THE ARCHITECTURE OF CARE

A New Approach

William G McMorran BA Dip. Arch. RIBA

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WINSTON CHURCHILL MEMORIAL TRUST

To Jan
with love

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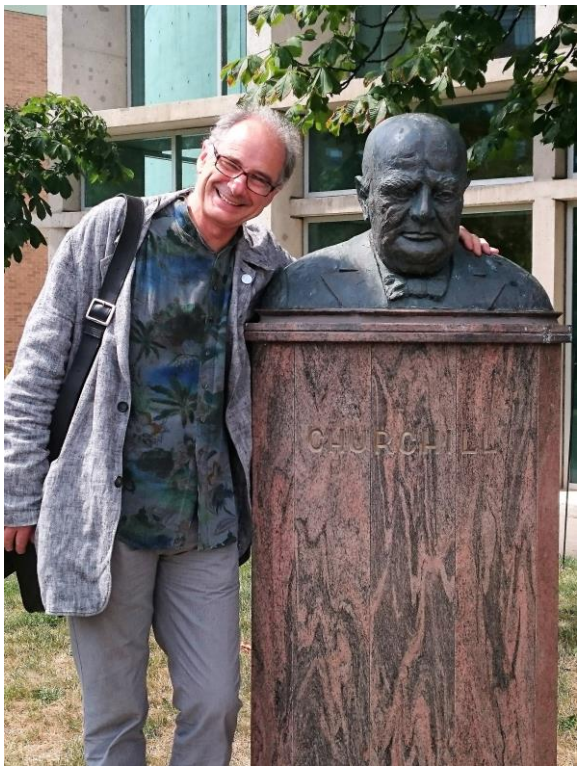
FAMILY

Special thanks go to Jan, Donald, Roland and Hugo for their forebearance during my extended disappearances travelling on the Fellowship and while writing this Report. In particular I am grateful for Roland's wise insight and suggestions while assembling and compositing all the information.



William is an architect and co-director of Architectonicus, a design practice established in 2012 to develop a new design approach for dementia care and the buildings within which that care is provided. (visit www.architectonicus.co.uk).

Churchill Memorial
Sunnybrook Veterans Centre
Toronto

Introduction / Summary

This Report demonstrates that residential dementia care building design, when fully integrated with successful new models of care, and new approaches to ageing, actively supports life affirming and affordable centres of care excellence

My professional life as an architect and designer, personal experience visiting relatives and family friends in care homes and psychiatric hospitals, and observation of a son working as a one-to-one carer for people living with acute autism and learning difficulties, has led to a belief that there is a fundamental disconnection between care and the environment within which that care is provided. The Travelling Fellowship, so kindly offered by the Winston Churchill Memorial Trust, has enabled an opportunity to examine this hypothesis.

At present, models of residential care generally coerce those people living 'in care' into becoming passive participants in daily routines that are out of their direct control. The opportunity for independent expression of personhood is substantially limited and a culture of dependence is consequently the basis of most care provision. Care staff become so fully pre-occupied by the pressures this dependence imposes that they are unable to create for themselves the empathetic, shared one-to-one care that would increase wellbeing in those they care for and reduce the frustration and exhaustion generally experienced by carers.

It is a situation that appears to be systemic in western culture and lies at the heart of the current care crisis in the UK. While writing this Report, an article in Property Times dated 17th February 2017 states that, 'The social care sector is on the cusp of a national crisis after more than double the number of care homes closed during 2016 than opened'. Currently over 20 care homes are closing each month. Less than 50% are replaced. What is of enormous concern is that these new replacement buildings are also destined to fail in the long term because their design encourages the existing outmoded and failing model of care. Increased financial support for a broken care model, will not resolve the problem. Instead, a fundamental change in the culture of care is required.

The intention has been to research the latest thinking in effective care for people living with a dementia, to personally witness this in practice and then to apply that evidence base to devise a possible new model of care architecture in the UK. This new model must fully integrate care and the environment, bringing a step change in benefit to residents and staff, and, while demonstrating manifest sustainable cost efficiencies.

Four dementia care initiatives were selected abroad, which had already received publicity as exemplars:

1) Hammond Care dementia villages in New South Wales
2) Australian Care Homes dementia communities and aged living projects in South Australia
3) Memory Care project at Georgian Bay north of Toronto
4) Meeting Centres for people living with a dementia as established by VU University in the Netherlands

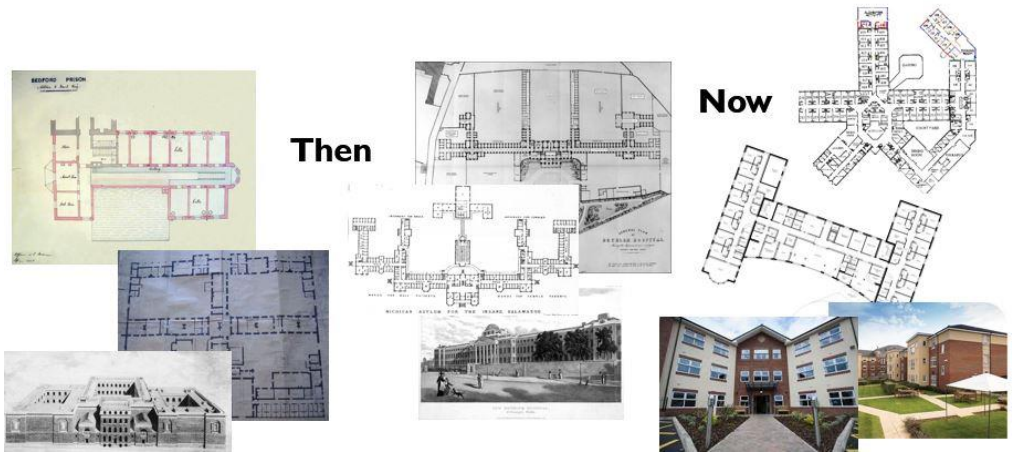
Additionally the Fellowship schedule was programmed to include participation in three major international conferences :

1) Hammond Care International Dementia Conference: *'Grand Designs - Are We There Yet? '* - Sydney
2) International Federation on Ageing - 13th Global Conference - Brisbane
3) Alzheimer Association International Conference - Toronto

The report demonstrates how current innovation in activity based care models abroad can be integrated with a new model for residential accommodation to empower residents, improve their health, reduce care staff stress, transform the role of carers in society, and introduce cost effective care delivery and affordable construction of care buildings.

Background

It can be argued that, historically, 'care' buildings have always failed those they 'care' for. Monastic hospitals and early penitentiaries provided cells along a corridor. Space was minimal, windows were small, welfare facilities non-existent. Rigour was regarded as curative in itself; and isolation of the individual supposed to discourage transmission of disease or encourage repentance for a mis-spent life. Diminution of the prisoner's sense of self was seen as a positive. Essentially the whole arrangement was the most basic people storage; effectively a giant human filing system. This arrangement was adopted for asylums; Bedlam Hospital being the most notorious example. Large numbers of patients meant that distances along corridors were vast making physical communication arduous and exhausting for staff. It became acknowledged that residential treatment in these building types was costly. The Minister for Heath in 1961 stated, 'for the great majority of these establishments there is no future use'. These buildings were demolished, but because many residents and vulnerable people required continuing support, in their place more localised accommodation was built. This included acute mental health care facilities associated with local hospitals, (including 'geriatric' wards often supporting people living with dementia), extra care and sheltered housing, and care homes operated by local authorities, housing associations and private care providers. Without fail, whatever the model of care, the building plans remained the same – small rooms and flats off corridors. Consequently the dis-orientation, isolation and passive dependence of residents has remained, to this day, together with the wasted energy and time of support staff still required to walk the long distances necessary to deliver what care they can, in an increasingly limited time frame..



Prisons - Asylums - Care Buildings : They are all the same

In a reaction to the corridor asylum buildings, the concept of a 'household' model of care began to be developed, and is still regarded as a potential solution. The model comprises a small group of bedrooms, arranged more like a private house, including a sittingroom, a kitchen and associated domestic accommodation. But this arrangement still relies upon passageways. Several of these cottage type dwellings are often grouped together on a small secure estate sharing outside spaces and group facilities. The concept aims to replicate life, 'at home'. However, despite their being considered a home-from-home, activities are generally segregated in exactly the same way as in one's own home. All the same problems of social disconnection remain. Without substantial assistance, independent access to daily routine and activity remains as difficult as in one's own home. Consequently the necessary high ratio of staff to residents, (2 - 5/6) creates an unsustainably labour intensive care model. But, most fundamentally the social structure is exactly not like one's own home, for in this model each resident shares 'their' home with the other residents.

In July 2016 the Care Quality Commission (CQC) stated, 'the sustainability of adult social care is approaching a tipping point…..care services for elderly and disabled people in England are being undermined by increasing financial pressure'. In October the Prime Minister said, 'experience of elderly in care homes must improve'. Each time the reason for failure is explained away as lack of money. What is not examined is why.

The CQC has identified the following seven common requirements across all care delivery in order to achieve a CQC rating of, 'Outstanding':

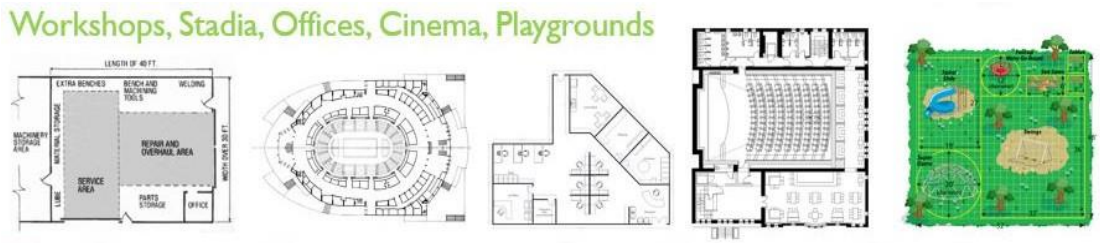
1) Personalised care planning
2) Tailored Activity
3) Development of New and Existing Skills
4) Continuous Engagement of residents and staff
5) Welcoming Place
6) Good End of Life Care
7) Bringing in the Community and remaining Active Citizens

These requirements are corroborated by research and neuroscience. However, less than 1% of all care organisations achieve this rating and many are closing. How can this be, when carers in general want to deliver outstanding care?

Consider each requirement in the context of all corridor based building types :

1) Personalised care planning – lengthy circulation routes prevent spontaneous access to care plans
2) Tailored Activity - carers must escort each resident separately to an activity of choice.
3) Development of New and Existing Skills – the daily journey from bedroom to dayroom is a barrier
4) Continuous Engagement of residents and staff – corridors separate and isolate
5) Welcoming Place – corridor environments are institutional not domestic
6) Good End of Life Care – corridor environments impose bed centric isolation
7) Bringing in the Community and remaining Active Citizens – corridors inhibit social engagement

Generally, in human life, we set up positive, purposeful surroundings to support us; from the layout of one's own home to the intricate multi layered public and private spaces of whole cities. Well understood building types have evolved to become archetypes that everyone recognises and knows how to use: workshops, stadia, offices, cinemas, concert halls, faith buildings, etc..



Some building archetypes

Playgrounds are an excellent example: opportunity for a child to independently choose their preferred activity is made abundantly possible by the layout of a wide range of safe spaces containing different play equipment. While playing it is possible for each young person to scan across and see what other playmates are enjoying and make further independent decisions about what – or what not – to do next. Learning by participation leads to confidence building; trusting friendships are established. Significantly, family and friends – 'the carers' - are able to easily and passively supervise the playground because generally sightlines are clear. The need for intervention and intrusion is minimised and anticipated difficulties can be pre-emptively handled before a crisis develops. This whole scenario would be ridiculously impossible were the playground and each play zone accessed by corridors and surrounded by high walls.

However, care has always remained delivered within a building typology – essentially a labyrinth of corridors and walls - that utterly fails to support the best endeavours of carers and those being cared for.

Where in the world could there be examples of buildings designed specially to support care?

NOTE : Red text highlights key issues concerning a new integrated care/building model.

AUSTRALIA

On the flight to Sydney I met Gabrielle. Her mother died three years ago from Alzheimer's. Gabrielle told me that her mother loved dressing up in vibrant colours but that this passion was denied to her at her care home. She knew her daughter right to the end of her life. Gabrielle said that Alzheimer's '*stripped her mother down to her soul until it shone through*'.

Arriving at Sydney Central railway station, I noticed, jammed against a life's possessions in a supermarket trolley, a large piece of card upon which a 'dero' had written in capitals:

'It's a No Brainer:
No Design : No Creation
No Mandate : No Continuation
So Create Is = Mandate'

At the moment of commencing my Fellowship this powerful mantra was to remain a constant inspiration

HammondCare Village – Woy Woy, NSW

The Care Model

HammondCare (HC) very generously included me in a party from Japan visiting their care village at Woy Woy, on the coast north of Sydney. This community is located on the outer limits of the town and comprises a group of six single storey cottages each providing shared domestic residential living for 14 residents. Over 25 years, HC have established a tried and tested model of dementia care that is uniquely integrated with a building type designed specially to support that model. The emphasis is on the cottages being 'just like a resident's home' and

Entrance to HammondCare village at WoyWoy

within which the support staff are encouraged to fully participate in the normal activities of everyday life; the chores as well as the enjoyable activities. The environment is designed to be expressly 'non medical' and 'uninstitutional'. Residents' physical health is closely monitored so that the 'invariably bad experience' of a hospital referral is avoided.

Responding to the needs of the individual and matching a person's care needs to the type of support available in a particular cottage are a key consideration of HC before they join the community.

