Creating Home in a Nursing Home: Fantasy or Reality?

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There is growing consensus that nursing homes should be less like hospitals and institutions and more like home. This is particularly relevant for long-stay residents, who may spend months or years living in this congregate setting. There are some questions as to whether a nursing home can ever be perceived as truly "home" in all it's deeper connotations. *Home* is very different from *house*. A house is a building. *Home* is a place that includes organizational, social/interpersonal, operational, and physical dimesions. There is a robust literature on home and the meaning of home, which is often explored on the basis of different groups, such as people who have lost their home to natural disaster, or the homeless, or people who are abused in their houses. There is also a substantial literature on the design of houses. This paper draws on some of this literature to explore ways in which nursing homes can be designed to reflect houses, and operated to reflect home.

The world we experience is a combination of personal and interpersonal events viewed against a backdrop of the natural and human-built physical environment, seen through the lens of personal experiences as well as socio-culture expectations.

> *Mid pleasures and palaces, though we may roam,*
> *Be it ever so humble there's no place like home.*
> *J Payne*

When one thinks of the typical, traditional nursing home, images of long, stark corridors, lined with residents in wheelchairs slumped over,

sleeping or moaning and reaching out to grasp the arm of every passer-by come to mind. Staff is gathered behind a large nursing station, doing necessary paper work, but also talking about what happened last night or last weekend. During meals, residents are brought into the dining room, often an hour or more before the meal, to sit and wait for the cart to come up from the kitchen so they can have a tray of moderately warm food, served on plastic plate warmers with plastic mugs, plastic-wrapped bread, and sugar from little paper packets. Staff set up one resident, then leave to get another tray and serve another. Residents are seated next to other residents with similar assistance needs, to make it easy for one staff to walk around a table and help 3 or 4 residents efficiently. There is nothing remotely like home about this description. At home, you sit in your favorite chair, listening to music, talking with family and friends, or watching your favorite television program. Before a meal, the aroma of food cooking wafts through the house, and people often gather in the kitchen and animatedly discuss the events of the day. Everyone sits down together, maybe grace is said, and food is passed around the table. Can these two, distinctly different images, ever be reconciled?

We are learning that the answer is, yes. It is possible to provide high quality care that the people who live in a nursing home need, and create both a design and an atmosphere where people can at least feel "at home" and possibly even come to call home. It is happening right now, in a small but growing number of facilities across the country.   What makes these places so different from the traditional nursing home? It begins with a set of values that focus on quality of life at least as much as quality of care—the traditional focus of nursing homes. If you ask residents of nursing homes what makes them happy, it is in large measure a few simple things. They want more control

over their lives. They want to be able to have positive relationships with those around them- residents and staff. They want to be treated with dignity and respect. They want to be able to engage in meaningful activities that make a difference[1]. These are not unreasonable requests. In fact they are very much the same things people who do not live in nursing homes want. So why, then is it so difficult to provide this? It is a combination of factors that have evolved over time, reflecting both cultural and regulatory biases. However, the purpose of this paper is not to focus on how we got here, but on what we need to do to change the future.

To be successful at creating places where people can feel at home, it is necessary to consider the different layers of the meaning of home. *Home* is psychological state and an expression of self, embedded within certain physical environmental elements. Each of these will be considered separately.

As a psychological state, being at home means to be safe and secure, and in control of our actions and our environment. There is almost nowhere else where

> *For a man's house is his castle. One's home is the safest refuge to everyone.*
> *E. Coke*

we have as much control over what we do (such as getting a snack), when we do it (in the middle of the night) and where we do it (eating it on the back steps). There are many ways that traditional nursing homes violate these principles. First, staff has virtually all of the power and authority, determining when people wake up, when and where and what they eat, when and how they bathe, what activities they do, when and where they do

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[1] This list is drawn from a multi-year research project examining quality of life among nursing home residents, where Kane developed the following list of factors related to high quality of life: security, comfort, meaningful activity, relationships, enjoyment, dignity, autonomy, privacy, individuality, spiritual well-being, and functional competence (R. A. Kane, 2001).

them, and the list goes on. Virtually every decision that one makes for oneself at home is now made by someone else, who may or may not know anything about your preferences.

