

# An Architect's Perspective of Nursing Home Design

By Lloyd Landow

**F**or 12 years, my mother has been a nursing home resident. When she entered the first home, she was ambulatory and able to take care of most of the activities of daily living. A year and a half ago she moved into a skilled nursing home, following a severe fall that resulted in a broken hip. The facility is located five minutes from my home, and I see her almost every day. Since it is a facility I designed, I have made it my architect's laboratory to see what works and what doesn't from an architectural perspective.

As architects, we must put ourselves into the minds of the people who use a facility in order to understand how to design it. My experiences have allowed me to understand the operations of the long-term care facility more so than any other type of building I have designed. I see it not only from the viewpoint of the administrators we work with, but also from that of the staff and the residents.

To begin, the decision to enter a nursing facility is rarely made by the prospective residents, and this vividly reinforces their greatest fear: that they are no longer in control of their own lives. Whatever the trigger point is, these formerly independent people are suddenly confronted with dramatic change at a time when they no longer can adjust to it. People need to feel that

they are in control of their lives—when to get up and when to go to sleep, when to eat and when to take a bath. Conversely, nursing homes must run on a schedule to maximize their staff's ability to provide quality, cost-effective care for their residents.

The result is a schedule for bathing and for eating, for getting up and for going to sleep. There is always someone watching over these formerly independent people as they go through the most personal aspects of daily life. The adjustment is never easy.

The dichotomy between what the resident wants and what the institution needs is not easily resolved. The challenge is to strike a balance between providing the resident with the best quality of life possible and the institution's need to provide cost-effective services while, at the same time, protecting the resident. The solution has two components. The first involves the enlightenment of the care givers and how they view their mission. The second is the design of the facility. It must maximize operational efficiency without sacrificing aesthetics and it must be economical to construct and maintain.

## Design Makes a Difference

Look at what happens to a person when he or she enters a nursing home. An adult who has led an independent life for 50 years or more—sharing a bedroom with

a spouse or, more often than not, having been widowed and now used to living alone—is suddenly thrust into a room with a stranger.

Historically, resident rooms in nursing homes were modeled after hospital rooms, with two beds side by side along one wall, with the lavatory on the hall side. If the

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resident next to the window closed the cubicle curtains around the bed, the person next to the lavatory was deprived of natural light from the window and the benefits of the heating and air conditioning unit. This design may be acceptable for the short stays associated with hospital care, but not in a long-term care facility.

Today we design rooms in a *bi-axial* or toe-to-toe configuration. Each resident's bed is on an opposite wall, with his or her own window and heating and air conditioning unit. If one resident has the cubicle curtains drawn, it doesn't affect the other resident. This design creates an economical facsimile of two private rooms sharing a lavatory. If the residents get along with each other they can leave the cubicle curtains open and socialize. If not, each has personal space.

In today's nursing home, the populations are so frail that 95% or more are in wheelchairs. Din-

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ing rooms must be designed to facilitate the space needs of this population and the carts that are used to deliver their food. When a resident acts out in the dining room, all of those in the room are adversely affected. Therefore, consideration must be given to acoustics and lighting to enhance the environment. We have experimented with background music, which can have a calming influence and almost instantly reduce the level of anxiety in the room.

## Building Communities

I have heard architects speak of designing places to allow privacy for residents. For the most part, the last thing residents want is privacy. They want the dignity of being treated as human beings. They want the camaraderie of their contemporaries to help them overcome their loneliness. They want the people who take care of them to treat them with respect and patience.

People in nursing homes have reached the stage of their lives where deterioration of physical abilities and levels of cognition change so rapidly that two people who are at similar levels and may form a bond today may be so different three months later that one won't want to be near the other. Residents are afraid that the bad things that are happening to their neighbors will also happen to them. They try to shut out their fears by shunning those whom they view as less cognitively or physically capable. A resident who has a nursing companion is socially ostracized by those who view themselves as alert. Those who remain ambulatory generally avoid those who are immobile.

A successful nursing home environment, from a resident's perspective, is one that offers choices. Socialization, when it is desired, should occur in a variety of settings based upon the homogeneity of the moment. The question

is: how do you create the flexible settings to allow this to happen within the constraints of codes and cost containment? We have to look at the way people live in a normal setting to arrive at the model for living in a special setting such as a nursing home.

Communities develop with streets and neighborhoods and places of recreation. People who live next to each other do not necessarily socialize with each other. Instead, they develop relationships with people with whom they have a commonality of interest. They socialize at organization meetings, in each other's homes, at neighborhood parks, at local clubs and at lunch in their favorite restaurants.

Nursing homes too should be designed as communities. Neighborhoods are created by the composition of streets, parks and other gathering places. Corridors have to be viewed as streets and resident rooms as their houses. Meeting places in the form of lounges take the place of local parks and gathering places. Just as good neighborhoods have a variety of places for people to gather, nursing homes should have the same variety of choices. Residents need to be able to meet and socialize with as many other people as possible in the hope of finding others with whom they can bond, if even for the relatively short span when they are cognitively and physically matched.

Today we hear a lot about designing nursing homes with "clusters," a group of seven to ten residents who live together in a subunit with the bedrooms grouped around a living room in an environment that replicates an extended family in a homelike setting. The residents are attended by nurse's aides who become their principal care managers. In theory it sounds wonderful and probably could function in a facility with a relatively stable population with

a majority of ambulatory and younger residents. In practice, however, clusters stifle the ability of people to meet and mingle on the scale necessary to satisfy their needs. They also preclude the cooperation between staff members that is so important in providing cost-effective care.

Sometimes when I look into the eyes of an elderly man or woman, I wonder what they were like when they were younger. It's difficult to recognize that the person who is babbling incoherently or drooling was once a useful member of society, a housewife and mother or an office worker or merchant, a professional or a tailor. And yet we must look at them for what they have been, not just what they have become.

One of the things I have learned from my parents is that everybody has an important place in this world. The greatest surgeon can't operate unless the person who cleans the operating room does his job. So, whether that person in the wheelchair was the surgeon or the housekeeper, he or she deserves to be treated with respect and a measure of love for the contribution they made when they were productive members of society.

The administrators, therapists, doctors, nurses and even the housekeepers contribute immeasurably not only to the physical welfare of the residents but also to their psychological well-being. These people do so day in and day out, with a cheerful disposition, treating the residents as members of their own family and truly caring. Interacting with them, I am constantly reminded of the need to be grateful, even when we are in places that are not of our choosing and where, if given the choice, we would not choose to be. ♦♦