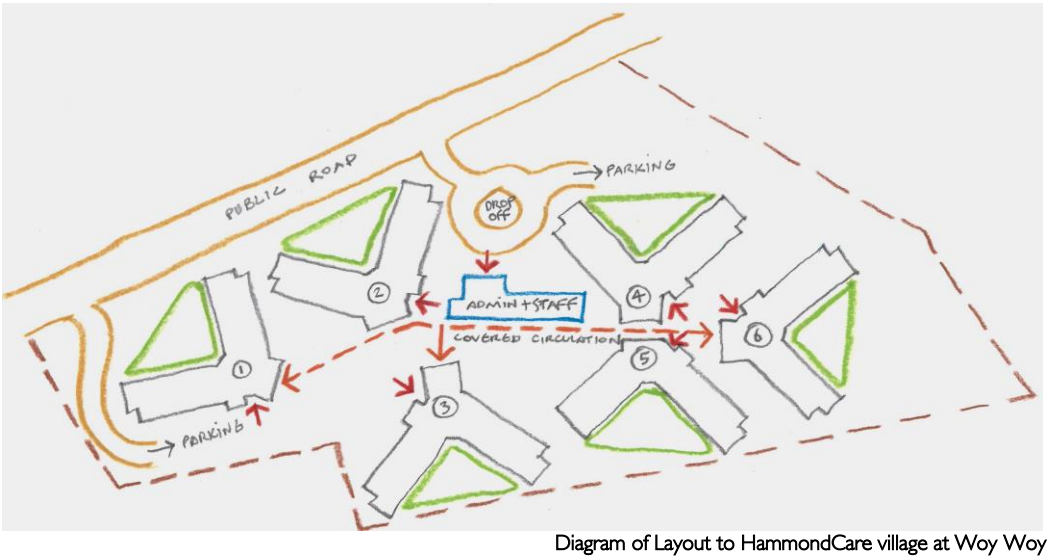


Diagram of Layout to HammondCare village at Woy Woy

HC endeavour to ensure that each cottage supports residents with similar ability types. To ensure this aim, a 'Care Planning Assessments Tool' (CPAT) is completed for each potential resident, together with a comprehensive record of their lifestyle and social history. The CPAT establishes medical history, physical attributes and the level of care required or applied for. Fundamental to the process is the graded assessment of abilities, including: communication, physical problems, self-help skills, confusion, behaviour, social interaction, psychiatric observations and carer dependency. These are plotted on a graph and matched with the care models provided by HC. Applicants whose CPAT graph indicates that their abilities are not compatible with the care model are recommended to seek an alternative care provider. Abilities critical to acceptance are: physical problems, self help skills and behaviour. HC also advise applicants that residents with high levels of confusion and low social interaction may become isolated or, conversely, distressed by the behaviour of their cottage companions. The model is consequently built around a generally quiet, moderated and low stimulus daily routine where 'surprise' is eliminated. Every six months a resident's CPAT is reviewed.

Emphasis is placed on relationship building, ensuring resident comfort and that each individual is engaged in as normal a life as possible. Building a strong bond between staff, family and residents is the aim. Staff are trained to use the cottage environment to optimise residents' physical and social wellbeing. Staff are permanently allocated to an individual cottage so that they are skilled in the model of care being provided there and encouraged to build trusting co-operative relationships with each other and the small group of residents that they permanently care for. In this way staff are empowered to make their own day-to-day decisions based on personal knowledge that anticipates the individual needs of each resident. Staff facilities are generous, providing a large kitchen, shower and locker rooms, a sitting room as well as a private garden verandah for relaxation/smoking. HammondCare are proud that their care staff are resourced from the local community and that there is negligible 'attrition'.

HC state that they 'want our cottages to be great places to live'. Environments are designed to 'promote dignity, maximise choice and independence and to feel like home, not a facility'. HC say that this is achieved by the following design principles :

- Make it small
- Make it domestic and familiar
- Reduce unwanted stimulation
- Make it a home, not an institution
- Highlight domestic equipment to enhance independent use (i.e. colour to define floor perimeters, w.c. seats, hot/cold taps etc..
- Good 'visual access', (i.e. clear line of sight)
- Access to outdoors
- Promote choice and autonomy

The Buildings

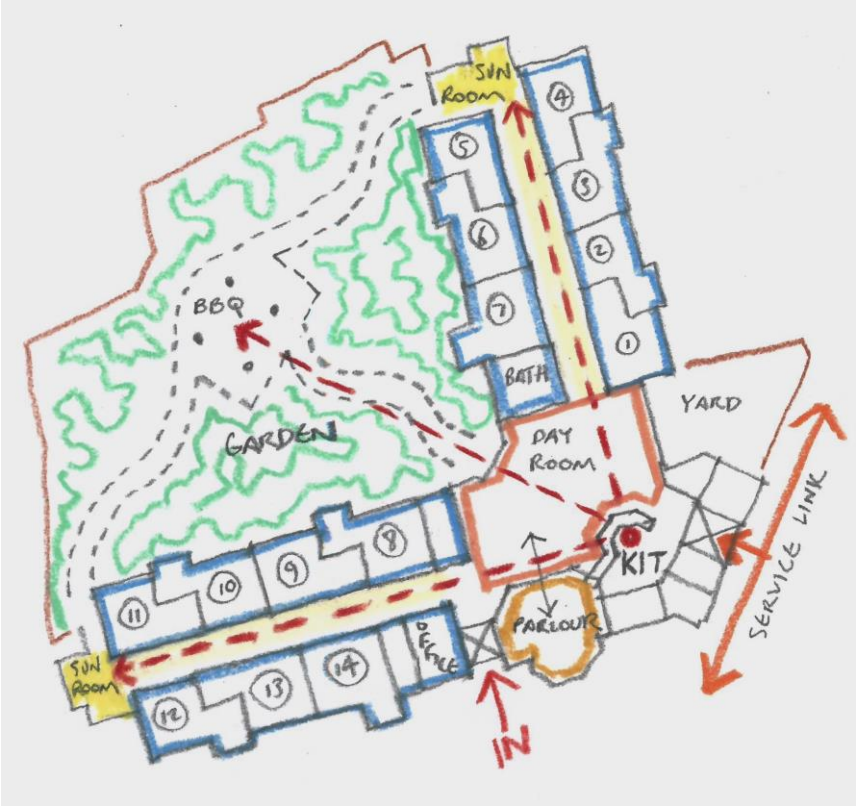


Diagram of Cottage Layout, HammondCare Village at Woy Woy

It is important to understand that HC are pioneers in the design of accommodation specifically for people living with dementia and initiated design features that are now generally adopted as standard good practice. The layout described below was built in 2004 and is based upon principles pioneered by HC some 25 years ago at 'The Meadows', Hammondville, NSW. (See 'Design for Dementia' Judd, Marshall, Phippen - Hawker Publications 1998)

The layout of each cottage is centred upon an open kitchen area shared by residents and staff. Meals are not brought in from outside; they are prepared and produced in each kitchen using produce stored in the kitchen and an adjacent larder. HC emphasised the importance of creating enjoyable cooking aromas that powerfully signal to residents the daily routine. The kitchen is laid out so that all key food preparation and washing up activities are carried out by a carer facing outward into a central day space and with line of sight down two bedroom wing corridors set at right angles on either side. In this way a single member of staff can view all the main shared spaces at a glance.

This unobtrusive and passive 'visual access' for residents and staff is the basis for the HC building model which, integrating with the care model, centres upon the regular structure of daily mealtime activities.

Adjacent to the kitchen are stores, a laundry, the nursing station/medicines room and an accessible w.c.. Close to the kitchen are arranged dining tables and chairs and, beyond, a choice of upholstered comfortable chairs and associated tables together with a variety of typical domestic furnishings including a clock, sideboard, pictures etc., i.e. all the paraphernalia of domestic living. Floors are carpeted in a single colour to avoid trip hazards caused by optical confusion. Close to the kitchen is a side room called 'The Parlour' offering a quiet sittingroom for residents in contrast to the central space which is relatively large and open. This also provides a place for visiting family and friends to share private time.

Sprinklers and mechanical ventilation is provided throughout. Access to the garden is at the internal angle where the two bedroom wings join.

Each of the two wings contain seven en-suite bedrooms laid out either side of a broad corridor and there is a spacious accessible bathroom. Bedrooms have wide doorways and each resident has their name on the door and some have a frame of personal photos on the adjacent corridor wall, to identify bedroom location and express personal ownership of their bedroom. Bedrooms are large, over 16m² in floor area (160ft²), and additionally there is a capacious fitted wardrobe and excellent generous en-suite facilities accessed through wide sliding doors. Personal possessions in bedrooms are encouraged. Furniture is selected and supplied by HC. The ends of each corridor terminate in a small sitting area called 'The Sunroom' which has a doorway leading to the garden.

The garden comprises a substantial triangular grassed space with flower beds situated between the two bedroom wings. Three footpaths link the two sunrooms and the doorway into the central day space. At the meeting point between the pathways there is a covered barbeque area with seating. The gardens contain a variety of shrubs and trees well maintained by HC and which mask the secure perimeter fencing. To the rear is a small fenced area also directly accessible from the central day space. This is hard landscaped and provides an entirely different outdoor ambience deliberately associated with domestic back yards.

Individual public/visitor access to each cottage is by means of a front door lobby located between the parlour and a small admin. office. Within the cottage this point of possible egress is deliberately modest, the doorway being painted to match the walls. This discretion is designed to prevent residents' attention becoming focussed on the opportunity to access the public environs of the village. Staff service access is also well concealed; a pass door is situated in a lobby adjacent to the kitchen. This door accesses a central internal circulation corridor that links all cottages and central services, including a central laundry.

Risk free participation by residents in everyday chores is managed by the open kitchen with the walk-in larder immediately adjacent. Similarly, a small laundry room contains washing machines and a sink for simple clothes cleaning. This offers residents an opportunity to participate in some domestic work. Soiled items are disposed through a discrete chute into a hygienic collection area, off the hidden service corridor, for cleaning in the central laundry.

A central administration building backing on to the service corridor contains a multi-use room with a well equipped kitchen and servery for training and social occasions. Staff said that when residents on a journey out of the village see this they regard it as 'the shop'.

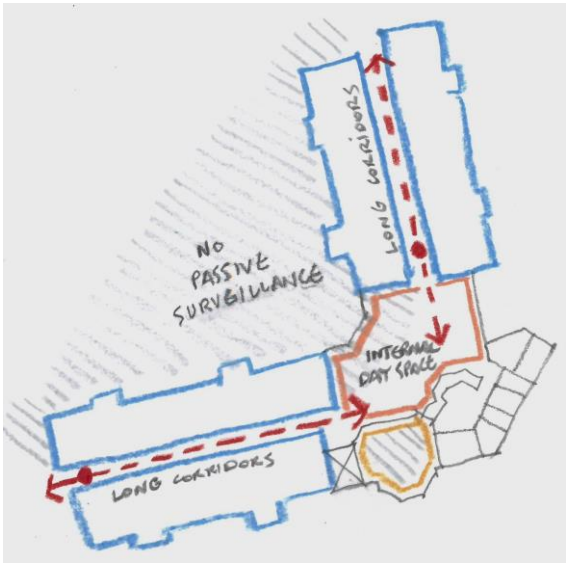
Critique

HC demonstrate a very organised and carefully integrated care model, whereby residents with well defined and understood levels of ability live within a carefully structured and moderated daily routine. Staff enjoy a close relationship with their individual cottages and their residents. The low stimulus environment is designed to minimise stress for both staff and residents. On the day of the visit, in the late morning, a pot roast was cooking in a sealed electric casserole on the kitchen worktop, and two residents were participating in a modest dance activity organised by a volunteer. A resident was sitting with two family members in the 'sunroom' area at the end of one of the corridors. Other residents were living in their rooms. No one was in the garden. The atmosphere was quiet and clean and tidy. The air quality was fresh and clean.

It was therefore a shock, during the cottage tour, to discover the elaborate central services infrastructure discretely concealed behind the kitchen. Its existence is justified to enable safe weather tight 24/7 staff access and intercommunication between the six cottages of the village, and to ensure that residents are protected from the negative aspects of necessarily busy everyday support routines. HC describe their built environment as a 'prosthetic' and a 'passive component of an integrated care system'. However, this description confirms the artificiality of the environment which has been carefully organised to ensure that residents lead as quiet a life as can be managed. While it can be asserted that all buildings are a stage, it was troubling to feel that residents were so thoroughly stage managed, and to wonder what exactly is the balance of benefit for the residents and the staff in creating such a controlled and benign lifestyle. This issue was briefly discussed. It was emphasised that the aim is always to ensure a quiet, safe, stable and risk free environment for residents. It remained of concern that the emphasis appeared to be residents' 'disability' rather than seeking ways to optimise their individual 'abilities'.

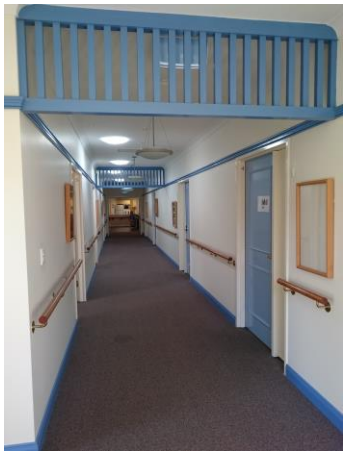
So, how does the stage-set function?

