Environments for Privacy, Safety, and Movement of Persons with Dementia

Maximal Privacy + Moderate Barriers = Minimal Intrusion

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Most nursing home residents with dementia live in areas of the facility that house residents with a range of cognitive abilities, including those who are cognitively intact. The challenge is to create environments that provide privacy, opportunity for movement, and safety for all residents using the least restrictive methods possible. Achieving privacy in a multiple occupancy room is a challenge, but the first step is to acknowledge that each resident has a defined private area in their room that should be acknowledged and respected. Unwanted intrusion can reduce quality of life for the residents. The goal is to create barriers on a continuum using the least restrictive method possible to ensure privacy and safety for all residents. It is possible to provide maximal privacy, moderate barriers, and minimal intrusion on units that are not locked Special Care Units.

Key words: environmental barriers, personal space, room configuration

Most nursing home residents with dementia live in areas of the facility that house residents with a range of cognitive abilities, including those who are cognitively intact. It is challenging to create environments that provide sufficient privacy, opportunity for movement, and safety for all residents, taking into account that residents have different interests and needs in general and that, on the whole, requirements of the person with dementia will differ from those of residents with intact cognition. This article discusses the challenge of using environmental barriers to create privacy and foster safety while permitting movement. It concerns using the environment to meet the needs of persons with dementia without compromising the needs of persons without dementia who live in the same environment.

Private spaces and barriers are two attributes of the physical environment in nursing homes that have the potential to significantly reduce intrusion into the personal space of residents. This article is about facilities that were built in ages past, some with private rooms, most with double-occupancy rooms located on double-loaded corridors along long hallways that lead to a centralized nursing station. It is about nursing homes that have been innovative.
in their approach to privacy and barriers as strategies against unwanted intrusion.

METHOD

The strategies described in this article are drawn from data collected in a large study of nursing-home quality of life with a substantial environmental component. This study involved interviewing and assessing the physical environments of 1988 residents who lived on 131 nursing units in 40 nursing homes located in 5 states. A major component of this study entails examining the relationships between the private and shared environments of the residents and quality of life. Quality of life is defined by 11 domains: autonomy, dignity, privacy, meaningful activity, relationships, enjoyment, individuality, security, spiritual well-being, comfort, and functional competence. Three separate environmental instruments were developed: (1) a 113-item resident room and bath checklist, completed from the perspective of a particular resident in a particular bed; (2) a 229-item nursing unit checklist; and (3) a 243-item facility checklist. The environmental checklists were composed of objective items that could readily and reliably be observed by trained interviewers. The intent was to explore the use of discretionary environmental features that went beyond regulatory requirements and see if they improved quality of life. For the most part, the items require noting the presence or absence of environmental characteristics, most through visual inspection but with some items noted through smell, hearing, and measuring. A light meter was used to assess lighting levels (or lack thereof) in private and shared spaces.

The first author trained 45 interviewers to complete the room-and-bath checklists in conjunction with interviewing residents. She personally visited all 40 nursing homes to make the facility-level and unit-level measures and observe innovative features for further study. Only 21 of the 131 units assessed were Alzheimer’s Special Care Units (SCUs), though most housed people with Alzheimer’s disease. The examples highlighted here come both from the results on the measures and the first author’s field notes.

PRIVACY

Although privacy is difficult in a double-occupancy room, numerous steps can be taken to improve it, and some specially designed double-occupancy rooms actually afford high levels of privacy. Even in the worst-case scenario, limited privacy can be achieved by relocation of the beds or the placement of a room divider that differs from archaic curtains positioned in the middle of the room or surrounding each bed. This study identified several innovative room configurations that allowed residents a sense of personal space or control over their own territory even in multiple-bed rooms. Each of these configurations achieved a sense of privacy and provided a barrier, even if they were just visual or psychological.

Five distinct uses of space were identified within the typical resident’s room. The areas as shown in Figure 1 include:

1. Resting/sleeping space
2. Private social space used for activities or visiting
3. Open, social shared space where staff and visitors are acknowledged before entering private space
4. Resident’s bathroom
5. Threshold area that provides demarcation between corridor and room

At a minimum, the sleeping space and private social space (areas 1 and 2 in Figure 1) should be identified as "belonging" to that resident. When staff make an effort to identify portions of the room that belong to each resident, then that resident can claim some ownership or territoriality over the space. When a more fixed separation such as a wall is not an option, it is possible to personalize the two spaces as if they were separate rooms. It is not difficult to provide different wall coverings for each resident’s half of the room. That creates two visually distinguishable separate areas. We found obvious disparities in allocation of space in shared rooms. Personalizing each part of the room can assist with alleviating this inequity.

Another approach to creating privacy entails placing two beds head to head with a divider. If freestanding closets or wardrobes can be used as the room divider, it is better. One resident will be facing the wall with the window while the other resident will be facing the corridor, as seen in Figure 2. With this configuration, one resident loses a window view but gains a corridor view, which is often preferable over a straight ahead view of the wall. This configuration alleviates the common complaint in shared rooms of who controls the window covering. It also enables the resident to express preference of a window view or a corridor view. The shared space in this room now becomes a small walkway to the corridor and/or to the bathroom. Intrusion into another person’s space has been curtailed and privacy has been increased.

