benevolent society

Nursing home or my home? Converting a nursing home to a home for people with advanced dementia

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Introduction

The Benevolent Society was one of three organisations to take part in the NSW Action Plan on Dementia: Dementia Conversion Model Project, organised by the Ageing and Disability Department. The project aimed to pilot a process to assist not-for-profit residential aged care providers to upgrade their mainstream facilities into more appropriate accommodation and care for people with dementia.

The Benevolent Society's aged care facility selected to take part was Eric Callaway House (ECH). It was built in 1982 as a 43 bed nursing home for frail older people. It is in Phillip Bay, near La Perouse, in the southeastern suburbs of Sydney.

From 1995, ECH only admitted residents with advanced dementia. It is now dementia specific in terms of its residents, 50% of whom have difficult behaviour and/or wander. From the time the nursing home began admitting people with advanced dementia, staff were given a lot of specific training and support. The grounds were made secure, but the building was quite unsuited to its new purpose.

We were concerned that the safety, comfort, lifestyle and dignity of residents, their families, friends and staff were not at the levels they should have been and we had wanted to make improvements in the building for some time. Taking part in the project gave us the assistance of consultants with expertise not only in dementia specific design, but also in good practice models of dementia care.

Together with our own key staff, the consultants formed the project team which met extensively from October 1998 to March 1999. We put a lot of effort into making sure families of residents and staff were involved in the project, through surveys, focus groups, meetings and newsletters.

The problems we identified:

- The large lounge and dining areas were no longer suitable for our residents. We had already divided meal times between two areas because some residents were disruptive, intrusive and noisy.

- Activities for large groups were no longer successful due to the limited concentration span and disruptive behaviour of some residents.
- Corridors were long and uninviting with shiny floors. Although always looking clean, they were cold and hospital like. The glare from the floors also increased the risk of falls for the residents.
- The garden area was not user friendly and was difficult to supervise. Although we had a paved walkway and a gazebo the garden did not provide enough stimulation. Outside areas at the back of building were unsafe due to uneven ground.
- There was no real connection between the inside and outside areas. The only protected outside area was a small patio off the entrance foyer.
- The front and only entry was unsafe because it was shared with delivery trucks and trades people.
- The bathroom was located at the north end of the building, posing questions of privacy and dignity for those residents being transported from the south end rooms as they passed through the central entry foyer.
- The treatment room was too small. There was no room to attend resident treatments. It was just big enough to house the medications, trolley, fridge and sink.
- Office space for the Director of Nursing, Deputy Director of Nursing, Administration staff, Nurse Educator and Diversional Therapist was inadequate. Offices were shared. There was no private area for interviews or to take enquiries.
- The Sister's station lacked security and privacy, especially at report time. Staff found it difficult to complete documentation because of constant interruptions and noise.
- The laundry was small. The amount of laundry had increased significantly due to the increase in the level of incontinence.
- Storage space was inadequate due to the increased numbers of water chairs, wheelchairs, trolleys and lifting equipment. Storage bays were long and narrow. Staff had to move equipment to get to other pieces of equipment.
- The activity area lacked access to kitchen facilities for the diversional therapy cooking programs and families and visitors had no access to tea and coffee facilities.
- There was no staff training area. The dining room, lounge areas and staff room doubled for staff education and meetings as required.

Constraints

We had to include many factors in planning for the future of ECH, including a number of constraints:

- The building is built land leased from the local council, who were not amenable to suggestions they give us the title.
- The site is long and narrow, surrounded by houses, and there was no opportunity to extend it.

- There was uncertainty about certification requirements by 2008.
- The Prince Henry Hospital (PHH) site nearby was about to be redeveloped, with the strong possibility that another aged care facility could be built within a kilometre of ECH.

Some of the options we considered and rejected included:

- Rebuilding on a nearby retirement village site also leased by The Benevolent Society. This would have been over the road from the PHH site. We would have had to increase the number of beds to make it viable, and this would have meant too many high care places in one small area.
- Build a second storey. This would have been very costly with the necessary lifts, would have been unacceptable to council because of the overdevelopment of the site, and would have meant relocating all the residents during the building work.

Outcome of consultation

The final outcome was very different to our initial concept. After consulting with all the stakeholders and considering all the options and constraints, we decided to redevelop the existing building.

The residents will remain in place and with precision planning, the redevelopment is proceeding in six stages with what we hoped would be minimal disruption to both the residents' lifestyle and staff routines. We knew some stages would be more difficult than others, but nothing prepared us for a week of hammer drilling and dust eating during stage two.

Although the structural changes are only now occurring, we have for some time been changing our care practices to bring them more into line with best practice models of dementia care. Individuality, flexibility, ongoing education and recruitment of appropriate staff are essential components in our care approach. We have increased hours for diversional therapy and are now able to run a variety of sessions simultaneously in smaller groups. This is working extremely well.

Although we are maintaining nine four bed rooms we are fortunate in having ensuite facilities in all multi-bed areas. In 2008 we will reduce one or two places to meet certification ratios.

What will we get?

- additional spaces for activities, staff training and hairdressing. The multi-function extension of four rooms has sliding walls that allow flexibility in the size of the area for resident activities, staff education and both resident and staff social functions.
- a comfortable lounge area for families to visit in private or a quiet area for staff to take individual residents or small groups.

- a safer and more pleasant main entrance that immediately displays warmth and friendliness.
- workable office spaces for staff.
- an additional kitchen serving area where relatives and friends are welcome to make tea and coffee and where cooking programs can again be part of the activity program.
- easy access to paved and covered areas for inside/outside living, especially for our much loved barbeques.
- a garden area that is safe for all residents to wander at will and that will stimulate and please those who visit it.
- a larger and more functional treatment room and laundry. Storage areas will be larger and easy to access. We will have a "parking bay" for the 14 water chairs we now use.
- safe floors for our residents to walk on. They will not be stepping over shadows or bending over to pick up shiny spots. The incidence of falls will decrease.
- reduced staff stress and time saved as resident supervision will be easier.

What have we learned?

We have learned through the project that we had to compromise. We did the best we could with what we had, but it is not our ideal. It was hard work, and very time consuming to involve families and staff and to look at every possible option.

Although the initial aim of the Dementia Conversion Model was to produce a management guide that other providers could use to undertake the same journey on their own, we highly recommend the use of external consultants. They brought fresh ideas, challenged our assumptions and kept us to a timetable.

The project has also confirmed our strong belief that buildings don't care for people: people care for people. Good buildings are a great help in creating 'homelike care' but they complement rather than substitute for the care provided by our staff.

"Homelike care" already exists at ECH. Our staff are exceptional in the way they not only care for our residents, but also for residents' families and friends and for each other. The structural changes when complete will enhance the existing care and lifestyle for our residents, their families, friends and staff. Together we believe they will more truly create a place people can feel is "home".