Diagram showing loss of visual access within the cottage layout : HammondCare village at Woy Woy



The village is situated at the end of a long residential street on the perimeter of WoyWoy and borrows its external appearance from the vernacular Australian suburb which comprises a variety of low pitched metal roof tops with wide eaves and verandahs over single storey timber, brick and cement rendered facades. The aim has been to completely blend into the local scene. Apart from the signalling entrance piers immediately off the street it is not easily apparent that 'The Village' exists, Many Australian homes express the personality of their owners externally by witty and idiosyncratic decoration, including collections of found objects, potted plants etc. The village shows no external sign of resident participation in expression of self. This is also the case internally, where, on the whole, although the selection of furniture and fittings and decoration is 'domestic', the general aesthetic is blandly uniform, a style that might be described as HC domestic retro.

The overall concept of clear lines of sight (visual access) is a positive and commendable strategy – good for staff surveillance and good for residents living with diminished ability to orientate and remember spacial relationships. However, the opportunity for this to benefit staff and residents equally and reciprocally is actually quite limited within the cottage layout. Once a member of staff is no longer situated at the kitchen focus then opportunity for passive surveillance of all areas is immediately lost. For example, once a carer or resident has moved only a few metres into a corridor from the day space, the opposite corridor wing and most of the dayroom and all of the parlour and garden are out of sight. The intention of clear views is right but the building plan is inflexible, actively preventing complete visual integration of all areas. This is most apparent in the relationship between dayroom / sunrooms and garden. Views of the garden from communal areas is very restricted and consequently it is not easy for staff to be aware of, or encourage, residents to independently use it. Once a resident has passed through the sunroom door they are also out of sight and the opportunity for passive observation is only possible in a limited way through the dayroom doors or residents' rooms directly overlooking the garden.



Corridors:
Care ?
Hotel?

The two corridors are each over 20m (62ft) long, creating a very non domestic circulation system that is well over 160ft in total length within each cottage. To mitigate the visual effect of this, the corridors are wide - nearly 2m - and at ceiling level ornamental screens unsuccessfully attempt to visually foreshorten the apparent distance needed to be travelled by residents and staff between bedrooms and the central day space. This, together with the desire to 'de-clutter' these circulation areas, results in large empty areas that make no contribution to the function of the cottage. HC do acknowledge this endemic problem of corridors, calling it 'sameness'. Unfortunately, the prison grille appearance of the corridor screens and the blank view from a resident's room toward the opposite corridor wall only highlights the problem. There is no sign of activity or opportunity for activity within corridors. Residents' doors all look similar and their framed photographs and printed names inadvertently increase diminishment, rather than expression, of self.

Residents are encouraged to bring their own possessions into their bedrooms but this appears to mean small items because there are insufficient surfaces available for them to be arranged according to individual decorative choice. In particular, windows to bedrooms have high, view obstructing, sills of insufficient width on which to place photographs and mementos. En-suites with outside walls have very small windows also located too high for residents to benefit from potential views into the garden areas. The opportunity for emotional attachment by a resident to their personal space is as limited as for anyone when occupying a motel bedroom.

The central day room, while spacious in itself, does not have a variety of clearly defined activity areas. Apart from dining tables and chairs, sofas and armchairs are pushed into the default care location against perimeter walls. The arrangement of embracing bedroom wings and kitchen/service area means that the day room is essentially an internalised space with limited natural light or aspect out to the substantial garden area. The layout design is an imagined domestic livingroom intended to be familiar to the average resident but one over which they have no apparent ability to actively and personally control, participate in creating or arrange to suit their individual need or inclination. The character of the parlour is very similar, but being a smaller space the effect of the retro décor is much more intense.

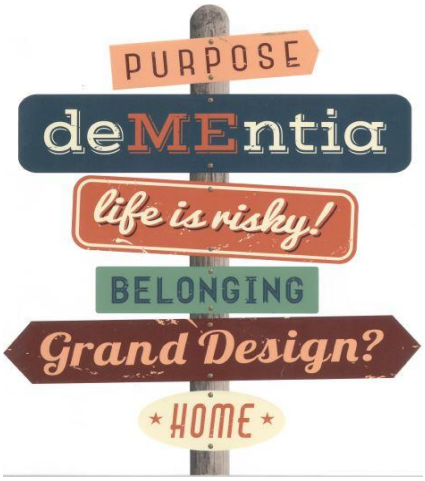
Summary

HC are successful in integrating their care model with the way the building supports their care model. Staff achieve job satisfaction by full knowledge and understanding of this model and its success in practice. Control of access to the everyday world beyond is absolute; the intended highly passive and protected life style is successfully delivered. The model is a very carefully considered stage set for residents who have been very carefully selected to fit that model. Because the village is distributed expansively across the site on a single level, it is not a model that can easily be replicated in the space hungry UK. This is acknowledged by HC, who are currently building a dementia care community several stories high in north Sydney.

Sydney Conference : Grand Designs

Plenary Session – Day One

Keynote speech: Dr Steven Judt, CE at HammondCare (Aus)



Steven asked the question – 'How much progress has been made in supporting people living with dementia?' He recalled the innovative care homes established by HC back in the 1990's (The Meadows). Because at that time care quality was substantially based on chance, the aim was to achieve a consistent level of care delivery. This was based from the outset on combining optimal environmental surroundings with person centred care. Key principles were: good visual access, resident participation in the everyday routine of meal preparation and cooking, an absence of long corridors and de-cluttering living areas especially removal of institutional style trollies.

Although there have been widespread improvements in basic care quality, Steven asked what became of that innovation and why has the movement not continued? He expressed concern that gradually a 'tick-box' mentality has resulted from the 'age of compliance'; that the downsides of systemisations become dominant without a real improvement in the quality of life. The emergence of highly protective, high surveillance care homes requires additional funding that in turn requires excessively large care communities, at least 60% larger than previously. The result is long corridors, trucked in food, public areas that look and feel like airport lounges, too much extraneous noise at night and excessive use of IT/control panels. He said, 'the tide has gone out' on small, familiar, truly homelike care communities.

Steven noted the growing 'at-home-good' mantra for increasing support for people in their own homes. But he noted that the project called Extended Aged Care at Home (EACH) no longer exists in Australia and is subject to a review whose outcome is not known until 2017. He expressed concern that if 90% of older people are supported at home then their care will be untenable. He said, 'You may not be doing the best by keeping them at home'; carers will struggle and there will be expensive consequential health issues for the whole family.

He is concerned that current statistics on likely numbers of people living with a dementia are inaccurate: 'We can't manage what we can't measure'. Accurate projected statistics for 2050 are urgently required because there is some data that indicates dementia incidence is declining. He conjectured that this is possibly related to a similar decline that has occurred in the last 20 years for cardiovascular disease in relation to incidence of smoking; life style choices may make a considerable impact on dementias: 'what's good for your heart is good for your brain'.

In summary, Steven felt that the future is a combination of initiatives based upon accurate data:

* Much more emphasis on the campaign, 'mind your mind', i.e. keep active, eat the right diet, and ensure social engagement.
* Care staff to have a mandatory basic understanding of dementias
* Key to quality is focus, especially on specialised services.
* Increased de-stigmatisation through strengthening supported homecare that optimises choice, inclusion and independence
* Further work required on severe / challenging behaviours related to un-identified pain and inappropriate environment.

An answer to Steven's query about lack of innovation might lie in a failure to address changing attitudes toward dementia, i.e. look at the person and what they can and want to do, rather than place people into benign dependent environments that are inclined to highlight illness and risk avoidance.

However, Steven concluded that 'the future lay with the courage and imagination of the risk takers out there'.

Emeritus Professor Mary Marshall (Sco): 'Designing to Reduce Distressed Behaviours'

Mary's current work is based upon existing accommodation specially built in Victoria for people with distressed behaviours living together in small groups. A literature review is due to be published.

Mary said that it was impossible to separate care and buildings and thought that the impact upon distressed people was in the proportion of 90% care provision and 10% built environment.

In summary, Mary said that it is a combination of features that makes a difference. The key factors are:

- Residential feel - as opposed to visual emphasis on security
- High levels of direct visual contact – improves communication (she evidenced prison design whereby the old hub and spoke cell block plan is being replaced by a 'direct supervision model' that arranges cells around a central shared open communal space. She said that this reduced build costs and allowed for separate groupings.
- Avoid corridors. Research indicates that 41% of agitated behaviour 'incidents' occur in corridors.
- Minimise institutionalisation by reducing use of handrails. Research indicates that most falls occur in residents' rooms. Falls do not occur frequently in corridors yet it is corridors that are always fitted with handrails. Encouraging handrail use when not necessary, negatively impacts correct walking posture; maintaining a conscious sense of balance is important for independence and fitness
- Small groups

- High levels of visibility stops falls and reduces aggression.
- Low contrast bright artificial lighting.
- The best function of good visibility is a predominance of natural light that also reinforces circadian rhythm. Getting access to the outside is important.
- Avoid excess noise - both generated and reflected. Easy to become a victim of noise which increases blood pressure. Consideration is required of room acoustics to mitigate background noise
- Access to nature and gardens reduces aggressive behaviours

Mary acknowledged that there is very little research into the effect of layout and wondered if more research will make a difference.

Mary's assertion that built environment has relatively little impact on stress levels seems contrary to her findings in terms of building layout.

Dr Kirsty Beilhartz (Aus): Music … The Food of Love

Kirsty reported on her two year programme at HC integrating music into their care model as a major component of engagement and connection.

She quoted Shunryu Suzuki, a Buddhist monk, who said, 'To express yourself as you are is the most important thing'.

Kirsty stressed the importance of embedding music into daily experience so that it becomes integral to life style. This can be done in three ways: 1) tailoring to the individual (HC are successfully providing residents with their favourite music preferences using headphones and ipods). 2) participatory groups – no more residents sitting in chairs with their backs to the wall 3) spontaneous expressive and creative opportunities in a range of settings.

Kirsty pointed out that music becomes just, 'noise' if meaningless. Orientation and location of the sound source is important so that tone and timbre can be fully appreciated. Care is required to: a) ensure appropriate sound absorbency/reflection in rooms, b) moderate extraneous back of house noises, c) be vigilant of conversation volume – this tends to increase at night d) not allow competition between different sound sources – too commonly radio and tv clash within same space.

The greatest benefit witnessed has been music's capacity to reduce agitation and distress when introduced flexibly (rather than formally) in response to need. Teeth grinding has stopped with music. Music alleviates pain, moderates behaviours, calms meal times and bathing. A resident who had been effectively dumb for three years began to talk coherently.

Music facilitates : expression of joy, freedom of movement, connection and rapport with carers family and friends, calming through familiarity, conversation and shared experience.

Panel Discussion : Has Dementia Design Innovation Plateaued?

Speakers: Mary Marshall - MM (Sco), David Hughes BA, Dip. Arch. RIBA DH (Eng), Tracy Paine TP(Eng) Angela Raguz AR(Aus)

Summary of Observations:

TP -Design out corridors = less stress including staff

AR - The physical build promotes social environment

MM - Manage the scenery - keep it quiet, manage the noise

DH - Keep it simple : would you have it in your own home - would you do it in your own home?

TP - Put kitchens in the centre – they are the heart of a home and enable staff interaction

AR - Who are you and why are you here? The home belongs to them: give them the ability to move freely

TP - Remodel: the 'household' model is the best way - previous models were intrusive

MM - We have moved from traditional corridor developments to small 10 bedrooms around a central area

DH – We are now moving to open plan 11/12 person households

MM - Use of balconies is possible - if sufficiently large then a false risk. Important to avoid wind exposure

AR - The system caters for the mediocre where everyone takes the same risk : we have always done it this way – laziness and complacency prevails.

DH - Attitude is that it is, 'too difficult' to take change forward – food gets brought in – staff. wear uniforms. Therefore no need to make it new all the time, instead innovate around the blockages and know the regulations better than the regulators

AR - No need to always make it new – the best model of care is not on the care plan; it is where carers and residents have really got to know each other.

AR - Bigger corporate players are catering for the baby boomer generation – 'be kind to your children – they will choose your care home'.

DH - The UK needs better leaders to start to push for change

TP - Belong (UK not-for-profit care group) try to look modern and fresh - if we can get it right for dementia we can get it right for everyone. The aim is independent, confident, safe living

DH - A common problem around the world is lack of enough intense competition between providers

MM - Good design is cost neutral - it is no more expensive doing it right

TP - Initial costs are more but long term costs are less due to low referrals to NHS and hospitals

AR - How do you cost an overall model of care?

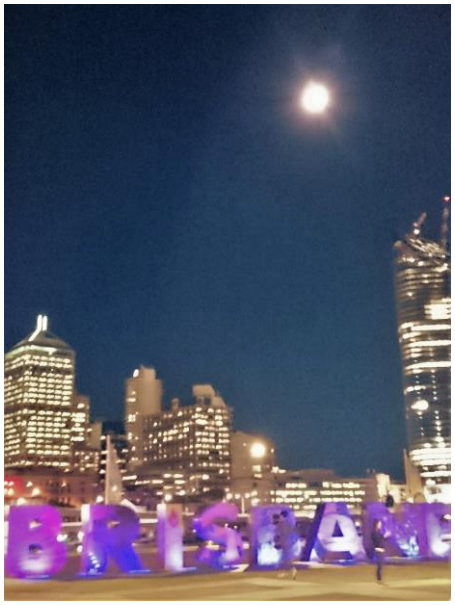
DH – Good or bad design affects us all - get the message out…

Plenary Session – Day Two

Prof. Stephen Post (USA):
Hope, The Continuing Self and Forgetful People

Stephen believes that there is too much hope in pharmacology and that prevention is, 'going nowhere'. He quoted the Hindu belief that every person has something of the eternal in them. The consciousness of someone living with a dementia is ultimately of no less value than that of 'less forgetful people'. Someone who is apparently difficult to communicate with is, 'still there'. He emphasised how aesthetic appreciation (poetry, music, fine art, dance, architecture, singing) offers 'deeply forgetful people enduring hints of self identity' and carers can sustain meaning in their own actions.