In facilities that are working to recreate home, all these processes are turned around. Residents determine, on a daily basis, when they want to wake up, whether they want to eat breakfast in their robe or bathe first, and what they want for breakfast, which may even be cooked to order for them. When this practice was first implemented, everyone worried about violating the regulation requiring no more than 14 hours elapsing between dinner and breakfast (Tag F368). However, the interpretive guidelines specify that "when a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.". While this allows some more flexibility, the language ("snack is served") continues to reflect a perspective of staff "doing for" the residents, not residents being able to control when and where and what they eat. When there is a well-stocked kitchen or pantry or snack bar, then residents can access food at whatever time they are hungry. Having "refrigerator rights" at a friend's house, meaning you feel comfortable enough to go to the refrigerator to get something to eat or drink without having to ask or be served, reflects a level of comfort, of being "at home" in this house even though it may not be your home. The same principles can apply in nursing homes. Residents should have refrigerator rights, either to a refrigerator in the shared kitchen in their household, or to a refrigerator in their own room. This gives people greater control over when and what and where they eat. Similarly, having a stove in the kitchen allows for the preparation of desired foods, when the resident wants it. Many of the risks associated with stove tops can be eliminated with

the use of induction cooktops, where the stove heats the pan to cook food, but the cooktop itself does not heat up. There will always be issues to be worked out for people who require special diets. But here again, at home people can choose the degree to which they want to follow a specified diet. Traditionally, in nursing homes, residents have almost no control over the extent to which they want to follow a specified diet.

Control and decisional authority extend to the daily schedule, and the extent to which residents can determine what they do each day. In most facilities, there is an activities department that tries to take into account residents' interests, but fundamentally they think in "group" terms because they are responsible for so many residents. It's very difficult to have an individualized perspective when you are responsible for entertaining 60 to 90 residents each day. In facilities that are recreating home, decisions about each day's activities are made each morning, by—or at least with input from—the residents. Rather than having an activity or recreational professional responsible for activities (and the activities budget), the direct care workers who work most closely with the residents and know them best, ask the residents what they want to do, and work to make it happen. This means a redeployment of staffing, so that the ratio of direct care workers to residents is higher, and they are given the time and budget control necessary to plan the supplies and equipment needed to enable to residents to do what they want to do. This is not an unlimited budget. Most residents recognize there are financial constraints. But they do get to participate in decisions about how the budget is spent.

Home is also an expression of self. Homes in the community reflect different styles of decor, and are filled with personal belongings, accumulated over a lifetime of travels and experiences and interests: sporting trophies, wedding and family photos and

portraits, furniture passed down from generation to generation. Some homes are casual by nature while others are formal, some grand and some humble. Traditional nursing homes, on the other hand, are sterile, all furniture and decor (if there is any) in the shared areas selected by an interior decorator to be easily cleanable and durable. Even in bedrooms, which are supposed to be the residents' space, identical furniture is provided and often rules prohibit or severely limit residents from bringing in items from home that would both give comfort and tell others something about the unique experiences and lifestyle of each resident.   Some traditional facilities have policies that prohibit residents from hanging anything on the walls, because of the maintenance associated with repairing nail holes.

While this type of policy is not specifically against regulations, it does, to some extent, violate the intent of the regulations. Tag F252 indicates that the facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. The interpretative guidelines define a homelike environment as "one that de-emphasizes the institutional character of the environment as much as possible and allows residents to use those personal belongings that reflect a homelike environment. A personalized homelike environment is one that recognizes the individuality and autonomy of the resident, provides an opportunity for self-expressions and encourages links with the past and family members." Most of the rest of the interpretative guideline focuses on personal belongings in the residents' bedrooms and when their absence should be questioned. While this is important, it does not address either residents belongings in the shared areas of the household, nor de-institutionalization of other elements in the setting. In homes in the

community, people often display their most treasured mementos in the living room, dining room and kitchen—the places where family spend the most time and guests are most likely to be. In order to create nursing homes that feel more like home, residents need to be encouraged to bring some of the favorite possessions to add to the living and dining room they are living in. This might be their favorite chair, even if it doesn't match the one it sits next to, or a wall cupboard that can be filled with the china collection of another resident, or a large painting that others might enjoy as well. By bringing personal possessions out of the bedroom and into the living room, it says this where we live, this is who we are. One challenge to this is the frequency of items being stolen in nursing homes. Rather than address the issue of theft by saying it's not tolerated and when something is missing it is fully investigated and resolved, we often simply acknowledge that it's a problem and let it continue to frame our thinking and decision-making process. Residents don't want to bring in possession for fear they will be stolen. In what other realm of life do we, as a society, simply tolerate this level of inexcusable behavior?

