ABSTRACT

HART’S HOME AWAY FROM HOME: AN INTEGRATIVE APPROACH TO DEMENTIA CARE

by Rebecca M. Hart

Typically people with dementia don’t receive specialized care designed to accommodate their needs and desires. The dementia care facility proposed in this document, Hart’s Home Away From Home (HHH), integrates ideas regarding dementia care from the last 20 years. From Lawton’s person-environment fit to Kitwood’s person-centered care, HHH takes into consideration the importance of physical and social environments. The foundation of HHH is built upon Lawton, Kitwood and three core principles: a) continuation of identity beyond cognitive decline, b) creating and sustaining meaning in life, and c) creating a home-like environment. Relying on these ideas, HHH is described from the ground up, with a focus on the physical layout, the team (staff, family) of HHH, and experiences (activities) for residents. The result is a care setting that honors, respects, and understands people with dementia. HHH provides guidelines regarding social, and physical environments, resulting in quality care for people with dementia.
HART’S HOME AWAY FROM HOME: AN INTEGRATIVE APPROACH TO

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**Background**

The general adult population aged 65 years and older will reach 70 million by the year 2030. According to the Alzheimer’s Association Facts and Figures report for 2010, the number of individuals who are living with Alzheimer’s, which is merely one type of dementia, albeit the most common type, reached 5.1 million people 65 years and older. Statisticians expect this number to increase to 7.7 million by 2030 (Alzheimer’s Association, 2010b).

Currently, people with dementia (PWD) constitute a large portion of those who are living in care facilities and the quality of care that they receive is gaining more attention. As of 2009, 47% of residents in nursing homes had a diagnosis of dementia and between 45% and 67% of residents in assisted living facilities had dementia (Alzheimer’s Association, 2010b). Interestingly, although there are special care facilities or units for PWD, the number of beds in these settings has actually decreased. As of 2004, only approximately 5 percent of the beds in nursing homes are in Alzheimer’s special care units, whereas approximately half of their residents are diagnosed with dementia (Alzheimer’s Association, 2010b). The lack of special care for residents with dementia is troubling.

Advocates have been calling for a culture change in the way that PWD are cared for for over 20 years (Calkins, 1988; Kitwood, 1997; Koren, 2010; Power, 2010; Rader, 1995; Thomas, 1994). Doty, Koren and Sturia (2008) describe the experience for residents within care settings that have adopted culture change. They emphasize that the residents are given privacy and choices, the same privileges they would have in their own homes. The needs and desires of the residents are the top priority and serve as the basis for how the care setting is run. Culture change also implements a less hierarchical staff culture and instead places most of the day-to-day decisions in the hands of the hands-on care providers. Finally culture change affects the physical environment, with an emphasis on small care settings with consistent care providers.

Most of the concepts within the culture change movement date back to the Omnibus Budget Reconciliation Act of 1987 (Federal Nursing Home Reform Act). The act, as quoted by Koren (2010), emphasizes the importance of providing “…services sufficient to attain and maintain his or her highest practicable physical, mental, and
psychosocial well-being” (p. 313). Although efforts have been made toward a culture change through the Pioneer Network (http://www.pioneernetwork.net; Misiorski, 2003), Eden Alternative (http://www.edenalt.org), and Green House movement (http://www.thegreenhouseproject.org), progress is slow (Doty, Koren & Sturia, 2008; Keane, 2004; Koren, 2010). According to a Commonwealth Fund survey, approximately 73% of health care opinion leaders hadn’t heard about culture change in 2005 but by 2008 this number of those uniformed had decreased to 34% (Koren, 2010). Sadly, many facilities still ignore the needs of PWD and do not provide them with specialized care (Holmes, Teresi & Monaco, 1992; Orrell et al., 2008). From personal experience, some facilities that do claim to provide specialized care treat their residents just as any person without dementia would be treated or possibly even worse. In fact, much of the time PWD are disregarded because they are thought to no longer be human but instead practically vegetables (Woods, 1999, p.35). The need for change is long past overdue and although the leaders of the Pioneer Network, Eden Alternative, and Green House movements have made improvements in dementia care, progress is still slow, and there are still many people with dementia who do not receive the specialized care they deserve.

Overview

This paper integrates literature regarding what has been learned in dementia care over the past 20 years and presents an approach to improving care in a plan for a single care setting. The theoretical frameworks of person-environment fit and person-centered care support why quality care for PWD is essential and serve as a foundation for the care setting proposed in this paper. There are several aspects to quality care, although the most important is that the care is personalized to the individual (Buckland, 1995; Kitwood, 1997; Koren, 2010; Woods, 1999). Quality care provides safety, while still respecting privacy and is effective in that the residents receive the care they need when they need it (Department of Health, 2008). The opportunity for residents to have choices within their care, interpersonal relationships, and comfort are also essential aspects to quality care (Atkinson, Ingham, Cheshire & Went, 2010). The caregivers play a large part in providing quality care and therefore they must be fully trained in the specific needs of people with dementia and how to best care for people with dementia (National Institute for Health and Clinical Excellence, 2010).
Following a through explanation of Lawton’s theory of person-environment (p-e) fit and Kitwood’s concept of person-centered care, and their application to PWD, the second section will explore three core principles. These principles include: a) continuation of identity beyond cognitive decline, b) creating and sustaining meaning in life, and c) creating a home-like environment. These principles are not theoretical frameworks, as Lawton and Kitwood’s are, yet derive from literature that focuses on fully understanding PWD, and determining how to provide quality care. The two frameworks and three core principles serve as a foundation for the third section of this paper. In the third and final section, a care setting for people with dementia is proposed. The proposal for the facility originates from existing literature and personal experience. It integrates elements of the physical and social environment, including staff training, activity programming, and the role of family within the facility. The following section introduces the foundational ideas of Lawton’s p-e fit, and Kitwood’s person-centered care, and discusses their applications to providing quality dementia care.

**Theoretical Frameworks**

**Person-Environment Fit**

Daily interactions with our environment are extremely influential. In fact, the effects of this relationship have been studied for well over fifty years. From Lawton and Nahemow (1973) to a more recent look at environmental research by Wahl and Weisman (2003), it is obvious that this area of study is still very important in understanding aging.

The relationship between person and environment is one that has been theorized about for many years. Beginning with Lawton and Nahemow (1973) and the competence press model, the field of environmental gerontology found its grounding. This model indicated that one’s behavior and mood is a function of both the individual’s personal competence and the influence of the environment. From this point, several models were developed based on the initial ideas by Lawton and Nahemow. Moos’ (1976) social ecology model expanded the concept of environment to include both physical and social environments, and their influence on one’s behavior, in addition to the influence of a person’s behavior on his/her environment. Even further development of environmental gerontology followed with Carp and Carp’s (1984) complementary/congruence model. This model introduced the idea of how important a good fit between a person and his/her
environment is for well-being (Wahl, 2001). As these various models have developed over time, a greater understanding of the relationship between person and environment has been accomplished. This is an essential step in order to provide quality care for those with dementia.