International Federation on Ageing (IFA):
13th Global Conference : Brisbane



Brisbane : The Winter Solstice June 21st 2016

Mission statement: The IFA envisions a world of healthy older people whose rights and choices are both protected and respected.

Dr John Beard (World Health Organisation): The World Report on Ageing and Health 2015

Global Strategy and Action Plan on Ageing and Health:

- Commitment
- Age-friendly environments
- Re-aligning health systems
- Developing systems for providing long term care
- Better measurement, monitoring and research

John is concerned about constant negative references to the 'global tsunami' demographic of increasingly ageing populations. He says that the real issue is about 'Intrinsic Capacity' and minimising lost physical capacity.

On a graph showing a slow curve of decline in Intrinsic Capacity as old age progresses, he identified three stages of loss in Intrinsic Capacity from high stability, through declining faculties to significant loss. If the right support is provided at each stage there is substantial mitigation in the progress of decline. In this way ageing populations are able to remain optimally well and end of life is a relatively short transition.

John proposes three key interventions:

1) Prevent communicable disease (especially pneumonia), identify and treat chronic illness.
2) Slow decline by provision of integrated services that treat a person as a whole, including adaptive environments and compensation for losses (accessible transport)

3) Long term care: maintaining lives of meaning and dignity, even for people with advanced dementia – build environments to help support them.

A decade of concerted action is required as there are so many knowledge gaps.

Expenditure on aging issues are not costs; they are investments. In USA most entrepreneurs are aged 50+.

How do we enable people to remain active? Health and learning appear to be key components. He advocates 'Healthy Ageing' rather than 'Active Ageing'. But presently there is lack of data, particularly for developing countries with too much generalised information on the 60/65+ age group.

John confirmed that long term care in the community is needed when there is significant loss in Intrinsic Capacity. He emphasised that this needs to be in a place that is right for that individual and that this is not necessarily 'in place' i.e. at home. Without an integrated environment homes are otherwise a prison.

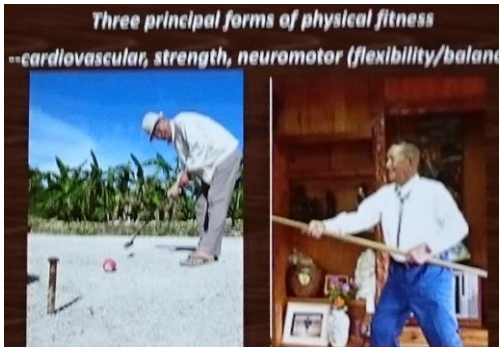
He advocates a global network of Age Friendly Cities and the development of 'whole life' courses to build a support system for everyone.

His key messages were: 'There is more beyond chronological age' and Intrinsic Capacity is hugely influenced by societal attitudes

Age Friendly Communities - Okinawa: Dr Bradley Wilcox

A study of the communities living in Okinawa where individuals often live well to a great age (exceeding 100), highlighted the importance of three key factors:

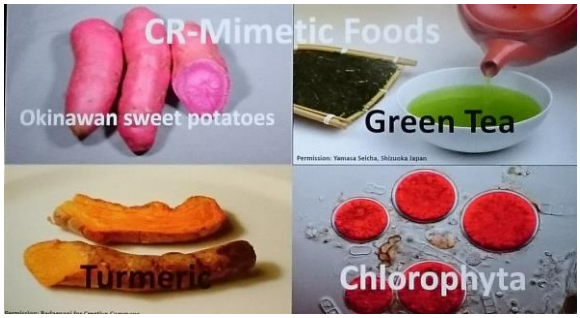
1)



Conference Illustration : Fitness

Physical fitness : three components a) cardiovascular, b) strength c) neuromotor (flexibility and balance)
Prevention of loss of muscle tissue is key.
High hand grip is key indicator + keep supple + 100% have never smoked.
The man photographed is aged 101

2)



Conference Illustration : Diet

Healthy Diet : Traditional Okinawa diet comprises 5 key features
-Low caloric density (plant based, low fat, moderate protein from soy, fish & lean meat
-High Nutrient Density (Vitamins A,C & E, potassium, magnesium, folate, healthy oils)

-Phyto-nutrient Density rich (anti-oxidants, polyphenols, flavanoids, carotenoids all mostly from green leafy and yellow root vegetables) +CR-mimetic properties
-Low in Glycemic Load (high quality carbohydrates from sweet potato)
-Anti-Inflammatory (CR, antioxidants, polyphenols, flavanoids, O3 fatty acids, curcumins)

Chronic inflammation due to bad diet leads to chronic ill health. In Okinawa the diet is high in tofu, vegetables, fruit, sweet potato, turmeric and green tea.

3) Psychosocial Resilience: Staying engaged – maintaining a role (women have a purpose as the eldest communicate between the ancestors and the family).

Conclusion

The conference highlighted the three key components for living well in old age :

Physical fitness - Healthy Diet - Mental Activity

It was acknowledged that environment is a powerful component but no presentations addressed dementia

Argyle Place, The Rocks, Sydney

Sessions on Age Friendly Communities tended to ignore dementia issues and concentrated on older people being able to either 'remain in place' or move to appropriately adapted accommodation in retirement type settings. However, the problem of old age vulnerability to losing control of where one lived was highlighted. Gentrification of inner cities means that older people living in long term rented accommodation are insufficiently protected against rising rents and eviction by property redevelopment. (This problem was personally witnessed in central Sydney, where an elderly lady living in Argyle Place at The Rocks, had found a role organising a residents' protest to the changes being proposed that meant she and other neighbours were likely to be driven from their homes)

Australian Care Homes Group (ACH) – Adelaide

ACH Chief Executive, Mike Rungie, is passionate that, as people age, their lives remain rich and independent. The benefits are manifest both in terms of life enjoyment and viability of care service provision. He sees this as entirely achievable and is ensuring that ACH are in the vanguard to make this happen. ACH Strategic Direction for 2015 – 2020 leads with Mike's quote: '*We've invested time in understanding our current and future customers better and what it is that people will want from us in the future*'. He regards this radical change in mind set – to see ageing as a positive experience - as, 'one last revolution of the baby boomers'.

ACH publish their 'Customer Impact Statement' (CIMPACT), which is used as the defining basis for all their care support operations. Desired outcomes are summarised as six 'Good Lives' elements which been established by listening carefully to residents and their families:

1) Unique – Unique lives are honoured through life experience, strengths, culture and spiritually
2) Being in Control – My life is mine; I am in control, make my own decisions and am my own boss
3) Optimistic – I have a sense of future and hope, of anticipation about tomorrow and of the things I want to do and the goals to work towards.

4) **Belonging** – It involves me having a variety of relationships, everyday roles, rhythms, routines, experiences and emotions
5) **Contribution and Engagement** – To enjoy the fullness of life through give and take in a variety of interests and passions such as sport, art, music and faith
6) **Healthy** – I am as healthy as can be

ACH make the point that those they support directly get to do what they want for themselves. ACH do not place themselves between the person and the action.

ACH arranged for visits to two very different care buldings : Colton Court in McLaren Vale and ViTA in Daw Park

Colton Court

The enduring success of Colton Court is the way it is embedded within the community of McLaren Vale both physically and socially. Key components of the care model are: exercise, strong relationships and open learning.

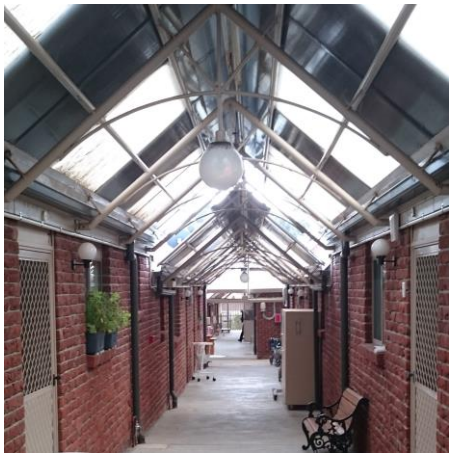
Colten Court : Street Frontage to Flats

At the perimeter of the site, flats for couples directly address the street frontages, each with front gardens and verandahs indistinguishable from the neighbouring single storey private residential housing. Residents can choose to maintain these outside areas independently, or ACH provide assistance. Living accommodation comprises 22 x 2 bed flats, 7 x 1 bed en-suites and a separate group of 8 en-suite bedrooms for people living with a dementia requiring nursing care. All flats have laundry facilities.

Coltern Court : Diagram of Care Home Layout

Residents are encouraged to bring their own possessions and furniture. The general ambience of Colton Court is entirely domestic with a very relaxed and skilled team of support staff who have intimate knowledge of each resident's needs but who seek to respect their independence at all times.

Colten Court : Internal Service 'Street'



Whereas independent access to the majority of 2 bed flats can be made from the street, service access is by a wide open air covered way. Although this circulation route is utilitarian it was observed to offer a popular means of social interaction.

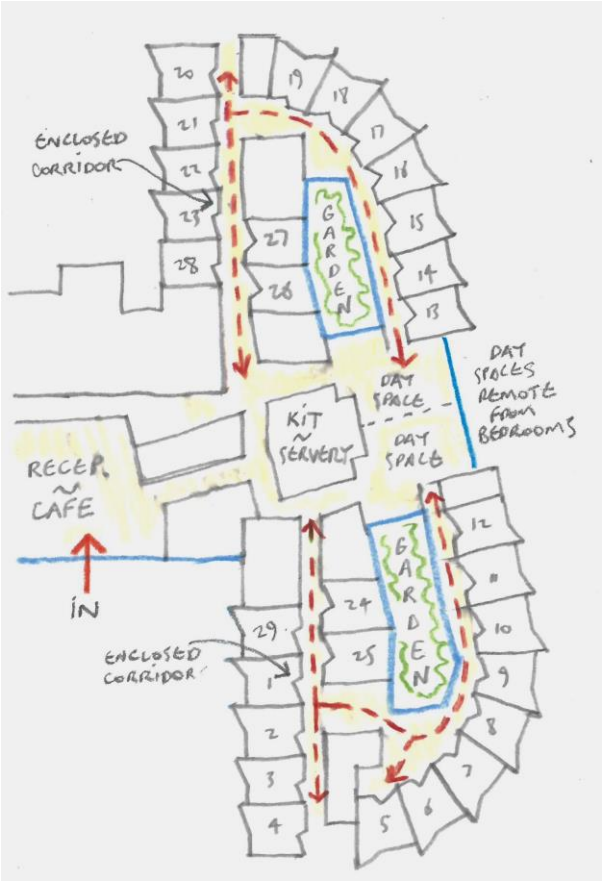
In many respects this community is similar to many supported living / extra care facilities in the UK, except that the numbers of support staff available to residents is substantially enhanced. Communal facilities are limited both for the flats and dementia accommodation, with travel along long corridor circulation to access what is available. In this regard, independence is actually highly limited beyond the boundaries of residents' rooms – just as it is here in UK – and must make the 'Good Lives' elements of living more difficult to happen.

Car parking demand has severely compromised outlook from 50% of the flats. Similarly, outdoor areas for residents of the dementia nursing wing are highly restricted. Poor visual access for both residents and staff creates difficulty in everyday supervision and consequent reduction in independent access to the outside.

Summary

The Colton Court care community is a direct part of the town, residents are entirely aware of their proximity to that community and are part of the daily life, servicing and administration of Colton Court; there is a palpable feeling of home and community. However, the arrangement of rooms and lengthy distances between them for care staff to travel in order to deliver 'Good Lives' individual support, introduces inefficiencies and consequential costs that appear to have made this model, although popular to users and visitors, unrepeatable. With more careful consideration, especially in the way the rear doors and windows of the flats look out on to the 'interior street', this important orientating main communication route through Colten Court could be substantially enhanced to the benefit of residents and staff.

ViTA



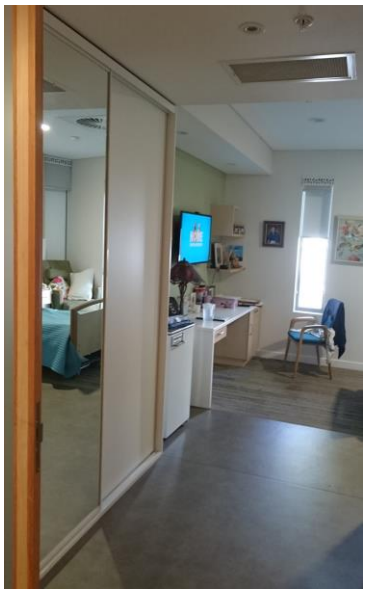
Vita : Diagram of Typical Floor Plan

A unique world first model for improving the health and wellbeing of older people, ViTA combines health, aged care and education. It is an innovative collaboration between ACH, South Australia Health and Flinders University. ViTA aims to enhance recovery and rehabilitation of older people from illness or injury by providing unparalleled access to a comprehensive range of technological, clinical and social best practice. Teaching and research are an integral part of this initiative. Mike explained that the building and support provided are designed to establish in the mind of those that are recovering from illness and injury that they are actively participating in their full rehabilitation back into their local communities. Their situation is intensely restorative because it is knowingly temporary; each person looking forward to regained wellbeing. Central to the model is a software programme charting each individual's progress and enabling support to be purposefully and appropriately directed to maintain momentum on the recovery pathway.