Despite the emphasis on personal belongings as the way to create a homelike environment, the interpretive guideline for Tag F252 also specifically mentions "minimizing the institutional character to the extent possible." There is nothing more institutional than a large nursing station and med cart that figure prominently in the center of the unit. Interestingly, the federal regulations do not directly address requirements for a nursing station other than to require the facility to provide sufficient space and to enable staff to provide residents with needed services as required by standards and as identified in each resident's plan of care. Some state regulations for nursing units are very detailed and address the station as one component of the overall unit, specifying maximum

distance allowed from the station to the furthest residents' bedroom door (NHRegsPlus, 2008b). It is clear, given the amount of paperwork that nurses and aides need to complete on a daily basis that there is a need for space and systems for this work to get done. But there are other alternatives besides the large central nursing station that staff congregates behind, often passively watching the residents who are on the other side. First, there are technological advances that can make the necessary charting requirements both more efficient and more accurate, systems that allow staff to electronically document physical care and psychosocial involvement at the moment it happens. There are medication delivery systems that can facilitate accurate dispensation (see www.TechforLTC.org for a description of different medication dispensing systems), either by staff or by residents. State regulations vary significantly in the extent to which they allow or encourage residents to manage their own medications. Indeed, as the NHRegsPlus website notes "the connection between resident self-administration of medications and resident autonomy is obvious. Little is known about the extent to which residents do administer their own medications in nursing homes, and the effect of that control on their well-being" (NHRegsPlus, 2008a).

There are other institutional elements that are not reflective of a home: the overhead paging system, call lights and buzzers at bedroom entrances, multitudes of the same furniture, covered in the same vinyl, throughout the facility so there is virtually no differentiation between spaces, 2x4 ft commercial style fluorescent lighting, a preponderance of highly polished vinyl flooring (either as a rolled product or as vinyl composition tile), and staff wearing uniforms are but a few. Each of these adds to the institutional character of place, keeping it from feeling like home.

As the last paragraph clearly demonstrates, there are also clearly aspects of the design of the building that impact how the place feels. Traditionally, nursing homes units were 60 beds, arrayed along a long double loaded corridor, because that was the number of patients one nurse could supervise at night. The front entrance to the unit often opened up directly on to the wing of bedrooms—not exactly what the front door of a house opens on to. Over time, the size of the units has been decreasing and in some cases the layout is being modified to be more reflective of how houses in the community are built. The extreme examples of this are the Green Houses and Small Houses that are currently under development. These projects take the traditional nursing home of 60-120 beds, and break them down into small 9-12 person individual homes, often building 5-12 adjacent to each other in order to achieve necessary efficiencies of scale for staffing purposes. The experience of walking up to these houses, ringing a doorbell and waiting to be let in is totally different from the experience of entering most nursing homes. Walking inside, one encounters a living room and dining room and kitchen, surrounded by bedrooms on 2-3 sides and a back yard on the other. It feels like a home. It's decorated like a home (though many still don't include much of the residents' personal belongings out in the living room area). It's scaled like a home.

These free-standing houses are not the only option. There are models that reflect a connected household concept. In some, the visitor still enters a "facility" entrance, but the design and scale of the households that residents live on reflect the size and style of houses. In others, the entrance for visitors is still from the outside directly into the house, but the internal connections allow residents to visit with friends in other households without having to go outside, which can be difficult for many in cold or inclement

weather. In all these models, a key concept is that the entrance of the household leads the visitor into the spaces that the front door of a house leads to—the living room and dining room, with a kitchen adjacent to the dining room. The kitchen is central—in the best projects it is clearly the hearth of the house, the place where people easily gather to drink coffee and read the paper, to find out what's going on for the day. Also in these homes the food comes out of the kitchen, at least from the residents' perspective. It may not all be cooked in this kitchen—though in some households it is—but there is sufficient food preparation involvement that aromas waft naturally out into the other areas of the house.

Many of these "ideals" can be achieved within existing facilities, if the provider has the values and commitment to make it happen. The traditional multipurpose day room can be reconfigured to create a kitchen and dining room. Food service must also be reconfigured to eliminate the tray service, with food served from steam tables or in family-size serving dishes that are brought to each table. Often one course of the meal is at least partially prepared on the household, as this is a natural part of a day's activity when living at home. In some facilities, these "units turned households" can be configured so they have a front door, just like the free-standing house model.

Another critical aspect of creating a physical environment that supports a feeling of home relates to the design of the bedroom. In many traditional nursing homes, people are assigned to shared bedrooms, usually with someone they have never met before. Many rooms are designed like hospitals, with two beds in the same space, separated by only a piece of fabric. This in no way resembles home. It comes from nursing homes' medical roots, as early hospitals were based on ward designs. The American Institute of Architects Guidelines for Architecture for HealthCare Facilities now recommends all new

hospitals be built with 100% private rooms (Facility Guidelines Institute, 2006) for both clinical and psychosocial reasons, and a similar standard should apply to nursing homes. There is clear evidence that sharing a traditional hospital-style bedroom causes much friction because of the loss of control and privacy. But there are variations in the design of shared rooms, with some designed so that each individual has his/her own territory and window but share a bathroom. These are referred to as enhanced shared rooms. There is currently insufficient evidence about the extent to which enhanced shared rooms are experienced by the residents as being more comparable to the traditional side-by-side shared room or to a private room. While there is some limited evidence that residents perceive a well designed enhanced shared room as being more like a private room than the traditional shared room in terms of privacy and personal space (Calkins & Cassella, 2007), more research is needed on this[2]. For instance, if the two halves of the room are still only separated by a piece of fabric, does that provide enough sense of privacy? Some progressive providers are building additions with all or a majority of private rooms, and turning existing side-by-side shared rooms into private rooms.