The relationship between people with dementia and their environment is even more noteworthy due to their compromised competence. Lawton (1980; 1989) addresses this idea in his environmental docility hypothesis, which can be applied to people with dementia and their surrounding environment. This concept claims that as one’s competence declines, the influence of the environment on one’s psychological and behavioral outcomes increases. Positive outcomes such as autonomy and comfort are the goal when attempting to provide the best quality of care (Lawton, 1989). Older individuals often must either adapt their environments or relocate to more supportive living arrangements in order to maintain behavior because of the decrements in personal competence. Considering PWD are much more vulnerable to their surroundings, understanding this relationship is even more important to providing quality care.

Lawton’s person-environment fit theory is founded on the various ideas regarding the relationship between person and environment. The commonly known equation about this relationship is that behavior is a function of both the person and their environment (B= f(P, E)) (Lewin, 1935). This equation was actually expanded to include the interaction between the person and their environment as another factor represented by P x E (B= f(P, E, P x E)) (Lawton, 1982). Lawton (1980) explains this interaction stating that, “the combination of subjective experience and external environment may have an effect on behavior that is in addition to and independent of either the person or the ‘objective’ environment” (p. 17). It is important to note that the term environment not only includes the physical environment but also the social environment.

At the base of this theory is a struggle for balance between autonomy and security. Parmelee and Lawton (1990) discuss the critical nature of both of these aspects in obtaining the best quality relationship between oneself and her/his environment. The challenge is that it is difficult to achieve a perfect balance between these two aspects. A feeling of security is obviously very important for any individual, but especially for those whose abilities might be compromised. At the same time, one’s ability to have some
control over her/his life is important for personal well-being. It has been found that, “...perceived lack or external locus of control has been associated with poorer adjustment, activity and physical health among older persons...” (Parmelee & Lawton, 1990, p. 466). Finding a balance between these two aspects has been a goal in caring for older adults for many years. An increase in one often leads to a decrease in the other, thus creating constant conflict. “Overly secure environments produce boredom, apathy, and withdrawal; too much autonomy leads to stress and its documented effects” (p. 468). Finding this balance is especially important in the care for people with dementia (PWD) and it is a major concern when designing environments for PWD. The problem with designing an environment for those who have memory loss is the need for increased security measures. Often it is thought that in order to have higher security, autonomy is no longer an option (Parmelee & Lawton, 1990). Even further, an institutional environment for those with dementia can actually hinder the opportunity for autonomy. It has been said that, “...institutionalization, along with the physical setting and the process of health care in nursing homes and similar environments, constitutes multiple cues that the individual is in fact helpless. These cues, coupled with environmental overpredictability and lack of opportunities for autonomous behavior may contribute to resident’s ‘mindless’ acceptance of, and behavior in accordance with, the implication that they are incompetent and dependent upon others” (Parmelee & Lawton, 1990, p. 475).

The environment creates a situation where these individuals conform to the roles that they are cued to fulfill. In fact, autonomous behaviors are found to be dependent on the support of caregivers (Baltes, Kindermann, Reisenzein & Schmid, 1987). If the actions of caregivers are independence supportive, then the resulting behaviors of older adults are those of self-care. On the other hand, dependence supportive actions by the caregivers resulted in dependent behaviors of the older adults. If opportunities for autonomy, as well as support of autonomous behaviors, are not present in an environment for a long period of time, individuals will conform to the role of helplessness and dependency (Baltes, 1995).

Langer and Rodin (1976) evaluated the impact of implementing opportunities for autonomy (i.e., personal responsibility) within a care setting. Personal responsibility appears to be an important factor in behavioral improvements for individuals with
lessened opportunity or ability to make decisions. To be specific, improvements in one’s mental alertness, participation in activities, happiness, and overall activeness were found with residents who were given responsibility for caring for a plant (Langer & Rodin, 1976). Follow-up found that the improvements remained over an 18-month time period. (Rodin & Langer, 1977). Although this evaluation was not conducted with people with dementia, the findings could have implications for the importance of autonomy among individuals with dementia.

Despite the fact that the relationship between people and their environments has been discussed for well over 30 years, Ballard et al. (2001) found that many nursing home facilities are still failing PWD. The issue could be that these facilities haven’t taken into consideration what we know works within dementia care. There is empirical evidence that special care units, which utilize the information to improve dementia care, have a positive influence on people with dementia (Colombo et al., 2007; Morgan, Stewart, D’arcy, Werezak, 2004; Weyerer, Schaufele & Hendlmeier, 2010; Zeisel et al., 2003). The development of special care units dates back to 1978 with the Weiss Pavilion, part of the Philadelphia Geriatric Center. This facility challenged much of what had been implemented in nursing home care for so long by having fewer residents and a large central area for socializing versus the typical long corridors. A year after implementation, they found improvement in several behavioral variables such as an increase in social behavior and therapeutic effectance (planned or staffed activities) and a decrease in pathological behavior (Calkins, 2003; Lawton, Fulcomer, & Kleban, 1984). Over the years advocacy and new approaches for specialized dementia care have continued to grow (Bruck, 1997; Calkins, 2003; Camp, 1999; Day & Calkins, 2002; Day, Carreon & Stump, 2000; http://www.edenalt.org; http://www.pioneernetwork.net; http://www.thegreenhouseproject.org; Misiorski, 2003; Rabig, Thomas, Kane, Cutler & McAlilly, 2006).

Three of the main movements in specialized care include the Eden Alternative, Pioneer Network and the Green House project. Dr. William Thomas started the Eden Alternative in 1991 in hopes of eradicating some of the lonely and hopeless feelings of people in long term care settings (http://www.edenalt.org). The goal of this movement is to create care settings that make life worth living through the infusion of animals, plants,
and children. The opportunity for residents to care for and interact with these elements of the environment helps to create meaning in their lives. Following Thomas in 1997, the Pioneer Network was formed to advocate for person-centered care for all older adults living in care settings (http://www.pioneernetwork.net). This group called for a culture change within traditional care so that the life of older adults, “…is life-affirming, satisfying, humane, and meaningful” (Misiorski, 2003, p.26). More recently, Thomas implemented another model known as the Green House movement. This concept further deinstitutionalized long-term care so that care is provided within a house, although the range of services provided to the residents is similar to that of a typical nursing home. The goal of this setting is to allow the residents to remain in the community, within a home-like environment, while still providing them the services they need. Green Houses allow residents to enjoy the privacy of their own bedroom and bathroom, and help them to feel at home with access to all areas of the house, while being treated as a part of a family (http://www.thegreenhouseproject.org/mission).

Despite the intentions of these movements to initiate wide-spread culture change, there is still much improvement to be made, particularly in dementia care. It is the goal of this paper to further develop the profound ideas for dementia care that have been discussed for many years. In particular, many of the ideas implemented into a Green House will serve as a basis for the care setting proposed in this paper.