The Building

ViTA : Front Entrance

ViTA : Bedroom Entrance



ViTA comprises half of one building, being directly attached to the hospital, but has been made distinct in outward appearance and internal plan and décor to reflect the philosophy of the centre, which focuses on residents' quality of life, not just excellence in care. As Mike said, hospital environments generally make you think of sickness and the possibility of decline, which is a pessimistic outlook, whereas ViTA offers recovery and empowerment, which is an optimistic outlook. Consequently, the building has been deliberately modelled on hotel-like accommodation with modern interior design and smart en-suite bedrooms with designer fittings and furniture. At the same time full technological life support is not compromised and remains discretely to hand.

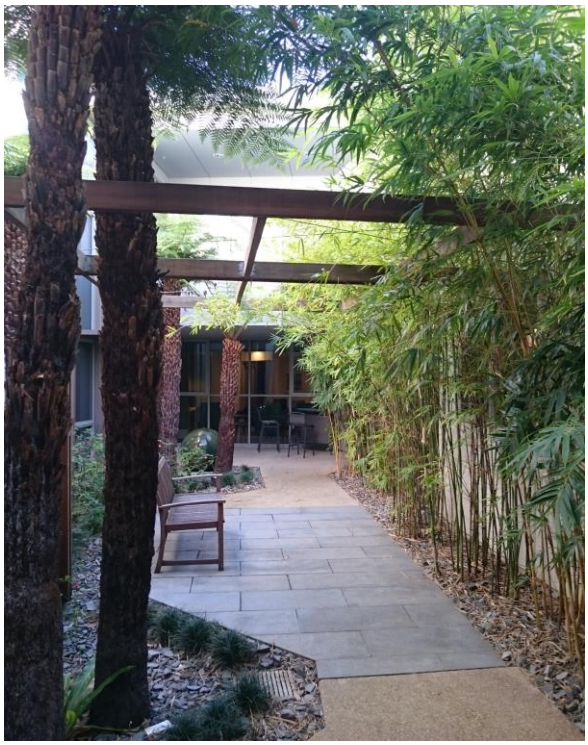
A central entrance and reception area between ViTA and the hospital includes a café for use by everyone and the local community. There are two floors of residents' en-suite bedrooms. Each floor comprises symmetrical butterfly bedroom wings arranged around two garden courtyards. Between the courtyards is an accessible central servery kitchen/kitchenette allowing independent preparation of meals and snacks, dining and living areas with aspect direct to the outside and into the courtyards. There are a range of service spaces for laundry, student staff welfare, activity rooms including state-of-the-art gym, hairdressing salon and cinema. All spaces are fitted out to the highest specification with fashionable contemporary furniture. Bedrooms and en-suites are very large (+20m2). The two storey courtyards are extensively planted with a variety of bamboo and other ornamental species and incorporate a winding pathway and seating for residents to use. Safety in the garden is not over emphasised. In order to encourage good posture and balance paving is not smooth and there are no handrails. The second floor area above accommodates a teaching facility for students, complete with a full size resident en-suite bedroom to enable in-practice learning of bedside skills. Apparently residents enjoy being volunteers.

ViTA : Shared kitchens in communal area

Critique

The ViTA care model is inspiring. The recovery concept, the thorough attention to contemporary design and the co-operative involvement of local government, university and ACH are all entirely admirable. It is a fine example of integrated provision of services within a building specially designed to support those services while, at the same time, lifting the whole perspective of older aged residents to anticipate, with optimism, re-entry into everyday life. The general ambience is of a luxury spa boutique hotel. Residents arrive back in the outside world optimally healthy, envigorated and re-empowered. The key is that their situation is temporary; just as always for people using the hospitality industry.

ViTA : Shared Garden Courtyards



The needs of residents living with dementia are acknowledged but not comprehensively addressed. Residents' rooms are accessed off wide corridors where each doorway is slightly recessed, providing a transitional threshold between public and private area, although there is little opportunity taken to actively use this space for individual expression of self. Projecting window bays to facades facing out from the building improve the throw of natural light into each bedroom. There is good visual connectivity with en-suite facilities from the bed. Internal orientation is improved by outlook into the courtyards, although at first floor level the ground floor gardens are visible only through windows, whereas these might beneficially have been open to both floors as top lit 'orangeries'. The planning layout introduces narrower rear internal corridors to maximise the number of bedrooms on each floor. Individual resident access to the day time activities and facilities is therefore compromised for someone living with a dementia, due to the difficulty of independent navigation of these internalised circulation routes.

ViTA: Bedroom thresholds adjacent to occasional sitting areas

On the day of the visit two issues with the model were apparent: 1) small groups of residents were sitting in a row of comfortable chairs apparently with no activity taking place, while a television transmitted an unobserved programme. This default scenario, so commonly witnessed in hotels, and especially care homes without a carefully organised programme of purposeful activity, may have been due to staff being busy attending to the needs of other residents, at a distance down the long corridors, 2) it was explained that, despite the very best endeavours of staff, family and relations, it is not always possible to place someone back into the community on schedule with their rehabilitation programme. Maintaining steady progress and transition therefore can be challenging.

It is clear that this model requires the substantial funding resources of its stakeholders to succeed. The concept of extending and maintaining quality of life within the community wholly anticipates the principles of ageing well as proposed at the 2016 Brisbane International Federation on Ageing

ViTA: Corridors mitigated by bedroom thresholds, worktops and sitting spaces

CANADA

2016 Alzheimers Association International Conference, Toronto

AAIC: At the CN Tower

This enormous conference, in terms of sheer spacial extent, content and delegate numbers demonstrated the extraordinary quantity and diversity of worldwide dementia neuroscience research and development. A constant background for the event was the presence of 'Big Pharma' and the 'promise' of chemical symptomatic treatment of dementia. Research Sessions included topics with the titles, 'Neuro-imaging : White Matter Hyperintensities / Cerebrovascular Diseases' and 'Neuropsychology : Early Detection of Cognitive Decline with Neuropsychological Tests'.

A principal purpose of the Toronto visit was an anticipated opportunity to visit the 'Memory Care' project at Georgian Bay, Penetanguishene, north of the city; founded upon the asserted therapeutic benefit of immersive reminiscence. To enable optimum resident association with strongly retained childhood and early adulthood memories, an entire care environment had been created utilising period household decoration, furniture, fittings and equipment, iconic period consumer goods including whole motorcars. The model was a derivative of the Hogewey 'Dementia Village' concept of dementia support located near Amsterdam. Hogewey comprises a closed community divided into sub groups, each comprising six residents selected for similar social backgrounds and beliefs, complete with an interior decoration and fit out considered appropriate for each lifestyle.

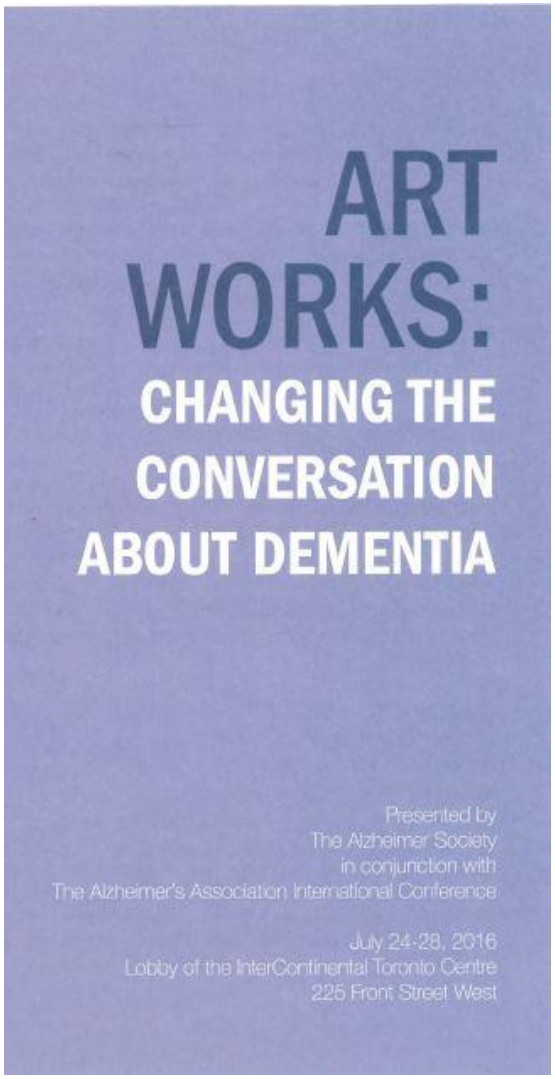
While at the conference during a meeting with Dr Sandra Black, a neuroscientist with the combined interests of stroke and dementia, it was a complete surprise to learn from her that 'Memory Care' had closed down. She explained that a combination of political and financial difficulties had led to the collapse. Although Dr Black did not elaborate on the issues, it is entirely conceivable that the intensive staff engagement required to deliver a care model based upon reminiscence is unsustainable both practically and financially, even for relatively wealthy North American residents. Memory Care was a private venture whereas Hogewey benefits from government support that funds the extra cost of the very high staff / resident ratio necessary for the small social groupings.

Given the failure of the reminiscence model, I asked Dr Black where, in her experience, outside the field of medical intervention, there is progress in models of support for people with dementia. She explained that there is an increasing evidence base to show that Alzheimer type dementias initially appear to impact the left brain more significantly than the right brain. Consequently, right brain performance can compensate for this and the already increasingly understood right brain capacity for emotional and aesthetic response offers a powerful way to reach and connect with a person developing a dementia. Dr Black thought that adopting this approach could create a window of opportunity amounting to some 2–3 years of additional cognition. I asked her if a right brain model of support existed. Expecting a negative response,

or to be told about a project outside the reach of my Fellowship itinerary, she said that I should visit the 'Dotsa Bitove Wellness Academy' in North Toronto. The 'Wellness Academy' had begun as a research project some 4 years previously and had established a regular and expanding daily membership of people living with a variety of dementias.

Co-incidentally I had already discovered the presence of the Wellness Academy. Overwhelmed by the highly technical neuroscience content of the Conference, I had to search for the very under-represented environmental and social research initiatives. Two caught my attention. One was titled, 'Art Works: Changing the Conversation About Dementia' and comprised a significant but easily overlooked small exhibition in the conference hotel foyer. The other was a poorly advertised but equally significant event comprising an evening production titled, 'Cracked'. This play is based upon a collaborative investigation by a group of artists, researchers into ageing, and people living with dementia and their family members. The commonality is the Wellness Academy. One of the most engaging paintings in the exhibition was a collaboration by Wellness Academy members and one of the play researchers is Christine Jonas-Simpson, Director of the Dotsa Bitove Wellness Academy.

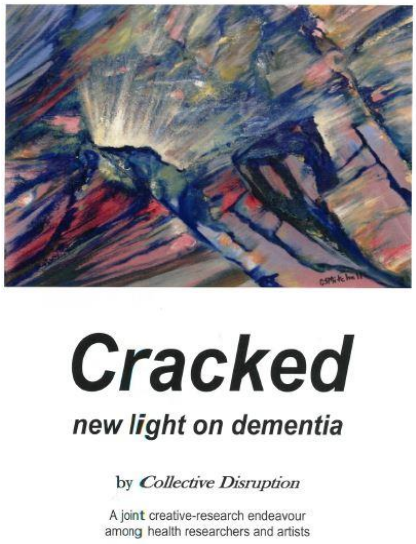
Catalogue Cover for 'Art Works' Alzheimer Society exhibition at AAIC 2016



Curated by Aynsley Moorhouse (member of the Alzheimer Society of Toronto), the 'Art Works' exhibition comprised paintings created by people living with dementia, their care partners and researchers. The aim of the exhibition was to demonstrate that artistic creation and appreciation transforms the prevailing negative perceptions of deficit, loss and sadness surrounding dementia into strengths founded upon joy, creativity, intellectual thought and relationships. Artist Lisa Meschino helped facilitate the Wellness Academy painting titled 'What is Possible', (below) co-created by two members of the Wellness Academy.

'What is Possible' – Collaborative painting by Wellness Academy members

Programme Cover for 'Cracked' at AAIC 2016



Also a collaboration, the play, 'Cracked', is based upon the idea that, 'relationships must be front and centre when providing care for people living with a dementia'. The title of the play is taken from 'Anthem' by Leonard Cohen : '*There is a crack in everything, That's how the light gets in* '. 'Cracked' is intended to, 'inspire alternative ways of seeing people with dementia as vital human beings with agency and possibility'. The programme concluded, '*memory, in all of its forms must be valorised, self expression must be nurtured, and the humanity and full citizenship of persons who are living with dementia must be fully supported* '. This perspective is in contrast with the dehumanising care practices that still prevail in most dementia care settings.

