everyday familiarity of *home*. Nevertheless, despite a loss of cognitive ability, a sense of *home* endures in the minds of dementia sufferers, even in the later stages (Frank 2005, Varley 2008). In a study of sufferers of Alzheimer's disease, Frank reveals how unsolicited outbursts from residents asking to 'go home' are in fact pleas for selfhood. Critically, she argues that it is the caregivers who are key to validating and sustaining a sense of Self, and thus a sense of *home*, through practices of care that recognize the residents as 'semiotic subjects' (Frank 2005, p. 193).

Volicer (2009) refers to the 'old' and 'new' culture in relation to perceptions of dementia and practices of care. For the former, dementia was associated with loss of function, 'problem' behaviors, safety and with regulation. The 'new culture' on the other hand celebrates what is retained, addresses behavioral symptoms, the dignity of risk and working with regulators. Similarly, Simard (2009) discusses the advantages of continuous programming; an approach to the care of people with dementia that leads to decreased behavioral symptoms and reduced medication, happier residents, increased verbalization, reduced falls and reduced social isolation. This provides all day, person-centered activities for people with dementia. By contrast, Parkinson (2010) condemns some care homes, including the one where his mother died, which he says are "little more than waiting rooms for death". Some of these places he says are "hopeless and depressing" (in Williams 2010).

Within the new culture, the design of residential care homes has received particular attention since the physical environment is recognized as being of key importance to support the wellbeing of individuals with dementia (Kolanowski and Whall 2000; Zeisel *et al* 2003; Brawley 2006, Regnier 2002; Verbeek *et al* 2009; Marshall 1998). For example, Zeisel *et al* (2003, p.709) discuss the correlation between behavior and environment resulting in "reduced aggressive and agitated behavior and fewer psychological problems" as well as "reduced depression, social withdrawal, misidentification, and hallucinations". As Marshall (1998, p.11) argues, "If the buildings and their carers relate to people with dementia as individuals, reinforce their sense of well-being and provide opportunities for them to practice their remaining skills, then the people with dementia are helped to function at their greatest potential."

2.4. Contemporary thinking about design for the elderly and for dementia

There are a number of recent changes in the way dementia is perceived, treated and accommodated through the constructed environment. Here the 'constructed environment' refers to both buildings and the surrounding human-mediated landscape. There is a large body of research that examines the importance of visual access to natural features and the provision of safe garden spaces for outdoor activities (Bossen 2010, Gibson *et al* 2007). In addition, maintaining visual and, where practical, physical connections to the communities in which these institutions are situated is seen to be beneficial (Judd 1998). Desirable characteristics for building design include support for everyday activities such as cooking, unobtrusive safety features, different rooms for different functions, single rooms to accommodate personal belongings, good signage and multiple sensory cues, facilitating orientation through visual access and visual cues (with a focus on objects rather than colors), the control of stimuli (especially noise), and small-scale buildings with a familiar style to create a 'homely' environment (Regnier 2002; Alzheimer's Australia 2004; Brawley 2006).

Although the literature on design for dementia encompasses multiple dimensions of *home* including practices of care, the 'making' of home through everyday rituals and the pursuit of privacy and autonomy for residents, there is a similar tendency to emphasize the aesthetics of *home*. Here, discussions focus on the tension between designing "a "home" environment and a therapeutic one" with, for example, the British norms of low lighting levels, subtle contrast colors and patterned carpets and the dementia design norms of high lighting levels, strong colors and plain surfaces (Phippen 1998, p.22). The desirability of providing way-finding 'cues' has also been questioned since this conflicts with the image of a 'homely' environment (*ibid*).

While there is generally widespread consensus around the characteristics of good design for dementia the meaning of 'homely' environments remains vague and slips easily into stereotyped ideals. In a review of two dementia institutions Sully (2008) demonstrates how the metaphor of the 'small town' is applied as a nostalgic and 'false' representation of collective identity. Further, the location of these institutions within a particular temporal context in an effort to stimulate memories from the residents' youth raises questions over their continued relevance to future generations (*ibid*).

Despite recognition of the complexities and culturally and socially situated meanings of *home*, the pursuit of a unified identity remains a key aspiration in the design of dementia facilities with attention focused on appropriate national, regional and local variations. In particular, institutions in Northern Europe and Scandinavia are commonly held up as exemplars of good design (Phippen 1998).

3. Case study

The remainder of this paper will examine these ideas in the context of a case study of 'Overspaarne' in Haarlem on the edge of Amsterdam in The Netherlands. This facility represents good practice in the design of residential aged care facilities. Overspaarne is an aged care home for 91 residents living in ground floor apartments, each having seven bedrooms. Information for this case study is drawn from a tour of the facility undertaken in January 2010 and in-depth unstructured interviews with its director, Esther Merkies, and a psychologist, Dr Teake Ettema, who played a key role in the development of the brief for the new home.