**Person-Centered Care**

Tom Kitwood, through his concept of person-centered care, mainly focused on the social environment, although his theory also has implications for the physical environment. Person-centered care is an essential idea in improving dementia care. Tom Kitwood first introduced the idea of person-centered care in 1997 with his book, *Dementia Reconsidered: The Person Comes First*. He believes that instead of focusing on the disease, the focus should be on the person. In focusing on the person, caregivers are reminded of the fact that PWD are still human and still have identities. The unique nature of each individual is not something that is completely lost when diagnosed with dementia. In fact, Woods (1999) goes as far as to say that, “The person with dementia was not an object, not a vegetable, not an empty body, not a child, but an adult, who, given support, might exercise choices and respond to a respectful approach” (p. 35).
Brooker (2007) provides a simplification of person-centered care known as “VIPS.” This acronym stands for placing value on all human beings despite cognitive ability, individual approach to care, recognizing the perspective of the PWD and trying to understand it, and finally providing support for one’s psychological needs. Applying this acronym to HHH should ensure that the care is of the utmost quality for the residents with dementia.

Person-centered care is a complex framework that Edvardsson, Fetherstonhaugh and Nay (2010) wanted to understand from the point of view of residents, family, and staff. Through their qualitative study, five aspects of this type of care were identified: knowing the person, welcoming family, providing meaningful activities, being in a personalized environment, and experiencing flexibility and continuity. These aspects provide a well-rounded definition of what person-centered care includes (Edvardsson, Fetherstonhaugh & Nay, 2010).

Kitwood’s enriched model of dementia provides a unique outlook on the experience of dementia. In order to provide the best quality of care it is essential to understand the many factors that play a part in how dementia can be unique to each individual. The equation associated with this model is: NI+H+B+P+SP = Dementia. Kitwood claims that neurological impairment (NI) is merely one part of the equation for how dementia is experienced. In fact, health and physical fitness (H), one’s life history (B), her/his personality (P), and the social psychology or environment (SP) in which the PWD exists, all play a role in how the person will act, and feel throughout her/his experience of the disease (Brooker & Surr, 2005). Acknowledging the interaction of these factors, and how they each affect the experience of dementia, is essential to improve dementia care. Once caregivers understand that the experience of dementia includes more than just neurological impairment, they can capitalize on the other factors in the equation in the daily care of PWD, thereby improving the experience of dementia.

Often people with dementia are either treated like a child or are ignored because their limitations and capabilities are not fully understood. Kitwood (1990) terms this malignant social psychology. He emphasizes that caregivers aren’t intentionally harming the PWD, yet their actions ‘depersonalize’ the individual. The components of social malignant psychology are in complete opposition to the characteristics of person-centered
care. Such malignant actions include lying to the PWD in order to get her/him to do something, patronizing her/him, or even not allowing her/him to use the abilities she/he still has. Such actions can be carried out without knowing how detrimental it can be to the personhood of PWD (Kitwood, 2002). It is a common assumption that a person with dementia is only capable of expressing ill-being characteristics such as being withdrawn, unresponsive, uncommunicative, distracted, tense, and agitated, whereas many of these characteristics are merely a result of the psychosocial environment. On the contrary, Kitwood identifies well-being characteristics such as initiation of social contact, expression of desire or will and helpfulness through his observations of those with dementia (Kitwood, 1997). Kitwood (1997) emphasizes three areas that deserve particular attention in designing care for PWD. Kitwood maintains that creating an opportunity for people with dementia to feel a sense of agency, a sense of social confidence, and sense of hope are essential in designing quality care and increasing well-being. In order to do so, Kitwood emphasizes the need for staff to “focus less on what is done and more on how it is done” (Fazio, 2008, p. 156). The goal shouldn’t be to get the tasks done but instead to make it an opportunity to further support the personhood of each individual.

According to Koren (2010) there are many aspects of a person-centered environment, including resident direction (ability for residents to make choices), home-like atmosphere, close relationships, staff empowerment, collaborative decision-making (results in less staff turnover), and quality improvement processes. Koren (2010) addresses changes within both the physical and social environment, supporting the integration of Lawton’s and Kitwood’s ideas while emphasizing the fact that these changes are not simple. Addressing both the physical and social environments is important for creating a quality care environment (Calkins, 2003; Lawton, Fulcomer, & Kleban, 1984; Rader, 1995; Reimer & Keller, 2009). An evaluation of the Weiss Pavilion provides an example of how only changes in the physical environment will elicit positive results in some behavioral aspects but not in others. Positive changes were found in pathological behavior and social behavior, yet there was a decrease in self-maintenance and the number of staff engaged in resident care. The foundation behind the Weiss Pavilion focused on the physical environment such as eliminating the long
hallways and color-coding areas. There was a lack of attention to the social environment. Thus with changes in both the social and physical environments improvement on more variables would have been possible (Lawton, Fulcomer, & Kleban, 1984). The evaluation of the Weiss Pavilion provides support as to why changes in both environments are necessary to develop an ideal care setting. The next two sections discuss empirical research regarding the role that the social and physical environments play in implementing person-centered care.

*Person-Centered Care: The Social Environment*

Person-centered care can and should be incorporated into all areas of a care setting, although as stated previously it is not simple to provide this type of care. Four main aspects essential to implement and maintain person-centered social interactions include: a) providing choices and preferences, b) supporting independence, c) promoting social interaction, and d) showing respect (Reimer & Keller, 2009). These categories must be accepted and implemented by the care staff.

The staff of a care setting are the key players in developing and maintaining a person-centered social environment. Woods (1999) emphasizes how person-centered care can make a difference in how the staff interacts with PWD. Instead of the belief that PWD have no opinion or understanding of their identities, the staff should not only ask their opinion but also seek to learn details about who they are. This would help to expel the aspects of Kitwood’s (1990) malignant social psychology and instead build upon a person-centered environment. At one point the PWD will no longer be able to express her/his life experiences verbally and it is at this point that it is extremely important for those caring for them to be able to include aspects of her/his past within the framework of her/his care. Hofland (1994) emphasizes how problematic it can be to discount the opinions of those with dementia merely because they have this disease. Taking the time to ask the opinion of a PWD or incorporating her/his unique identity into the care is an essential part of developing a person-centered social environment.

In addition, the activities and daily care must be modified to fully incorporate person-centered care. There is a great body of literature that supports the benefits of person-centered care for the social environment of PWD living in care settings (Curle & Keller, 2010; Geboy, 2009; Hofland, 1994; Nijs, de Graaf, Kok & van Staveren, 2006;
Reimer & Keller, 2009; Sloane et al., 2004). Several examples of this research are highlighted below.