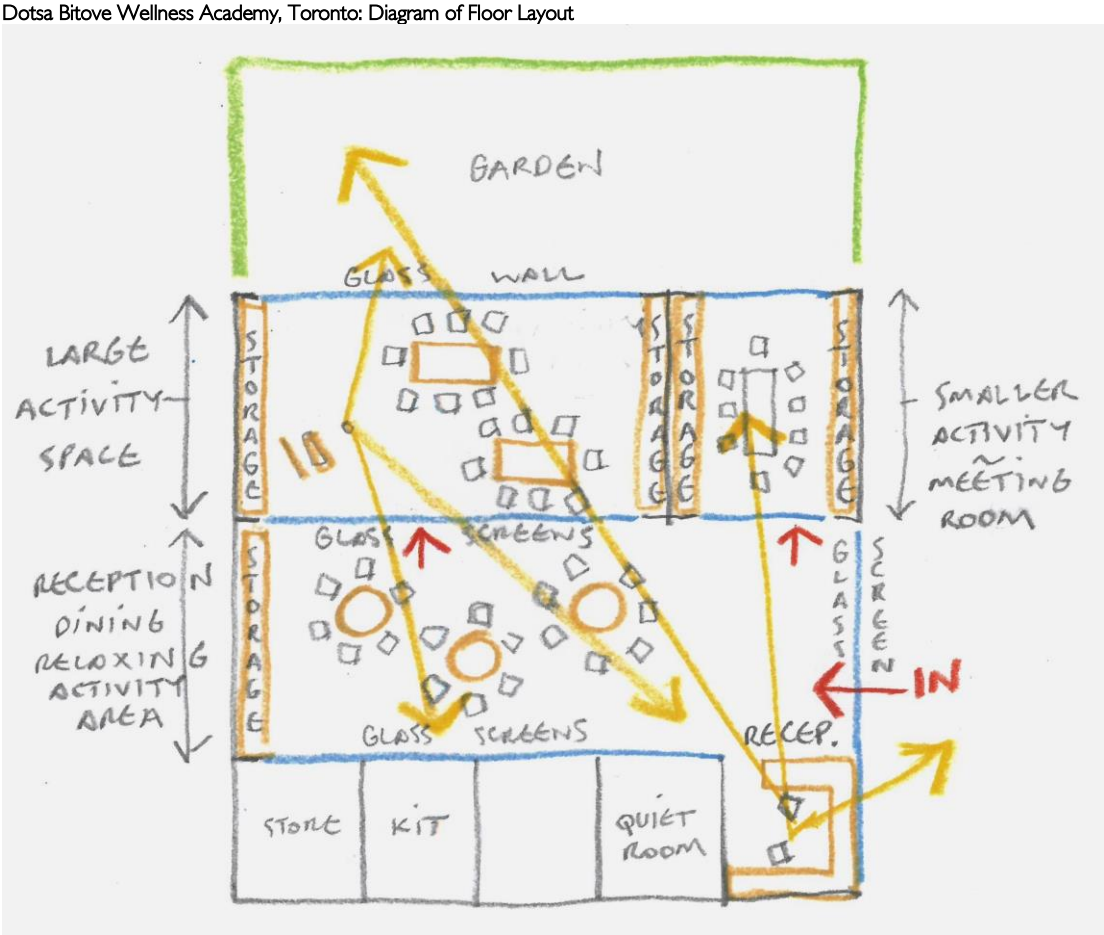
Compared with the attendance of the main conference, which numbered thousands, the audience for 'Cracked', at the hotel theatre across the road, was tiny; numbering less than fifty. The play was a moving and engrossing story of people with dementia and their families, from early onset and diagnosis through to learning new and positive lives in the context of long term care. An open discussion between audience, actors and all participants involved in staging the play was an opportunity to listen first hand to key figures involved with the emerging arts based dementia support initiatives currently being developed in Toronto. In conversation I met Mark McAlister President of the Canadian Camphill Community and a leading member of the Rudolph Steiner School and Community at Richmond Hill in North Toronto. I discovered that he had already visited the Wellness Academy and was keen to link up with the project manager again, he kindly offered to accompany me on a visit to the Academy.

Dotsa Bitove Wellness Academy

Dotsa Bitove Wellness Academy, Toronto: Main Activity Space

The Academy occupies ground floor space at the rear of the Canadian National Institute for the Blind (CNIB) at Bayview north Toronto. It is a unique centre of innovation in active learning through relationship building and inspiring arts based programmes for people living with a range of dementias. It is a York University Health Network research project sponsored by the Bitove family. Arts and movement form the basis of engagement and connection between people living with dementia*: 'We provide and encourage opportunities for personal growth and discovery through creative activities, active and continuous learning, artistic expression, lively discussion, intergenerational exploration, exercise and enjoyment'*.

Dotsa Bitove Wellness Academy, Toronto: Diagram of Floor Layout



Within the CNIB building, an area of some 300m² has been wholly refurbished to create two large main activity spaces with subsidiary quiet room, meeting room, kitchen, stores and staff and resident welfare areas. All areas are spacious with high ceilings and excellent direct lines of sight. There is impressive use of contemporary interior finishes and fixtures, timber framed doors, storage cabinets and glazed partitions, coloured walls and floors, maximum use of available natural light and good quality low contrast artificial light. Great care has been taken to ensure well ordered and tidy spaces, carefully arranged to support Academy Member engagement in each activity. All spaces are open and available to all members, artists and support staff. Everyone is equal. All learning activities and relationships are non-judgemental. No mention is made of dementia. Everyone is there to enjoy participating in a well structured programme of week day activities between 9.00 a.m. and 4.00 p.m.. These are planned and published in advance for each month. Every day, at 12 noon, there is a 45 minute break for lunch which is produced and served within the largest of the main activity rooms.

Each day is carefully structured to cover a range of cognitive pursuits and arts based activities including exercise. Music is a key component of many activities, being a powerful way to connect and obtain response (Ref. p.16 - Dr Kirsty Beilhartz : Music…The Food of Love). Commencing with drinks and conversation the morning comprises two main sessions beginning with a crossword and current events followed by an outdoor pursuit or a visual art activity or a theatre improvisation. After the lunch break there is light exercise that can include Tai Chi/Yoga/walking. A further two sessions in the afternoon include dance, musical instruments, and singing. At the end of each day there is a gentle 'wind down' activity. It is a full day (see the illustrated August 2016 programme below). Irrespective of their dementia, members are clearly engaged and committed to maximise their personal involvement. Nowhere was there any sign of patronage by Academy staff or passive observation by Academy members.

The learning experience is entirely immersive and participatory; i.e. precisely not a one-off event or entertainment. Everyone is living in the moment, to each individual's maximum capacity. They are not dwelling upon perceived limitations.

Dotsa Bitove Wellness Academy, Toronto: Typical Programme of Activities

BITOVE WELLNESS ACADEMY — AUGUST 2016 ~ FREEDOM TO BE & GROW

15	16	17	18 – FILIPINO DAY	19
9:00 Coffee Conversations **9:30** Crossword, current events and Scrabble **10:00** Outdoor Creating w/**CLAYTON** **11:00** Art w/ **KATIA** **Noon** Lunch **12:45** Nia w/ **JENNIFER** or Walking Club **2:00** Creating w/ **ROBIN** **3:00** Dancing w/ DJ **FRANCIS**	**9:00** Coffee Conversations **9:30** Wonderful Waffles w/**CLAYTON** **10:30** Art with **STEFAN** **11:00** Visual Arts w/ **JANICE** **Noon** Lunch **12:45** Yoga w/ **LINSEED** or Bitove Walking Club **2:00** Creating w/ **ROBIN** **3:00** Dancing w/ DJ **FRANCIS** **3:00** News & Other Current Events	**9:00** Coffee Conversations **9:30** News & Other Current Events **10:00** Karaoke **11:00** Theater Improv w/ **RANDI** **Noon** Lunch **12:45** Let Your Yoga dance w/ **LESLEY** or Walking Club **2:00** Jazz Time w/ **PETER** **2:00** Ukulele Class **3:00** Dancing w/ DJ **FRANCIS** **3:00** For the Birds	**9:00** Coffee Conversations **10:00** News from the Philippines w/**VELTA** **11:00** Filipino Crafts w/**FRANCIS & LESLEY** **Noon** Lunch **12:45** Karaoke Club & Dancing **2:00** Touring the Philippines w/ **FRANCIS** **3:00** Wind-down & Water Colour w/**MELISSA**	**9:00** Coffee Conversations **10:00** Bocci or Bingo (depending on weather) **11:00** Theater Improv w/ **RANDI** **Noon** Lunch / The NEWS w/ **VELTA** **12:45** Let Your Yoga dance w/ **LESLEY** or Walking Club **2:00** Talking Thailand w/**AYNSLEY** * **2:00** Ukulele Class **3:00** Dancing w/ DJ **FRANCIS** **3:00** For the Birds
22	**23**	**24**	**25 – CHINA DAY**	**26**
9:00 Coffee Conversations **9:30** Crossword, current events, and Scrabble **10:00** Outdoor Creating w/**CLAYTON** **11:00** Art w/ **KATIA** **Noon** Lunch **12:45** Nia w/ **JENNIFER** or Walking Club **2:00** Creating w/ **ROBIN** **3:00** Dancing w/ DJ **FRANCIS**	**9:00** Coffee Conversations **10:00** Crossword, current events, Scrabble OR other table activities **10:30** Art with **STEFAN** **11:00** Visual Arts w/ **JANICE** **Noon** Lunch **12:45** Yoga w/ **LINSEED** or Bitove Walking Club **2:00** Creating w/ **ROBIN** **3:00** Dancing w/ DJ **FRANCIS** **3:00** For the Birds	**9:00** Coffee Conversations **9:30** News & Other Current Events **10:00** Crossword OR other table activities **11:00** Theater Improv w/ **RANDI** **Noon** Lunch **12:45** Let Your Yoga dance w/ **LESLEY** or Walking Club **2:00** Music Time w/ **SIMON** **2:00** Ukulele Class **2:30** **Care Partner Conversations (CPC)** **3:00** Dancing w/ DJ **FRANCIS** **3:00** Self – A Portrait	**9:00** Coffee Conversations **10:00** China in the News w/**VELTA** **11:00** Characters & Calligraphy w/**MIAO & LESLEY H.** **Noon** Lunch **12:45** Tai Chi w/ **ACADEMY STAFF** **2:00** The Great Wall & Other Captivating Sites of China w/ **LESLEY** **3:00** Singing & Dancing w/ **FRANCIS** **3:00** Wind-down & Water Colour w/**MELISSA**	**9:00** Coffee Conversations **10:00** Wii Fun Fitness **11:00** Theater Improv w/ **RANDI** **Noon** Lunch / The NEWS w/ **VELTA** **12:45** Nia w/ **JENNIFER** or Bitove Walking Club **2:00** Music Time w/ **SIMON** **2:00** Ukulele Class **3:00** Dancing w/ DJ **FRANCIS** **3:00** Self – A Portrait
29	**30**	**31**		
9:00 Coffee Conversations **9:30** News & Other Current Events **10:00** Outdoor Creating w/**CLAYTON** **11:00** Art w/ **KATIA** **Noon** Lunch **12:45** Nia w/ **JENNIFER** or Bitove Walking Club **2:00** Creating w/ **ROBIN** **3:00** Dancing w/ DJ **FRANCIS**	**9:00** Coffee Conversations **10:00** Crossword, current events, Scrabble OR other table activities **10:30** Art with **STEFAN** **11:00** Visual Arts w/ **JANICE** **Noon** Lunch **12:45** Yoga w/ **LINSEED** or Bitove Walking Club **2:00** Theater Improv w/ **KATHLEEN** **3:00** Dancing w/ DJ **FRANCIS**	**9:00** Coffee Conversations **9:30** News & Other Current Events **10:00** Karaoke **11:00** Sing & Write w/ **BETH ANNE** **Noon** Lunch **12:45** Nia w/ **JENNIFER** or Walking Club **2:00** Music Time w/ **SIMON** **2:00** Ukulele Class **3:00** Dancing w/ DJ **FRANCIS** **3:00** Wind-down & Water Colour	**NEW AT THE ACADEMY** • **INTRODUCING** Themed Thursdays!! Academy staff take members on exciting adventures around the world for the entire day during the month of August. • NEW walking club after lunch (weather and staffing permitting) • What is "For the Birds"? With all the beautiful green space just outside our door in August we will be hanging bird feeders and taking care of our winged friends in the yard. • Art in the afternoon – note that several days will finish with art activities in the common room; water colours and portraitures for the month of August	

Before joining the Academy, staff work with prospective members, their families and friends to gain a very clear idea of individual strengths and weaknesses. In this way, once attendance begins, the Academy ensures that each member feels safe and empowered to fully explore the wide range of learning opportunities provided. Confidence and independence is built sustainably. The Academy reports minimal levels of disruptive behaviours, most of which can, in any case, be mitigated long before a member becomes anxious about a situation. Sight lines are clear across the combined spaces, enabling unobtrusive passive observation by all staff.

Dotsa Bitove Wellness Academy, Toronto: Colourful Interior

On the day of my visit, after an introduction to the philosophy and work of the Academy, we were invited to join the 11.00 a.m. art session. There were two large tables arranged in the activity space closest to the large windows looking out upon the adjacent garden space. Approximately eight Academy members sat at each table. The activity that morning was drawing a self portrait using a choice of paper and crayons, and was led by an artist skilled in communication and who knew each member personally. I was introduced as a guest participant to the members who were keen to know the purpose of my visit and tell me of their visits to the UK. Clearly some people were living with early on-set dementias while two members were more advanced and exhibited some dis-inhibitions. One member needed to get up and move about the room and the other expressed concern that they did not know what they were doing and why they were doing it and firmly folded their arms to emphasise their situation. These two members received one-to-one skilled support. At all times their responses were accepted and included in the general discussion that was developing around the table about the task in hand. Each of us brought to the table individual anxieties about our various abilities to draw a portrait and to do so as part of a shared group experience. By using a large format computer screen and a song, the artist explained a simple step by step approach to formulating a face, adding eyes, ears, nose and hair to a notionally circular outline representing the head. We observed each other's characteristic features, made polite - and impolite – suggestions as to how they might be represented and coloured.