3.1. Overspaarne, Haarlem

The building was built in 2007 and replaces buildings that were small and had interconnected wards. The design of the new building is based on economic necessity and design principles (Ettema, T. Merkies,

E, 2010). Economic necessity required that expensive land had to be developed into a multi-storey development, though this conflicted with the principle of having elderly infirm people on the ground floor. The solution was to build apartments for older people on the upper floors and the care home on the ground so as to make the development economically feasible. A number of principles underpin the design. These include the idea of small group living, connection to the street, privacy within each 'home', direct access to the ground floor and the integration of the building into its local context. In addition there are other principles and ideas not related to the building design that are focused on the autonomy and privacy of the residents and an ethic of respect for residents in the practices of care and conduct of staff.

Design was seen to be very important (Ettema, T. Merkies, E, 2010). According to Merkies, "I have never realized how much a building adds to the good feeling. Before I came here I worked in a hospital ward. People started to wander and they don't know where their place is. How can you make a hospital ward look homely … this building helps so much in feeling safe, secure. They [the residents] recognize this is the living room, this is the bathroom, and this helps make them feel secure." She added, "We should not protect people from society, we should put them right in the middle." Ettema observed that older people, particularly those who cannot get out, want to feel connected to society, and to see children play, people going to and from work and shopping, hence the importance of embedding this facility in the city. The benefits are not limited to the residents according to Merkies but also extend to the health and wellbeing of the carers. As important as the design of the building is, Merkies and Ettema highlight the importance of the care philosophy. They argue that the best outcomes come when both design and care philosophy are consistent.

3.2. Homelike characteristics of Overspaarne

Small group living at Overspaarne comprises 13 'homes' each with 7 residents. The facility is located in the city and is not isolated from the day-to-day life of people of all ages. The building is not 'visible' as an institution but is integrated with its context. In this case the building appears to be a six-storey apartment building – a very common sight in Amsterdam.

As for most dwellings, these homes have a front entrance that is accessed directly from a public street. Homes are located on the ground floor to allow residents greater access as well as respecting their limited mobility. Each home has a lobby facing the street and like all homes it has a doorbell and people wishing to enter need to be invited in. Some relatives of the residents have a front door key so they can visit at any time. However, normally staff, tradespeople and relatives ring the doorbell to gain entry. Similarly, staff wishing to enter via the backdoor are required to ring the doorbell.

Corridors are wider than those of most homes but the planning of each home ensures that they are relatively short. While the plan of the overall facility appears institutional, in use each home has the appearance of a city apartment. The reception area is institutional but residents would have little need to use it. The design puts all homes on the street edges and communal facilities in the center with views to internal courtyards.

Each resident has his or her own bedroom and are encouraged to bring their own furniture and personal possessions. Domestic rather than commercial kitchens are provided in each of the 13 homes. Each home has a living and dining room and two bathrooms. Cooking, cleaning and laundry are undertaken within the home. Kitchens are small but efficient and domestic in feel and are open to the dining living room. Cooking pots hang from rails but plates are located in cupboards with opaque doors. The furniture and fittings in the living spaces are domestic. Color schemes are light and neutral but color accents in the form of bright chair upholstery enliven the space.

In addition to the building design, other practices conducive to the making of *home* include customizing the menu for each home according to the likes and dislikes of the residents and shopping for

food at the local supermarket. Language and behavior are also important. Residents are spoken to respectfully. The residents pay to be there and therefore all other people coming in to their home are guests. Staff too are required to behave in this way.

3.2.1. Institutional characteristics of Overspaarne

While kitchens and laundries are provided for in each home, carers cook and clean and are always present just as nurses are always present in a hospital. Throughout the day, different carers work in the home according to their shifts. The residents are sharing "their" home with six other people who are not likely to be related or their choice of household companions.

Bedrooms have furniture and ornaments belonging to the residents. Nevertheless, single beds are hospital-like having height adjustment and, irrespective of timber bedheads, are institutional in appearance. The 'timber' vinyl or linoleum floor finishes used here are not common in most homes though real timber is and has been used in other Scandinavian care homes. Lifting systems capable of carrying residents from their bed to the shower or toilet (when needed) are visible and institutional in appearance.

Corridors are wider than those in most homes since they have to accommodate wheelchairs and possibly trolleys. Ceilings utilize suspended ceiling tiles and these are associated with commercial and institutional buildings.

Unlike many other care homes, where a bathroom is provided for each bedroom, Overspaarne provides two bathrooms to each home. This was a deliberate policy aimed at reducing the workload of carers who clean the bathrooms and who are often asked by residents to assist them in the bathroom as well as reducing building cost and allowing the savings to be used to provide larger and better equipped bathrooms.