Person-centered care is especially important for staff to implement into daily care. “Pleasant dining experiences are created when staff value the social aspect of meals and find ways to honor residents as individuals” (Reimer & Keller, 2009, p. 328). Reimer and Keller reviewed Nijs, de Graaf, Kok and van Staveren (2006) who incorporated these interactions between staff and residents into mealtimes. In addition, the interventions in this study included food placed on the tables and served in casserole dishes, and allowing residents to choose what they wanted to eat. The results show that there was a significant improvement within the intervention group as malnourishment decreased from 17% to 4%, whereas malnourishment in the control group actually increased from 11% to 23%.

Some residents may need assistance during mealtimes and this is the perfect opportunity to support autonomy, thus aiding in the constant struggle between autonomy and safety. It is essential to determine the exact level of assistance that the individual might need, as too much assistance can be demeaning, whereas not enough can result in either frustration or even malnutrition. This difficulty in finding a balance was identified initially by Lawton (1989). He claimed that,

“Regardless of the level of competence of the person, appropriately expanding the opportunities for choice and other forms of environmental flexibility is likely to give the older person an increased chance to be behaviorally proactive and affectively self-regulating and, therefore, to be most successful in enhancing positive affect” (p. 160).

The balance between overcompensation and under compensation of a person’s cognitive decline is extremely important when considering quality of care.

Person-centered care applied to bathing has been shown to have a positive impact (Hoeffer et al., 2006; Rader et al., 2006; Sloane et al., 2004). Sloane et al. (2004) conducted a study to determine the benefits of applying person-centered care to bathing for PWD. Two different types of person-centered bathing were compared to typical bathing practices. One bathing practice was a shower that was personalized for each resident. Tactics to emphasize individuality included providing choices, covering the resident with towels to keep them warm, using bath products, or modifying the water spray. The second was a towel bath in the individuals' room, which entailed massaging
warm water and no-rinse soap into the residents’ skin to make them clean. The resident remains covered at all times during the in-bed method. The results showed definite improvement, compared to traditional bathing, both in a decrease of aggression and of agitation in both types of person-centered bathing, with the residents who received a towel bath in bed showing slightly less discomfort. Although person-centered care has been shown to be beneficial in bathing practices it should also be implemented into other aspects of care.

*Person-Centered Care: The Physical Environment*

Providing person-centered care also depends extensively on the physical environment. One must feel comfortable in her/his environment and the environment must support their personal needs. Thus, people with dementia must be allowed to express their personality by choosing what they want to put in their room and how they want to arrange it. The opportunity to have control over one’s environment seems to be an important factor to implementing person-centered care (Felton & Kahana, 1974; Hofland, 1994; Moos & Lemke, 1985; Moos & Lemke, 1994). Allowing the residents to have control over these various aspects of their room will promote a person-centered care environment as well as create an environment where the person and environment “fit” together, thus resulting in positive outcomes. Hofland (1994) discusses the need for residents to have control within their private living areas. For example, he emphasizes the need for a person with dementia to be able to control her or his own lights and heating as well as have the ability to lock her/his bedroom door. The decorations and furniture within their personal environment are also an essential aspect of providing person-centered care.

Environmental preferences are another important concept to address within the physical environment (Kahana, 1975; Kahana, 1982; Kahana & Kahana, 1983). Kahana (1975) introduced the idea of congruence between a person and their environment. In particular they focused on the preferences a person might have within the environment and how important it is to the well-being of older adults for their preferences to be incorporated. These preferences not only include aspects of the environment that the older adults actually like or don’t like but also include aspects of the environment that meet their needs. Incorporating these environmental preferences is an essential step to
person-centered care. This is an example of the convergence of p-e fit and person-centered care.

Reimer and Keller (2009) address environmental preferences of PWD and claim that it is essential to provide smaller dining rooms with home-like features in order to minimize overstimulation during mealtime. These authors reviewed an observation study done in retirement homes by Curle and Keller (2010) that found that the physical environment did play a significant role in how social residents were with their tablemates. They found that those residents who sat closer to a busy hallway or to the entrance of the care setting were either distracted from conversations or were actually more social by using these distractions as conversational starters. This variation provides more support for a person-centered approach to mealtimes in that some residents might thrive on being set near commotion but for others it might be too distracting. The noise level was also found to be a significant factor in how socially engaged individuals were during meals. If the noise was too loud then the residents couldn’t hear sufficiently to engage in conversations. Thus the background noise such as music or other conversations must be monitored to ensure that the physical environment is supportive of the individuals needs (Curle & Keller, 2010).

There are many aspects involved in creating a person-centered environment within a care setting. Developing this type of environment can be even more difficult for people with dementia as they often have a difficult time expressing their desires. Thus it is important to learn individual desires early on before the disease takes away the ability to express them as well as to work with the families to fully understand each PWD. Even still, this is not always possible and therefore it is up to the staff to pay particular attention to the likes and dislikes of the resident as they care for them. The staff within a care setting plays a significant role in creating and maintaining such an environment and thus proper training is essential. With proper training of the staff, in addition to a physical environment designed with the qualities of the residents in mind, person-centered care can be achieved.

The integration of Lawton’s and Kitwood’s perspectives, as well as social and physical environments, is essential to improve quality of care for PWD. In conjunction with the integration of these theories, this paper is grounded in three core principles
which are developed based on an extensive literature review: a) continuation of identity beyond cognitive decline, b) creating and sustaining meaning in life, and c) creating a home-like environment. Following is a thorough explanation of these principles and how they should be addressed within the physical and social environments of a care setting.

**Core Principles**

A considerable amount of literature addresses what needs to change in dementia care and how to incorporate these changes. Based on an extensive literature review, theories of person-environment relations and person-centered care provide the foundation for three main principles that are essential to improve dementia care: a) continuation of identity beyond cognitive decline (Caddell & Clare, 2010; Cohen-Mansfield, Golander & Arnheim, 2000; Fazio, 2008; Fazio & Mitchell, 2009; Jennings, 2009; Myser, 2007; Sabat, 1992; Sabat, 1999; Sabat, 2002; Small, Geldart, Gutman & Scott, 1998; Tappen, Williams, Fishman & Touhy, 1999; Touhy, 2004), b) creating and sustaining meaning in life for PWD (Harmer & Orrell, 2008; Phinney, Chaudhury & O’Connor, 2007; Edvardsson, Fetherstonhaugh & Nay, 2010; Netten, 1993), and c) creating a home-like environment (Cohen-Mansfield & Werner, 1998; Robinson, Reid & Cooke, 2010; Verbeek, van Rossum, Zwakhalen, Kempen & Hamers, 2008). These three principles serve as the foundation for the dementia facility proposed in this paper. The relationships of these principles to Lawton and Kitwood’s theoretical frameworks, and how each principle applies to the social and physical environment of the proposed dementia care facility, are explored in the following sections.