Gradually self consciousness, embarrassment and anxiety dissipated as conversations were struck up peripheral to the main event. After about 20 minutes we were all busily engaged and I realised that the Academy had worked its magic. We were all having a lot of fun, doing the task, listening to the artist and getting to know each other better. The member who had needed to keep moving around the room had remembered a song from the past. This was quickly found by the artist on the internet and immediately, to the delight and surprise of everyone, music filled the room. We all participated in a spontaneous dance which generated enormous pleasure. Feeling bonded into the group, this member was now sufficiently confident to sit at the table and enjoy contributing to the creation of a drawing depicting him with his wife. Similarly, the man with the folded arms had become engaged thinking about his grand children, who the support worker knew about, and together they were formulating a picture of him sitting in his wheelchair with the children arranged on both sides. Involvement in the moment was complete. As the hour passed we all had fun looking at each other's portraits and by then the bonds of friendship had been made and I was invited to stay for lunch where conversation and friendship could be developed. I learnt from one member that they had been a specialist photographer of musical events; I was privileged to be shown a sophisticated digital camera and given a demonstration of its capabilities. Another lady told me about her wartime experiences in the north of England. Dementia problems might have been implied but were never overtly expressed.

The point was in sharing good news about lives fully led, and what could be most fully lived, right there and then, in that moment. The whole day was about joy, welcome and respect; we were all equally teachers and learners together. A member said to me, 'This is my family'. This impression was confirmed by one of the Academy artists, (Lisa Meschino), when working with members: '*As connections formed in the composition of the painting, so, too, did they form between the participants themselves. Inhibitions and self-judgement were replaced by a spirit of playful adventure. Conversation and witty banter flowed as we responded to the moment of art-making and to each other*'.

The only critique that might possibly have been made was that, because of the nature of the building – an institutional college – there was insufficient connectivity between internal and external spaces. A perfectly suitable garden space with a variety of trees, shrubs and paving, and even raised planters, existed beyond the window, but there was no direct access. Opportunity for individual spontaneous use of nature was consequently compromised, but remediable.

Conclusion

Since commencing in 2013, over a period of three years the Academy has demonstrated that, with care in refining the programme and finding the right manager to ensure successful delivery, it is entirely possible for people with a wide range of dementias to completely engage with arts based learning, every day of the week for seven hours a day.

I had witnessed a possible model for residential care. The environment was modern, colourful, relaxing and purposeful. The work of the members was pinned up everywhere, from large paintings to exquisite poetry. Much of the best work was collaborative. The lived experience was real, vital and in the moment.

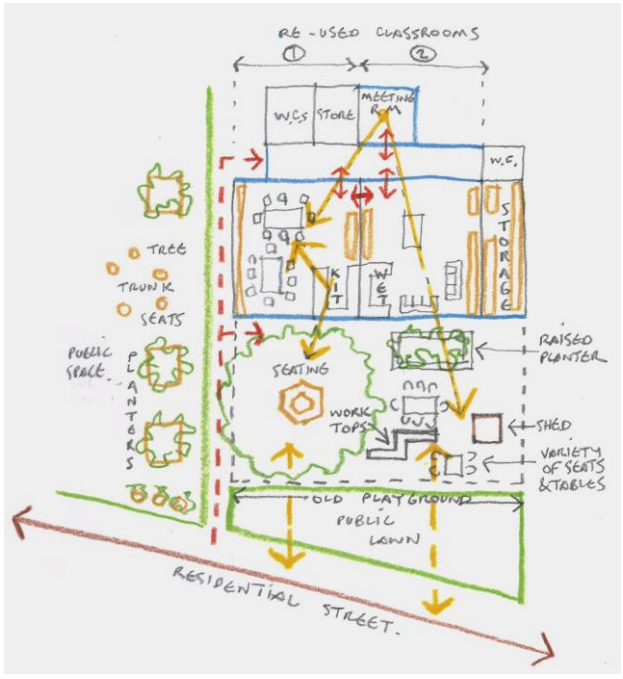
Reprise

While returning to the city centre Mark took me to see the Rudolph Steiner School at Richmond Hill. It is as fine an example as I have ever seen of a building designed specifically to support the activity contained within it; in this case a very particular and innovative way of educating young people. I reflected that it must be possible to similarly create learning communities for people living with dementias

NETHERLANDS

King Arthur Groep: Soest Activity Centre

King Arthur Groep Activity Centre, Soest : Street Frontage



King Arthur Groep Activity Centre, Soest : Diagram of Floor Layout

The 'Activity Centre' established by the King Arthur Groep in Soest, near Amersfoort, in the Netherlands is based upon the 'Care and Support in Dementia' research programme commenced over 20 years ago by the Department of Psychiatry at VU University Medical Centre, Amsterdam. (This programme is now being evaluated for use throughout Europe – see www.meetingdem.eu)
Led by Head of Research Prof. Rose-Marie Droes, the programme is designed for people with mild to moderately severe dementias, living within local communities. To date more than 140 'Meeting Centres' have opened in the Netherlands. Academic assessments have indicated that the initiative has been effective.

All activities within a Meeting Centre are carefully devised to build, within an atmosphere of fun and enjoyment, individual confidence and social connectivity. Participants exhibit fewer problems with mood and behaviour, they experience improved self esteem and carers report enhanced job satisfaction through increased ability to deliver person centred care. There is evidence that admission to residential care is delayed. The ultimate aim is to ensure that every community in the Netherlands has access to their local 'Meeting Centre'. Since 2014 this initiative is now part of a European Union Joint Programme for Neurodegenerative Disease Research (JPND) extending the initiative to Italy, Poland and the UK. In England two 'Meeting Centres' have been established initially in Droitwich and most recently in Leominster. Open on three days each week, from mid morning to mid afternoon, the Leominster meeting centre already has attracted a growing membership of over 50 people with dementia and their carers. However, these centres are supported by limited EU research grants. It remains to be seen if, in the UK, a sustainable funding model can be established.

In the Netherlands, because the initiative is so far advanced, Prof. Droes recommended that Soest should be visited because it is an excellent example of the most progressive model.

King Arthur Groep Activity Centre, Soest : Frontage and Garden

Soest is a large town with a population of 45,000. Initially, the Activity Centre occupied a spare room within a local church but this arrangement was not ideal for development of a permanent care model. During the search for an alternative venue, an unoccupied infant school building was discovered already situated immediately adjacent to an existing community centre. The location is in a residential side road, close to the local railway station and local bus routes.

The building is a simple single storey prefabricated steel frame structure, comprising two classrooms with support facilities beyond a glazed corridor running parallel with the rear including an office, meeting room and welfare accommodation. Between the front of the classrooms and the street, the old playground has been adapted to become an accessible garden. When asked what changes had been necessary to make the building and environs accessible to people living with a dementia the answer was, effectively, none. That the needs of very young and more senior generations are met by the same building is significant.

The high ceilings,+3m, allow good penetration of natural light through the predominantly glazed walls. Window sills are low and wide enough for use as a seat or shelf, increasing visual access and orientation, across the garden, out into the community.


King Arthur Groep Activity Centre, Soest : Main Activity Space

Circulation is simple because the single length of wide glazed corridor facilitates way finding. Both rooms originally contained wet areas for activities and a small kitchen. These have been adapted so that the main activity room now has a large kitchen worktop facing into the space, and the other, a useful arts activity area and washup facility. King Arthur Groep ensure that all main rooms in their care projects

are fitted with a kitchen. In this way volunteers preparing the mid-day meal can interact with Activity Centre members and cook at the same time; and members join in with food preparation, washing up etc.. They say it improves social interaction and means that no member of staff ever needs to leave a space to prepare a snack or a drink. And besides, meal making and sharing is one of the most basic and enjoyable of human social activities. Within the Soest Activity Centre no space is private. Doorways, coat hooks, fitted equipment in general, including sanitaryware is all as provided for young children and works perfectly for people with dementia. Everything is at eye level and obvious without any need for elaborate signage.

Activity Centre Garden : Variety of seats + shed

Activity Centre Garden : Raised tables & planters

The original school playground has transformed easily into a series of safe activity areas, the existing raised sand pit is now a raised flower bed that members can enjoy and sit next to in easy reach of the plants that they are growing. A small shed contains tools and equipment. With the help of a volunteer, members have constructed their own raised work bench and planters. The access footpath is lined with wooden figures made by members themselves and a collection of gnomes belonging to a deceased Activity Centre member populate the garden in his memory. The old playground fence is almost invisible in its context of childhood enclosure.There is total integration of interior and exterior spaces, as the classrooms open out directly upon the playground. By negotiation with the local council, the centre has been granted use of a piece of open land immediately adjacent to the centre entrance. What was a deserted open lawn now has raised beds, tree stump seats and colourful painted bird boxes.

This occupation of the immediate environs symbolises how the centre has integrated itself into the heart of the community. An otherwise vacant municipal space now has context and meaning.

Of particular significance is the interior decoration and furnishing. This has been selected by Activity Centre members. Much is begged, borrowed or donated from within the local community. Much amusement is obtained by members rummaging amongst unwanted items in charity shops and adapting gifted items. Lighting, too, was essentially a range of second hand or cast out domestic fittings.

The atmosphere is absolutely non-institutional. Nowhere is there a single piece of corporate style furnishing. A projection screen is simply a section of wall painted white. Everywhere there are opportunities to engage spontaneously in meaningful activity, just as one might with any object of meaning within one's own home. Indeed, a member said to me, 'We are a family, this is my home; the exact same response as witnessed at the Wellness Academy in Toronto.

The Soest Activity Centre is large enough for 20-25 members each day and is run by one skilled independent professional care provider, employed by the King Arthur Groep and one volunteer, a retired professional mental health carer. Local volunteers make lunch each day. The centre is open six days a week from 9.00 a.m. until 5.00 p.m. weekdays, and until 2.30 p.m.

Saturdays. Members arrive either independently by walking or cycling, or are brought by car by family members or collected from their home by an accessible mini bus. The mini bus has been carefully selected so that members can walk into the compartment behind the driver and their companion and sit together on a bench seat. In this way independence, participation and close social contact is maintained during a journey. The rear of the bus is a storage compartment, useful for equipment, wheelchairs, picnic baskets etc.. Although there is a notional programme of activities each day, it was stressed that it is the members that ultimately decide what they would like to do.

On the day of my visit all members were busily occupied in one of the classrooms. There was an arrangement of tables of different sizes to facilitate various activities and social engagement. Similarly there was a wide variety of seating; all secondhand furniture. Although the second classroom is conceived as a quiet space, no one was using it; everyone was enjoying sharing the experience of being together. Members were all people living with a dementia. Although family members and friends are welcome, the centre offers respite and an opportunity for carers to maintain a working life during the 8 hours that the centre is open.

Activity Centre Entrance : Members' hand made welcome

Although there is not the same emphasis on arts based learning as provided at the Toronto Wellness Academy, it was very noticeable that activities were broadly similar and organised to accommodate natural rhythms and stamina of members during the day. Although participation is encouraged no activity is compulsory. Emphasis is always on personal interests and capabilities or simply an opportunity for conversation. Activities include, cards, 'Rummikub', scrabble, party games, watching movies, puzzles, crosswords, lectures on art, culture and nature, listening to music, moving to music, making music, crafts, painting, drawing, needlework, knitting, embroidery, woodwork etc.. There are monthly trips out using the mini bus. Four times a year there is an event to which all the community is invited, to break down stigma, increase knowledge and share experiences in living well with dementia.

As at the Toronto Wellness Centre I was invited to share lunch with all the members. Several were keen to practise their excellent English and tell me of their experiences living in the UK.

The atmosphere was absolutely similar to that experienced at the Wellness Academy; relaxed, humourous and joyful. As for the Wellness Academy, great care is taken to understand the needs of each member by carefully liaising with partners, family and carers well before a potential member joins the centre. As at the Wellness Academy no mention is made of dementia; similarly everyone is equal and free to contribute without judgement. The whole purpose of each day is to enjoy the shared capacity for each member to maximise what they are able to do. That the whole raison d'etre for the Wellness Academy is shared learning and that the setting for the Soest Activity Centre is a found building originally designed for early learning, is a delicious serendipity.

Before returning to the UK, an opportunity arose to visit a 21st Century library which is a model for contemporary community learning and engagement. 'The Chocolate Factory' in Gouda is a fine example of a building re-used to maximise social participation and engagement. Sight lines are clear, opportunities exist everywhere for a variety of learning experience for all ages. There is wit in the design. A centre piece is the candle lit café restaurant. The main spaces are flooded with natural light. Access to learning and knowledge is re-imagined: Buildings for people living with a dementia require the same radical transformation.

CONCLUSIONS

The Dotsa Bitove Wellness Academy in Toronto and the King Arthur Groep Activity Centre in Soest demonstrate that day long models of immersive learning and social engagement for people living with dementia are deeply positive and therapeutic experiences for all participants – members and carers, family and friends, volunteers and community groups. Furthermore, these models are repeatable and sustainable day after day without stress upon support staff or generating ennui through repetition amongst those being supported. In fact, the reverse is true; the experience is bonding and empowering, there is joy and anticipation. 'THIS IS MY FAMILY'.

Activities happen in modestly sized, simple shared spaces where participants and the support team can directly see, in their line of sight, not just an obvious set of activity choices, but also their colleagues, with whom they will share their day. Opportunity for engagement is immediate. Each member is able make independent, meaningful personal decisions on an equal footing with everyone else within the room. Although, in both cases, there were two activity spaces available, it was noted that, on the whole, the participants had bonded so well that they preferred to do and share together. The choice of an alternative room was there, but was apparently not critical to the success of the care model.

At the Wellness Academy the interior spaces are high, well ventilated (with no feeling of oppressive over heating), lighting is bright with low contrast, walls and floor colours are sky blues and ochre/terracotta earth tones. The main activity space is immediately adjacent to a large window wall looking out upon a garden and maximising available natural light. Sightlines are direct, utilising glass partitions. At a glance, everyone can see everyone and all the activities available. The main space doubles as a dining area for lunch and snacks. The overall aesthetic is contemporary, fresh, ordered, organised and purposeful.