Creating private spaces in conventional shared rooms is rendered much more difficult if more than 2 residents...
are housed in the room. We found no good examples of privacy-creating innovations in triple rooms or greater.

We found 2 facilities in the study and 1 during our pretest where the double rooms afforded an unusual amount of visual and auditory privacy. Figure 3 depicts the most ideal double room configuration we studied. The door from the main corridor opens into a foyer shared by the “roommates”; a shared bathroom is located on one side of the foyer and a large staff closet on the other. A floor-to-ceiling wall separates the two parts of the room with an accordion-type door in each section of the room providing maximal privacy. Ample wall space and movable closets provide flexibility in furniture arrangement. Two sisters who were sharing a double room of this type created a bedroom area in one section of the room and a sitting area in the other. Other residents prefer to remain separate from the resident on the other side of the wall. This goal of separation can easily be achieved because each side has its own window, temperature control, and movable closet; it would be aesthetically feasible to have different window and wall treatments. The staff closet is ideal for storing linens and continence supplies (which often are in public view in residents’ rooms); this convenient location of staff closets alleviates the necessity of staff members going to central closets, making them more available to the residents at critical times.

A different way of achieving privacy in double rooms was found in one of the pretest facilities. In each double room, the door from the main corridor opened into a wide internal hallway with the shared bathroom at its far end. Individual floor-to-ceiling heavy decorative curtains were located at the entrance to each resident’s section of the double occupancy room. The spaces on either side each had their own window. Residents may choose to keep the curtains open or closed, and we noticed both patterns. One resident may choose to keep the curtain open and thus view the corridor to the bathroom and the door to the unit (which itself may be open or closed), while the roommate may choose to keep her curtain closed. (Note that, in this model, staff must be dedicated to ask residents their preferences and close the curtains if the resident requests, whereas the wall in the previous example creates a permanent barrier.) In each of the facilities with double rooms with maximal privacy, staff reported few roommate conflicts or requests for room changes.

**BARRIERS**

In addition to strategies that promote privacy, provide control over personal space, and potentially thwart intrusion, other strategies have been applied to provide barriers against intrusion. Such intrusion would usually be from other residents, but also from animals, as in an Eden facility. Often these barriers are either ignored or create such an obstacle that they are a hindrance to staff, whereas others are subtle and effective in reducing unwanted intrusion.
The most common barrier is the mesh baby gate that folds up, never seems to fit the door opening properly, and often results in pinched fingers. One facility built wood gates that looked much like the headboard of a bed with two high posters on each side. This was not only a visual barrier, but also a physical barrier because they were so heavy that it was difficult to move them. A more effective version of the gate is one made of mesh fabric that is secured by Velcro strips to the doorframe.

Hanging a sheer curtain over the door opening created an unusual barrier. The problem with this strategy was that the curtain rod in place prevented the door from being closed and the curtain prevented staff from viewing the resident without entering the room. A very active wandering resident who used a walker challenged one facility by attempting to enter any open doorway. This facility did not have a separate SCU unit so the resident had the freedom to wander throughout the facility. The solution in this situation was to place tall poles on both sides of the walker and a bar across the top of any entryway where the resident was not welcome. The wandering resident was unable to enter rooms where the bars were in place and the bars were easily removed so doors could be closed.

A barrier can be as simple as a sign next to a resident’s door requesting that the resident’s door be left closed and that people knock and announce themselves before entering. It was frustrating to note how many times this simple barrier was ignored. One blind resident mentioned her feeling of loss of control because staff routinely disregarded this simple barrier.

Personal items on display in resident rooms are often an invitation to unwanted intrusion and, as a way to deter this behavior, many nursing facilities discourage residents from bringing personal items from home for fear of their disappearance. This is a barrier taken to an extreme that prohibits personalization. An innovative approach to this problem is to build shelving around the perimeter of the room at a height that residents cannot reach but that can be viewed from the bed or chair.

One facility in the study, built in the 1970s, could serve as a prototype for providing maximum privacy combined with moderate but innovative barriers. The rooms and baths are all private, the windows in the rooms are large and low, and the doorways are very wide. Outside each resident room is a space adequate to place a chair, almost like a front porch. This is the open social shared space where staff and visitors are acknowledged before entering the private space. An intriguing feature is the use of Dutch doors. Resident room doors are literally cut in half, maintaining the original hardware. The half doors can be latched from the inside, prohibiting wandering residents from entering but allowing residents to watch activity in the corridor as well as allowing staff to view residents in their rooms without entering the room.

CONCLUSION

A person’s behavior in his or her environment is directly related to the design of the space, and an optimal environment is designed to meet the specific needs and preferences of an individual. It is unwise to expect that every resident will enjoy the privacy that a private room affords or that a single barrier will exclude all unwanted intrusion, even in that private room. One approach cannot serve all equally. Residents’ needs and preferences should be considered and respected. It is wise to think of privacy and barrier strategies on a continuum using the least restrictive barrier and, at the minimum, identifying and respecting the private personal space of the resident. Remember that staff and animals can be intrusive in their behavior just as much as other residents. Most important, it is wise to be creative and not expect a locked unit to provide maximal privacy, moderate barriers, and minimal intrusion.
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REFERENCES