**Continuation of Identity beyond Cognitive Decline**

Providing person-centered care and the continuation of identity beyond cognitive decline are related. Before attempting to develop a person-centered care environment, a complete understanding of identity in PWD is necessary. A person with dementia must be recognized as a person rather than as a “carrier” of the disease. In fact, much literature focuses on the continuation of identity despite cognitive decline (Caddell & Clare, 2010; Cohen-Mansfield, Golander & Arnheim, 2000; Fazio, 2008; Fazio & Mitchell, 2009; Jennings, 2009; Myser, 2007; Sabat, 1992; Sabat, 1999; Sabat, 2002; Small, Geldart, Gutman & Scott, 1998; Tappen, Williams, Fishman & Touhy, 1999; Touhy, 2004).
Understanding that identity can continue even as the disease progresses serves as a basis for why person-centered care is important. The staff and their interactions with residents, in addition to certain aspects within the physical environment, can both support this principle. Once the staff believes and understands that PWD still have an identity, proper care can be provided.

Evidence of Continuation of Identity

Often people with dementia aren’t given the respect they deserve due to a misunderstanding of how cognitive decline affects their identity. Some believe that PWD have nothing to offer to society. This perspective results in poor quality of care. One individual who holds this belief is Cooley (2007). He states, “selfhood includes rationality in addition to ‘the capacity to have feelings and to be aware of them…and to enter into relationships with others’” (p. 41). Although it can be argued that this disease steals a person’s ability to be rational, in contrast to Cooley’s assertion, numerous researchers believe that PWD are still capable of having feelings and entering into relationships with others (Kutner, Brown, Stavisky, Clark & Green, 2000; McFadden, Ingram & Baldauf, 2001; Russell, 1996). Based on the work of these latter researchers, selfhood is still very apparent in PWD, possibly even into the very late stages of the disease.

There is evidence that at least some aspects of identity remain throughout the duration of the disease. As early as 2003, Moore and Hollett stated “this destructive assumption about loss of personhood is not supported by research or by theories based on the human science perspective” (p. 163). Six years later Caddell and Clare (2010) review both qualitative and quantitative studies and the consensus is that some aspects of identity remain beyond cognitive decline. A person’s identity isn’t completely lost until death.

Cohen-Mansfield, Golander, and Arnheim (2000) looked at different role identities among individuals with dementia, including professional, family-role, leisure activities, and personal attributes. The criteria required the participants to have had dementia for at least 6 months. Through interviews with residents, family, and staff they looked at past roles and how well these roles are presently internalized. Overall the family role was the most prevalent identity that remained yet it did vary based on the person, likely depending on which role had been the most important in his/her life.
Regardless, the degree of these roles was lower in the present than in the past, signifying that the dementia has affected, but not eliminated, aspects of one’s identity.

Despite the unknowns, a person with dementia still has self-identity and thus should be treated as such (Caddell & Clare, 2010; Cohen-Mansfield, Golander & Arnheim, 2000; Fazio, 2008; Fazio & Mitchell, 2009; Jennings, 2009; Myser, 2007; Sabat, 1992; Sabat, 1999; Sabat, 2002; Small, Geldart, Gutman & Scott, 1998; Tappen, Williams, Fishman & Touhy, 1999; Touhy, 2004). A facility must be founded upon the idea that PWD still hold an identity. The staff must be trained to support the resident’s identity, the daily care must be carried out with this principle in mind, and experiences must be designed so that the resident’s identity is incorporated.

Continuation of Identity: The Social Environment

Caregivers or staff, which will be used interchangeably throughout this paper, play an important role in maintaining the identity of a PWD, as sometimes the PWD needs a little help in claiming his or her identity due to the disease (Fazio, 2008; Myser, 2007; Westius, Kallenberg & Norberg, 2010). Fazio (2008) emphasizes the ideas of Kitwood, and says “Persons with dementia need others to ‘hold their story’ and to respond to them as ‘thou in the uniqueness of their being” (p. 156). Myser (2007) emphasizes the need for family and society to help to “re-construct and restore”…. “the ‘fading personhood’ of a soon-to-be demented adult” (p. 58). Although much of the supporting literature for this principle addresses the concept of personhood or selfhood, they are in fact supportive of or even synonymous with the concept of identity. Thus, in this context, identity, personhood, and selfhood are used interchangeably. The relationship between these terms is important to comprehend in order to see the connection between the continuation of identity, and Kitwood’s person-centered care.

Many think that once people with dementia reach a certain point they are no longer themselves because the disease has taken over, yet it may just be that they need a little more help in defining who they are. “One of the most powerful assumptions in our habitual way of thinking and feeling about dementia is that the erosion and loss of brain function precludes relationality in a deep sense and hence precludes being a social persona and having a social identity” (Jennings, 2009, p. 427). This type of thinking can be extremely detrimental to quality dementia care (i.e., safety, privacy, choice,
interpersonal relationships and comfort). If cognitive loss is thought to also bring a loss of identity, then it is easy to dismiss the need for personalized care, as each person with dementia can be considered the same. Touhy (2004) voices this concern: “If viewed as ex-people, empty shells and bodies from which personhood has been removed, how can we expect caregivers to establish meaningful relationships or to design therapeutic interventions?” (p. 44). Sadly, those with dementia are often ignored in care settings because of the assumption that they have either lost or are in the process of losing their identities. Even so, there has been much research that states otherwise.

Every interaction within a care setting can support identity. These interactions could be during daily care, or during social activities. There are many opportunities to build this principle into a care setting (Briller, Proffitt, Perez & Calkins, 2001; Briller, Proffitt, Perez, Calkins & Marsden, 2001; Hung & Chaudhury, 2011; Marsden, Briller, Calkins & Proffitt, 2001; Perez, Proffitt & Calkins, 2001). Hung and Chaudhury (2011) address specifically how mealtimes can adapt to support identity within PWD. “As mealtimes offer a means to make connections between the staff and the residents, dementia care experts suggest that the seemingly mundane dining experience could have potential to create extraordinary avenues of supporting personhood and enhancing quality of life in residents” (p. 2). Several themes arise from this ethnographic study that when implemented into a care setting would support the identity of PWD. Examples include providing a relaxed environment where questions and answers are respected and answered, stimulation, respect, inclusion, validation, connection, and empowerment (Hung & Chaudhury, 2011). These themes essentially apply to all interactions in a care setting, including bathing, getting dressed and the experiences designed for PWD.

Continuation of Identity: The Physical Environment

Creating a physical environment that supports the continued identity in people with dementia, relates to person-centered care, creating and maintaining meaning in life, and creating a home-like environment. Many of the same physical environment features discussed in these sections also support the identity of PWD. Such features include, personalizing bedrooms (Calkins, 2003; Netten, 1993), supporting the independence and abilities that PWD still have (Reimer & Keller, 2009), and providing a domestic kitchen
for the residents to fix themselves a snack or get a drink, just as they would at home (Cohen & Weisman, 1991; Davis, Byers, Nay & Koch, 2009).