Fig 1. (a) Dining and living room seen from kitchen; (b) Typical bedroom

4. Discussion

While the case study building cannot be held up as being exemplary in every respect, there are many attributes of both the design of the building and the care philosophy that are effective representations of key notions emerging from the literature review. Chief among these are that *home* is multi-dimensional and complex; that the idea of *home* is often romanticized and trivialized through decoration and

superficial understandings; and that the making of *home* in an institution relies on three often neglected but important issues: the provision of privacy, autonomy and respect for the residents.

Recent thinking about the design of nursing homes places a premium on person-centered activities and a focus on a person's retained attributes and capabilities rather than on their deficits. This in turn has design implications. The provision of familiar domestic-scaled kitchens, laundries and living and dining spaces within each apartment, as well as larger spaces for group activities, on the site but external to the apartments, provide opportunities for residents to lead active lives undertaking familiar and meaningful tasks. The care philosophy of Overspaarne encourages carers to work around the daily needs of the residents rather than set work schedules based on routine tasks. If several residents wish to sit around the dining table and sing, the carer will play his or her role in making that activity enjoyable. This activity, among others, was observed during the visit to the nursing home.

Sociologists, together with nursing home workers and managers, have observed the influence of the design of nursing homes, both positive and negative, on the behavior of residents as well as the morale of those working in these homes. Well-designed homes, they argue, reinforce a sense of wellbeing, allow residents to practice their remaining skills and reduce aggressive and hostile behaviors.

The Overspaarne nursing home, through an integrated design and care philosophy, provides autonomy, privacy and a sense of wellbeing to residents. Importantly, the institution is embedded in a densely populated city allowing residents to be visited by family members (who are permitted to have keys to the apartment) and to leave the institution and participate in outside activities, thereby being part of the 'real world'. Above the ground floor nursing home is a commercial housing development. From the street, other than where the institutional entry is located, the building is not recognizable as an institution. The design of the facility is familiar and not obviously institutional except for the community facilities in the center of the site. Apartment designs and furnishings are contemporary and comfortable and do not represent a frozen moment in time, say the 1950s. However, many residents bring their own furniture to their bedroom and in some cases to the living room. This provides a sense of authenticity and familiarity without being cloyingly sentimental as is the case in the 'decorated' living rooms of a number of other nursing homes visited.

From observation and the accounts of carers at Overspaarne, the nursing home does appear to provide a respectful environment that reduces aggression, improves the wellbeing of residents and the morale of carers. The apparent success of the design is strongly associated with the care philosophy. This extends to the menu, customized to the likes and dislikes of each resident; shopping at the local supermarket, with residents who wish to participate; cooking in the apartment, with the active participation of any resident so inclined; and respectful behavior and use of language by non-residents including carers.

5. Conclusion

There is strong evidence that good design, in parallel with an appropriate care philosophy, has a key role to play in the wellbeing of the elderly, including those with dementia. This paper has explored notions of *home* in the institutional context and discussed those in relation to a case study of a building that represents good practice in The Netherlands in particular and Scandinavia in general. This approach to design favors apartment-style living in which the number of residents per apartment is relatively small although the number of residents in the institution may be quite large. The design of these homes is respectful and contemporary and does not play to stereotyped ideas of what old people might like. These are less like "waiting rooms for death" than homes that many of us in middle age might imagine for ourselves.

Nevertheless, these nursing homes are institutions. The seven residents living in each apartment in Overspaarne are in all likelihood not members of the same family or friendship circle. Carers are in their

space most hours of the day. The degree of autonomy exercised by residents may be less than that of a person living in their own home. Should we be concerned about the institutional aspect of nursing homes?

Most of the residents of nursing homes are not capable of living independently. If they were, most likely they would do so. The reality then is that these homes serve several functions and just as the notion of *home* is complex and multi-dimensional, so to is that of the institution. Contemporary well-designed nursing homes do provide aspects of *home* while at the same time providing the resources required of an institution that cares for people in a state of physical and cognitive decline. Dementia is after all a terminal illness.

Consequently, the idea of designing a 'homelike' environment may not express well the intention of good design for such institutions. Instead, the notion of 'therapeutic landscapes' from the field of health geography might provide a better fit (see for example Williams 2002). This acknowledges the true purpose of these facilities – the support and wellbeing of people experiencing the ageing process not only through the design of the physical landscape of the building and exterior spaces, but also through the relational everyday practices and social connections – and may more readily support the privacy, autonomy and selfhood that are fundamental to making *home*. Furthermore, many aspects of these facilities will necessarily respond, through design, to the practical necessity of addressing the very real needs of people who are frail and ill – not all of which are compatible to the idea of being 'homelike'. The provision of a *home* is only one aspect of that purpose.

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