At the Soest Activity Centre the spaces are similarly high, with good natural ventilation. Because the main space was also directly adjacent to the garden, natural light floods the room and compensates for the otherwise domestic style lighting. But, as this was not an 'academy', the overall lighting effect felt entirely appropriate for the ambience of the room. The overall aesthetic is ad-hoc, 'homespun' and cluttered in a positive sense. Everywhere there was lots to do with a wide range of objects that each member has played a part in selecting. The space is clearly their own. Sightlines are direct, utilising the old school glass partitions. Everyone can see everyone and all the activities available, at a glance. The main space doubles as a dining area for snacks and lunch and includes an open kitchen in one corner. An enormous influence upon the versatility of the main space is direct access to the garden which offers a wide range of outside activity options all year round.

There is much in common in the way the Wellness Academy and Activity Centre utilise space. Both have a manifest atmosphere of delight in a shared sense of purposeful creativity and learning. There is abundant opportunity to maximise right brain ability.

Direct sight lines and the resulting opportunity for independent resident choice must be the guiding design principle.

RECOMMENDATIONS FOR A NEW RESIDENTIAL CARE BUILDING MODEL

With reference to the accompanying sketch layouts and illustrations, and taking into account the examples witnessed when travelling:

- Arrange bedroom / apartment accommodation to directly embrace the main activity area, without resort to corridors - opportunity for immediate engagement is imperative

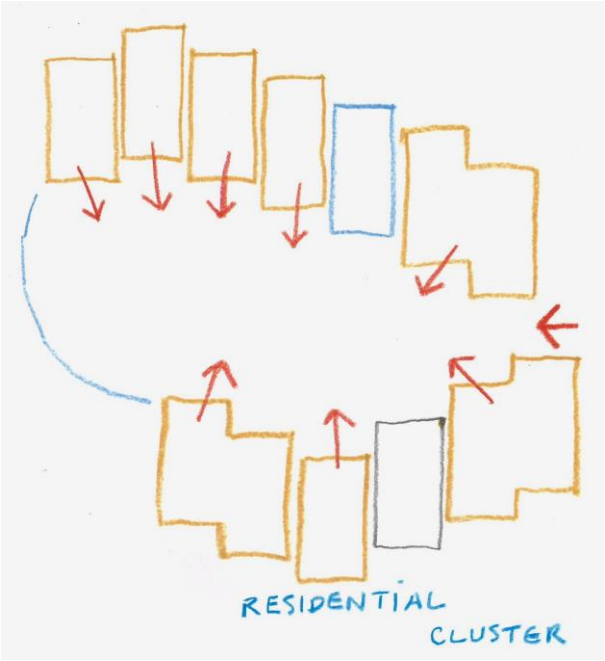


Diagram of a notional group of residential accommodation

- The main activity area to allow direct lines of sight for residents and staff – enabling way finding for residents and maximising ability for un-obtrusive visibility of residents by staff

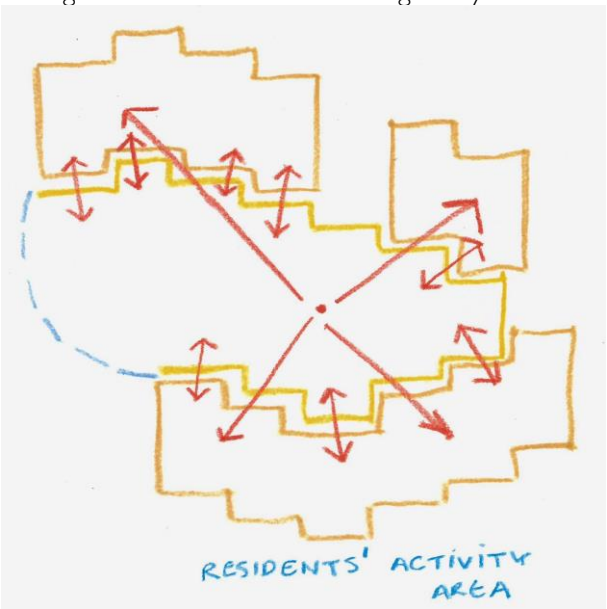


Diagram of a notional activity area embraced by residential accommodation

- Ensure direct integration of inside/outside spaces, i.e. a small garden area to be in wide and full view from interior

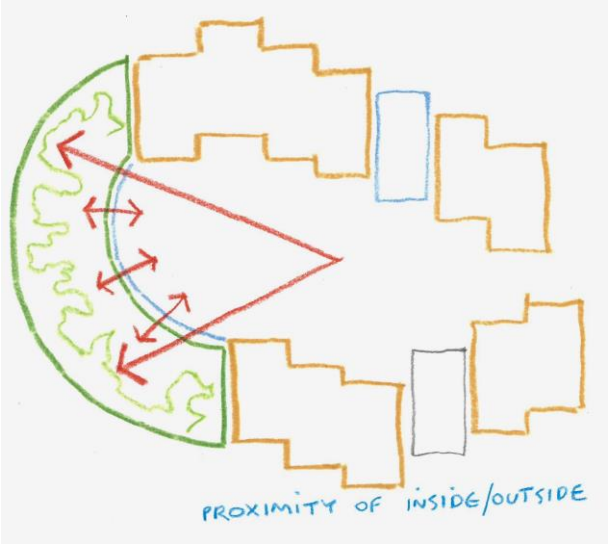


Diagram of notional secure garden space opening directly from activity area

- Each resident's personal identity is expressed by a 'threshold' area immediately outside their private space; to act as a transition zone between private and public areas; a place for expression of self by use of personal objects, a safe place of one's own in which to sit and observe, and meet and greet.

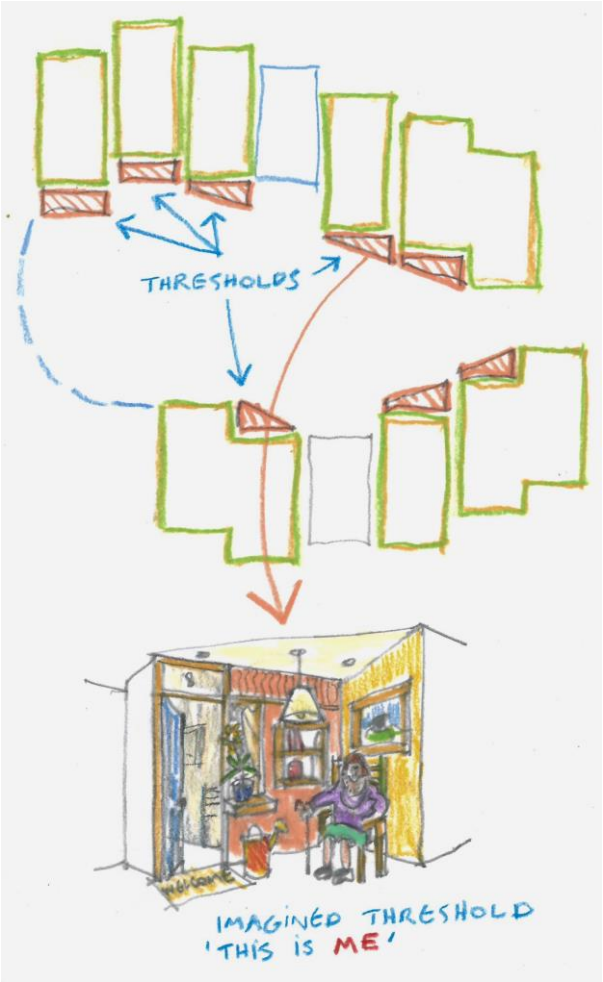


Diagram of threshold areas opening directly from residential accommodation and illustration of typical furnishing

- The main activity area to provide sufficient space for a 10-12 resident social group, with optimally maximum of two professional skilled dementia care staff (+volunteers). A wide variety of permanently available activities should be possible within this space throughout the day, including:

    - An outward facing kitchenette for meal preparation with optional dining table layouts
    - Various work table configurations for a range of shared participatory activities supported by immediately available presentation equipment – projector / screen / internet access / loudspeakers, interactive whiteboard etc.. The area should enable both pre-arranged and spontaneous activities without need for re-configuring furniture or disrupting other simultaneous activities
    - Sufficient space for structured and spontaneous dance, movement and exercise with music (possible to easily push furniture out of the way – on castors)
    - Quiet area – choice of seating options with extensive open views to outside
    - IT 'office' area with filing, storage, computer/s, printer/scanner
    - Library with choice of seating options
    - Bar associated with kitchen
    - Maker Space with ready to use materials and equipment + wash up/wet area
    - Staff base (but note that King Arthur Groep use tablets – no designated office
    - Shelving and presentation panels for residents to display their work and possessions and acting as space dividers

Diagram of complete notional corridor free residential dementia active living accommodation

- Main Activity space environment to provide:

    - Good natural ventilation (or assisted mechanical fresh air infusion
    - Maximum natural lighting) high ceilings
    - Variety of dimmable LED light fittings - to obtain low contrast but effective highlighting of different activity areas and opportunity to modulate light levels appropriate to time of day; particularly end of day twilight / dusk
    - Colour and texture to emphasis different activity areas - on ceiling, floor and furniture/fittings - use of similar tones avoids visual confusion
    - Wide, low, accessible window sills maximise natural light penetration, allow clear views between internal/external spaces, encourage spontaneous seating and use as display shelves for personal possessions
    - Sufficient space to accommodate residents' choice of furniture and fittings, including threshold areas with individualised doorways / door handles etc.
    - Appropriate sound absorbancy to mitigate noise transference between noisier/quieter space
    - Flexible space use - with exception of kitchen/bar/staff base - all equipment and furniture to be mounted on castors so that space requirements to meet special needs of each resident group can be fine tuned quickly. Availability of small power from floor, ceiling and walls is important.
    - Threshold spaces between inside and outside create intermediary climate and ambience; avoiding sudden change and an opportunity to acclimatise and choose

- Garden Space environment to:

    - be small enough for ease of access, passive observation and maintenance to allow a continuous journey without having to retrace steps
    - have an intimate variety of activities, including: high work bench, high planting-out tables, tools shed and materials storage shelves, weather resisting exercise equipment, raised beds with inbuilt seating, running and still water protected by decorative trellis, a variety of 'soft' perimeters, including woven hurdles and willow mixed with climbing plants
    - be filled with safe flowering/fruiting/scented plants to do things with e.g. dwarf fruit trees in raised pots, fruiting shrubs, edible herbs.
    - have a variety of seating types laid out to encourage participatory activities
    - use animals and birds as initiators of activity - feeding / cleaning / petting /noise
    - have safe surfacing - granularised rubber / artificial grass. Use no real grass as compromises year round use and is high maintenance

Taking into account the above, reconsider each CQC requirement for 'Outstanding' care in the context of a corridor free building model (see p.6):

1) Personalised care planning – immediate access to care plans and spontaneous note taking
2) Tailored Activity : each resident able to maximise own ability to nearby activity of choice
3) Development of New and Existing Skills – easy to re-visit preferred activities immediately beyond private space
4) Continuous Engagement of residents and staff – everyone equally shares main activity space without recourse to adversarial corridors
5) Welcoming Place – the main activity area belongs to the residents – it is their home filled with interests, possessions and equipment they need and want

6) Good End of Life Care – close by a resident's private room there is busy activity, the option remains to observe and listen, and on good days participate – no isolation down a corridor
7) Bringing in the Community and remaining Active Citizens – Social engagement occurs spontaneously

The common ingredients of 'Outstanding' care become achievable automatically:

Residents become actively contributing members of their community. They are enabled to:

- be active
- have choice
- see the purpose of each space
- know support is always on hand if they need it
- know that they are safe
- create their own home

Care staff become community builders. They are enabled to:

- spend their day facilitating social activity
- see where everyone is - at a glance
- easily ask another team member for help
- know what a resident wants to do because of where they are
- feel confident that their skills are being directly applied to real person centred care

Construction: time, cost, quantity

An arrangement of rooms generally in accordance with overall spaces outlined can be rapidly erected using modern high strength lightweight prefabricated steel frames, enclosed in a proprietary insulated cladding system decorated in a variety of rain screen options.

A large amount of naturally lit, well ventilated flexible space is created quickly.

A cost exercise carried out with specialist contractor McCanns Design and Construction envisages a 62 bed project costing £4.25m for a 60 week programme = £68k per bed space, inclusive of interior fit out, external landscaping, associated facilities (admin, laundry, kitchen, storage, training room etc.) and mechanical and electrical installation including sprinkler fire suppression.

This 'cluster' model, for arranging private space around the shared activity space, facilitates staged construction. Cash flow can be managed by occupying an initial completed cluster before work proceeds on subsequent cluster stages.

The steel frame enables future adaptation / complete refurbishment and bolt on rain screens enable refreshable exteriors over time.

All costs are directed at the creation of space used to support person centred care. Money is not wasted on useless corridor areas.

FINALE

The Dotsa Bitove Wellness Academy and the King Arthur Groep Soest Activity Centre are entirely independent initiatives, unaware of each other's remarkably similar and successful care support model. They share a passionate conviction by their associated researchers, care specialists and professional nurses, that people living with dementia are enabled by daily structured support to enjoy a real and rich life affirming place in society. Both projects inhabit simple, contemporary, non-institutional spaces, organised to directly facilitate immediate participation. All participants are entirely engaged, in the moment and in complete equality with shared activity that lasts a whole day almost every day of the week. To witness this approach operating so effectively in two instances 6000 km apart was a profound experience. These initiatives offer the basis of a real opportunity to create an entirely new model for residential dementia care and ultimately, all care.

Cut away sketch view of possible two storey, corridor free, active living dementia community accommodation

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