Davis, Byers, Nay and Koch (2009) discuss a particular physical feature, known as life-skill stations that can be supportive of one’s identity. These life skill stations have been a recent addition to care settings for PWD and are meant to be comforting and reminiscent of who the individuals were and what they did, before they moved to a care setting. Life skill stations might include a carpenter’s workbench, a vanity/make up station, an office station, and possibly even a nursery for some women to reminisce of maternal instincts (Moschner & Greer, 2001). Davis, Byers, Nay, and Koch (2009) discuss how the office station could include stationary, envelopes, and other typical office supplies to make the station more realistic. Moschner and Greer (2001) emphasize that, “life skill stations encourage residents’ minds to focus on experiences from earlier times in their lives, improving their demeanor as they gain a sense of purpose through the familiar activities,” (p. 36). The use of life skill stations has recently become more popular within dementia care settings due to the impact on residents’ identities and purpose.

The continuation of identity despite cognitive decline is an important component of providing quality care. Although the identity of those with dementia is shown through research to remain somewhat intact throughout the course of the disease (Caddell & Clare, 2010; Cohen-Mansfield, Golander & Arnheim, 2000; Fazio, 2008; Fazio & Mitchell, 2009; Jennings, 2009; Myser, 2007; Sabat, 1992; Sabat, 1999; Sabat, 2002; Small, Geldart, Gutman & Scott, 1998; Tappen, Williams, Fishman & Touhy, 1999; Touhy, 2004), help from others is also shown to be extremely beneficial in supporting this identity (Fazio, 2008; Myser, 2007; Westius, Kallenber & Norberg, 2010). In addition, specific additions to the physical environment, such as life skill stations, can have a positive impact on, and be supportive of one’s continued identity (Davis, Byers, Nay & Koch, 2009; Moschner & Greer, 2001).

Creating and Sustaining Meaning in Life

Finding meaning in life is extremely important. Often, the daily life of a person with dementia is extremely monotonous when living in a care setting. Meaning can be different for every person, yet it is something that brings about enjoyment, connection
and belonging, as well as autonomy and identity (Phinney, Chaudhury & O'Connor, 2007). According to a study by Harmer and Orrell (2008) in which the majority of the residents interviewed had moderate dementia, some residents claimed, “days were monotonous, with little to do, poor quality interactions and they felt restricted by the environment” (p. 552). It is essential to understand that every person is unique and therefore what is meaningful to one person may not be meaningful to another person. This idea supports the fact that creating and sustaining meaning in life is a subset of the person-centered care principle. Determining an all-encompassing way to create meaning in a care setting will not be sufficient, as people with dementia are different and thus need varied opportunities for finding meaning in their lives. Understanding what is meaningful for residents depends partially on their life stories, and partially on knowing who the individuals are now. Residents’ life stories can provide insight into meaning but they are not the whole picture considering that PWD change, not only because of the disease, but also due to the normal personal development process. Although creating meaningful opportunities within a care setting is not an easy task, it will help to improve the quality of life for those with dementia.

Creating and Sustaining Meaning in Life: The Social Environment

Part of the difficulty in developing meaningful opportunities for people with dementia is the fact that every person is unique. Even so, Phinney, Chaudhury and O’Connor (2007) conducted a study on PWD in the early to middle stages of the disease to determine what constitutes “meaningful” and to understand why something is considered meaningful. The results show that there are four categories of meaningful activities: a) leisure and recreation, b) household chores, c) social involvements, and d) work-related activities. These activities can also be thought of as different occupations, which according to Brooker and Surr (2005) are one of the key psychological needs of PWD. Occupations provide an opportunity for PWD to be “…involved in the process of life” (p. 31).

Phinney, Chaudhury and O’Connor (2007) also sought to determine why having such meaningful activities in life is important for individuals with dementia. The PWD’s responses were compiled into three categories: a) enjoyment and pleasure, b) connection and belonging, and c) autonomy and identity. Similarly, in a different study of residents,
staff, and families, Harmer and Orrell (2008) found that a meaningful activity was one that brought enjoyment, a sense of identity, and a sense of belonging. Each of these categories is very similar to what has been found to be important in quality of life for PWD. “The QOL literature indicates that preserving the ability to experience positive emotions and the absence of depressed mood and anxiety are important for PWD” (Kwasky, Harrison & Whall, 2010, p. 191). Providing meaningful activities for the residents can be a key aspect in increasing the positive emotions and thus the quality of life for PWD.

Typically once a person with dementia moves into a care setting, routine activities are offered on a daily basis. A staff member interviewed during Harmer and Orrell’s (2008) study states, “We have an activities coordinator who arranges things for them to do, for those who can participate…I think if residents could appreciate that activities is a therapy…that it is helpful for them to engage in activities…” (p. 553). The problem with this thinking is that the staff member equates meaningful with therapeutic and from the previous studies of PWD there seems to be a lot more to creating meaningful opportunities such as enjoyment, supporting identity and belonging (Edvardsson, Fetherstonhaugh & Nay, 2010; Phinney, Chaudhury & O’Connor, 2007).

Creating and Sustaining Meaning in Life: The Physical Environment

Personalization of the physical environment influences the ability to create and sustain meaning in life for those with dementia. Lawton’s early ideas emphasized the importance of personalization within care settings. Personal items signify what has been important to an individual throughout her/his life (Calkins, 2003). By incorporating personal belongings into his/her bedroom, he/she will be much more likely to engage with the surroundings. Thus the environment of a care setting must provide an opportunity for PWD to feel good enough about themself and their situation to find meaning in things. “The degree to which residents have personalized their bedrooms may reflect how they feel about being in residential care and/or affect how they feel about being in residential care” (Netten, 1993, p. 20). Residents who are further along in their dementia probably won’t be able to personalize the room themselves. Therefore help from family or friends will be important. It might be that having familiar belongings around leads to more positive feelings. Regardless, if residents are comfortable in their
environment then they are more likely going to be able to find meaning in their activities. On the contrary, “apathy and socially disturbed behavior, however, do provide likely alternative reactions to difficult or understimulating situations” (Netten, 1993, p. 21). In support of Lawton’s model, individuals respond based on their surroundings and thus environment is incredibly influential in creating and sustaining meaning in life.

The principle of creating and sustaining meaning in life is essential to incorporate into any care setting. As discussed, creating meaning is influenced both by the social environment of activities and care staff, and the physical environment of the care setting. At the foundation of creating and sustaining meaning is a properly trained staff. The staff must seek out opportunities to daily create meaningful situations for the residents. With support from the care staff, and a physical environment that incorporates personalization, meaning in life can still exist in a care setting. By incorporating meaning into a care setting, quality of life for the residents should correspondingly improve.