Summary

It is challenging and expensive to conduct rigorous research on the impact on quality of life of these new house-based nursing homes models, but there is a small body of research that has looked at these issues. The results suggest that there are significant improvements in quality of life, no detriment (and perhaps improvements) in quality of care, and potentially also improvements in satisfaction for staff (which may translate into

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[2] For more on this, see Calkins (this issue) and (Calkins & Cassella, 2007)

reduced staff turnover). Families also are happier with this model (R. A. Kane, Lum. T. Y., Cutler, L. J., Degenholz, H.B., & Yu, Tzy-Chyi, 2007), which can translate into higher occupancy rates for the provider.

There are costs associated with these changes—particularly changes to the physical environment. These costs can be difficult to recoup, particularly if a facility serves a high percentage of Medicaid residents. States differ dramatically in how they determine their reimbursement formulas, and what percentage of capital costs are allowed to be folded into the reimbursement formula. Fortunately, there is also much that can be done that does not involve significant capital costs. An organization committed to changing its approach to care can do so, though change is always difficult.

There is a need for more funding for research that specifically focuses on the role and impact of the built environment on all outcomes. Conducting rigorous and generalizable research on

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>
> *Dorothy, in The Wizard of Oz*

environmental outcomes is challenging, as it is difficult, if not impossible to randomly assign residents to specific conditions, and the number of variables that need to be accounted, if not controlled for, is extensive. Yet billons of dollars are being spent to build new facilities, with very little understanding of how the built environment impacts residents, families, visitors and staff. The evidence that does exist supports the positive correlates of creating nursing homes that feel more like home and hospital.

If there is consensus that this approach of creating a home where nursing care can be provided improves the quality of life that we, as a society, are striving to provide to our frailest elders, consideration needs to be given to how to help facilities afford

changing from the institutional/medical facilities we have historically created to creating

home.

Recommendations

There are so many recommendations for systems, processes, environmental features that need to be changed to make nursing homes feel more like being at home that this list could easily go on for pages. The list was kept to 15 recommendations, recognizing that every person who is engaged in trying to improve nursing homes will be able to add to this list.

1) Eliminate the central nursing station as the barrier between staff and residents: give staff office space, encourage/require more efficient electronic charting and other systems that capture care as it is being given, and support systems that put the staff in more direct contact with residents.

2) Develop new documentation systems so the focus can be on the care that is given, not documentation to maximize reimbursement.

3) Require new construction to reflect the household model, with 24-hour resident-accessible kitchen. Some states still require a 2-hour fire wall around the stove, while other do not. Review codes to allow greater resident access and participation in kitchen and food related activities, while maintaining safety (e.g. allowance of induction cook tops).

4) Disallow meals served on trays.

5) Change medication distribution systems to eliminate the large medication carts.

6) "To the extent possible" referring to the use of personal belongings is often implemented based on what is convenient for the staff or facility, with no real effort made to actually maximize resident choice or options. Surveyors need to ensure that facilities are actually accommodating residents' desires.

7) In facilities that do not have all private rooms, residents should always get the final say on with whom they share a room.

8) Surveyors need to place a greater value on (and therefore assess the extent to which) residents have direct input into their daily schedule (for each individual resident), the activities they engage in, how budgets are set and what money is spent on.

9) Residents should be given the opportunity to be involved in hiring of staff.

10) Facilities need to make resident-centered care principles a core value, include this in training for all staff, and incorporate them into job descriptions and evaluation tools. Similarly, direct care workers should be given more training and support for implementing resident-centered care principles. It is a travesty that training requirements for being a direct care worker may be as low as 40 hours, half of which is classroom and half of which may just be following someone on the floor giving care. Manicurists are required to have 400 hours of training before they are certified.

11) All staff should be given comprehensive dementia-training, as individuals with dementia comprise the majority of nursing home residents.

12) Administrators and owners/Board members should be required to work one day every other month as a caregiver. They need to know what is really going on. They should also be required to spend at least 24 hours as a resident, being given care (being fed, being bathed, and participating in activities).

13) Residents who are on restricted diets should be given greater opportunity to choose the extent to which they want to follow the restrictions – in consultation with their physician and family as appropriate. But the final say should rest with the resident.

14) No resident should be prevented from being able to freely spend time outdoors, which doesn't mean only being to go out when staff have time to take them.

15) Fund more research on the impact of the physical environment on both resident outcomes (clinical and satisfaction) and staff outcomes (burden, efficiency, and satisfaction).

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