Creating a Home-Like Environment

In conjunction with culture change that was initiated well over 20 years ago (Calkins, 1988; Kitwood, 1997; Koren, 2010; Power, 2010; Rader, 1995; Thomas, 1994), there has been a movement away from institutional care and toward home-like care (Baker, 2007; Cohen & Weisman, 1991; Day & Calkins, 2002; Marsden, Briller, Calkins, Proffitt, 2001; Verbeek, van Rossum, Zwikhalen, Kempen & Hamers, 2008). When people move into a care setting the relocation can be troubling and the interaction between the care staff and residents plays a significant role in how at home residents feel (Moore, 1999; Robinson, Reid & Cooke, 2010). Incorporating home-like aspects, such as personal furniture and domestic decorations, into the care setting can also help ease the transition (Cohen & Weisman, 1991; Marsden, Briller, Calkins & Proffitt, 2001). In fact, home-like environments within care settings have been shown to improve well-being for residents (Cohen-Mansfield & Werner, 1998; McAllister & Silverman, 1999; Schwarz, Chaudhury & Tofle, 2004; Sloane et al., 1998). Although, “Noninstitutional design offers reduced benefits, however, if not coupled with supportive caregiving practices,” (Day & Calkins, 2002). It is both the social and physical aspects of a care setting that must be addressed in order to properly provide a home-like environment. Following will be a
discussion of the social and physical environments and the literature regarding their importance in a home-like dementia care setting.

Creating a Home-like Environment: The Social Environment

A home-like environment must include proper organizational characteristics and a care staff that emphasizes home-like experiences. Within institutional settings, the daily life of residents is usually run on a schedule. Residents are woken up at a specific time, they eat at defined times, and are given showers based on a schedule. There isn’t much opportunity for the residents to voice when they want to engage in these daily tasks. This is in opposition to residents’ homes before they moved into a care setting. Therefore in order to provide a home-like environment, the residents are given choices, and allowed the freedom to engage in these tasks when they want to. Eliminating a daily schedule is very important for a home-like atmosphere (Briller & Calkins, 2000).

Relationships are another important aspect of a home-like social environment (Calkins, 2001; Carboni, 1990; Groger, 1995; Robinson, Reid & Cooke, 2010). A study by Robinson, Reid and Cooke (2010) looked at the impact on residents of moving from typical care settings to dementia care cottages. In particular they wanted to determine what is was that made a care setting feel home-like. Many of those interviewed emphasized that beyond the physical environment of the cottages there needed to be relationships between the staff, families, and residents in order for the cottages to feel like home. Even still, it is more than just relationships; it is every aspect of the social environment. “It is the patterns of activities and interactions, the ways meals are prepared and served, and opportunities for greater control and privacy which are typical at home but exist to a lesser degree in other settings, that make a place like home” (Calkins, 2001, p. S75). Although making a care setting feel like home is important to the quality of life for people with dementia, it can be extensive as it does necessitate changes in both the physical and social environments.

Creating a Home-like Environment: The Physical Environment

Implementing a home-like atmosphere is generally accomplished by making changes to the physical environment. From the private bedrooms to the living rooms and kitchen, there are many opportunities to support the feeling of home. Furniture from home can be brought to furnish one’s bedroom and to make a resident feel more
comfortable (Cohen & Weisman, 1991; Marsden, Briller, Calkins & Proffitt, 2001). The ability to decorate one’s room exercises autonomy and choice, which are very important to encourage in PWD (Langer & Rodin, 1976; Parmelee and Lawton, 1990). A domestic kitchen is another essential part to creating a home-like environment (Cohen & Weisman, 1991). Beyond having home-like appliances and decorations within the kitchen, making it accessible at all times is important. Within residents own homes they were able to go into their kitchen whenever they would like and fix a snack or get a drink; therefore this should be allowed in a care setting. Living rooms and dining rooms with residential looking furniture, flooring, and decorations, also aids in the development of a home-like environment (Marsden, Briller, Calkins & Proffitt, 2001).

Cohen-Mansfield and Werner (1998) conducted a study to determine whether implementing a home-like physical environment would improve the lives of PWD in a care setting. In particular they focused on what effect such an environment would have on wandering. They found that the residents spent much more time in these areas and thus it reduced the amount of wandering. They also found a statistically higher level of observed pleasure between baseline and during intervention. These results are promising as to the benefits of implementing a home-like physical environment.

The principle of creating a home-like environment ties directly into the previously discussed theoretical frameworks and core principles. In fact the previous concepts all serve as a foundation for why a home-like environment is important, as well as how to implement one. At its core, implementing aspects of home into a care setting helps to create a better fit between a person and his/her environment. If the environment is familiar and the resident feels comfortable, he/she is more likely to have increased contentment and positive social interaction (Cohen-Masfield & Werner, 1998). In addition, creating a person-centered care environment, and creating and sustaining meaning in life both correlate directly with the principle of a home-like environment. Having the opportunity to personalize one’s space not only can increase the feeling of home but it also emphasizes a person-centered approach. It emphasizes the identity of the person over that of a patient, and allows for his/her preferences to be included in the environment. Also, when a resident has a personalized space, he/she is more likely to be able to find meaning in his/her daily life. The relationships between the different
theoretical frameworks and core principles support an integrative approach to providing quality dementia care.

The next section will present a proposal for a dementia care facility, Hart’s Home Away From Home (HHH). This proposal uses the ideas of Lawton’s p-e fit, and Kitwood’s person-centered care as its foundation. In addition, every aspect of HHH is grounded in the three core principles discussed previously: a) continuation of identity beyond cognitive decline, b) creating and sustaining meaning in life, and c) creating a home-like environment.

Proposal for Hart’s Home Away From Home

Hart’s Home Away From Home (HHH) is a care setting designed specifically for people in all stages of dementia. Those residents in the final stages of the disease have the choice to remain at HHH and continue to receive personalized care until the end of their life. Because HHH does not have the capability to provide IV fluids or feeding tubes, those residents who desire and require these types of care will have to move to another location. As HHH is a private pay facility, it is important to note that if a resident’s personal funds run out she/he will be required to move to a different care setting that she/he can afford. The foundation for HHH is Lawton’s person-environment fit theory, Kitwood’s person-centered care and the three previously discussed core principles of continuation of identity beyond cognitive decline, creating and maintaining meaning in life, and creating a home-like environment.

Following is a discussion of the physical design of HHH. A detailed description of each area within the facility is provided. Rough estimates of the cost of the facility and staffing are then provided. Subsequently there is a discussion of the staff selection, hiring process, and training for HHH. Finally, a thorough discussion of the ideas behind creating meaningful experiences within the facility as well as examples of what these experiences might look like is presented. The role that families play in HHH will be discussed throughout the different sections as appropriate.

Before launching into the detailed description of HHH, a caveat is in order. Without question HHH and other dementia-specific facilities are designed to provide individuals with dementia with the greatest quality of life possible. At the same time, however, the availability of these settings removes these individuals from the larger
society, which can have negative consequences for members of the larger society. It is hoped that facilities such as HHH can provide models of care that ultimately extend beyond specialized care settings so that individuals with dementia are well-integrated into the community and maintain high levels of well-being.

**Physical Environment**

Lawton’s person-environment fit theory, emphasizes the importance of one’s environment for her/his personal well-being, and therefore is a key factor in the physical design of HHH. Designing a physical environment is the first essential aspect in providing quality care for people with dementia. Many areas within the physical layout must be designed and built specifically for PWD. Although each area of HHH will be discussed in detail, the overall layout and design of the facility deserves attention first. This is followed by discussion of the private areas of HHH including the bedrooms, private bathrooms, and staff relaxation area. Next is a discussion of the semi private/semi public areas including the communal bathrooms, the dining nooks, and small living areas. Subsequently the public areas will be explored (Altman, 1975).

**Overall Layout**

A drawing of the layout of HHH can be found in Appendix 1. The shape of the facility is that of an octagon stretched horizontally, similar to that of the Corinne Dolan Alzheimer Center at Heather Hill in Chardon, OH. The layout is open with bedroom doors opening to common areas such as a living room or experience room (Calkins, 1988; Cohen & Day, 1993). There are two dining rooms, one on the left of the octagon and one on the right. The kitchens accompanying both dining rooms back up to the central courtyard. The central living and experience rooms are also adjacent to the central courtyard, thus ensuring that lots of natural sunlight enters the facility (Briller, Proffitt, Perez & Calkins, 2001). This facility has 30 single bedrooms, each with its own personal bathroom and shower. There are also communal bathrooms near the central living, dining, and social areas. The doors of the bathrooms are painted a color different from the walls as well as have signs on them that have a picture of a toilet and the word “toilet” written on them. The background of the signs and the words are in contrasting colors so that the residents can easily read them (Briller, Proffitt, Perez, Calkins & Marsden, 2001; Calkins, 1988). These decisions are made to help create autonomy for the residents and to
ensure that the environment supports the person’s needs. These factors will assist the residents in finding the restrooms by themselves and in support of person-centered care will provide respect and dignity for the residents.

Each room in the facility follows the same basic guidelines in regard to the types of paint and floor colors. Even so, the specific colors and decorations will be unique to each room in support of a home-like atmosphere. No two rooms are identical in a home and thus no two rooms are identical at HHH. The personalization of the residents’ rooms will be discussed in a subsequent section dedicated to this particular area of the facility. In regards to the shared spaces within HHH, the flooring is light colored. It has been found that people with dementia can sometimes mistake dark flooring for a hole and thus they won’t walk on it (Briller, Proffitt, Perez, Calkins & Marsden, 2001). Some rooms, including the kitchen and dining room, will often have food or drinks spilled on them. These rooms have resilient floors that look like hardwood floors, as this is easier to clean, whereas the rest of the shared spaces are carpeted as to support a home-like atmosphere (Briller, Proffitt, Perez, Calkins & Marsden, 2001; Calkins, 1988, Marsden, Briller, Calkins & Proffitt, 2001).

With respect to lighting, the majority of older adults suffer some level of eyesight loss and it is essential to accommodate for this loss in a care setting. It has been found that indirect lighting provides the greatest light coverage without shadows (Briller, Proffitt, Perez & Calkins, 2001; “Lighting for Older Eyes”, 2003). Briller, Proffitt, Perez and Calkins (2001) claim that this type of lighting “can provide a quiet and cool ambience” (p. 12). The indirect lighting in HHH is created using cove lighting. The fixtures are attached to the wall and the light reflects upwards onto the ceiling, and then reflects back down to light the entire room with diffused light. Because of the fact that indirect lighting results in less visual contrast there is supplemental lighting in each room as well. This includes several small chandeliers in the dining room and lamps in sitting spaces (Briller, Proffitt, Perez & Calkins, 2001).

**Private Areas**

**Resident Rooms and Bathrooms**

In the absence of research regarding optimal room sizes for PWD, HHH provides a personal living space of 10X16 for each resident. This size is comparable to the
bedroom size provided in Green Houses ([http://www.thegreenhouseproject.org/faqs](http://www.thegreenhouseproject.org/faqs)). As this is the only completely private space that residents have at HHH, it is important to provide as much space as possible, without compromising the refuge aspect of a bedroom. Too large of a room could be considered overwhelming. In addition, this size will allow residents who are in wheelchairs plenty of room to maneuver throughout their bedroom.

In order for a resident to be able to identify which room is his/hers, a sign on each door will have his/her name on it. These signs are brightly colored with a contrasting background and letter color, and are placed flat on the front of the door (Briller, Proffitt, Perez, Calkins & Marsden, 2001; Gross et al., 2004). As sometimes the door might be propped open, each resident also has his/her own shadow box hung right next to the doorframe of the room. Within the box, a resident and his/her family may put keepsakes and pictures that the resident might be able to identify as his/her own. These shadow boxes will not only help a resident find his/her room but it also incorporates the identity of the resident into the physical environment (Gross et al., 2004; Namazi, Rosner & Rechlin, 1991). These boxes are locked to ensure that other residents do not remove the possessions (Cohen & Day, 1993). The use of these boxes will be optional and can be removed for residents who decide to not put pictures and/or other familiar objects within them. Directly above the shadow box another colorful nameplate (with the resident’s name on both sides) is hung perpendicular to the wall so that the resident can identify her/his room as she/he is coming toward the room from either direction. In order to comply with ADA guidelines the shadow box and perpendicular sign don’t protrude from the wall more than 4 inches. The shadow box is hung 60 inches from the floor to its center ([http://www.access-board.gov/adaag/html/](http://www.access-board.gov/adaag/html/)). Sometimes the need for way finding cues, as well as the benefits to the self-esteem of a resident finding his/her bedroom on his/her own, outweighs any privacy concerns with providing such cues (Marsden, Briller, Calkins & Proffitt, 2001).

The color scheme of each resident’s room and bathroom is another opportunity for personalization. Several different options of color schemes are provided to each resident prior to relocating to the facility. Brighter colors are offered as they are not only more inviting for the resident but they are also easier for the resident to see (Alvermann,
Darker colors can often be identified as holes, and/or absorb light making it more difficult for the resident to see (Briller, Proffitt, Perez, Calkins & Marsden, 2001). If the resident is not able to verbally state her/his preference, the colors will be placed before the PWD and the one that she/he interacts with the most with will be the color scheme chosen (Marsden, Briller, Calkins & Proffitt, 2001). In this context, interaction might include touching, holding onto, or even just prolonged eye contact. The opportunity for choice relates back to Kahana (1975) and the emphasis on accommodating environmental preferences.

Residents also have the ability to decorate their rooms as they desire. They may bring furniture from home and hang decorations on the walls (Cohen & Day, 1993). Families will play a significant role in the decoration process, as some residents might be at a stage within the disease where they are not able to make decorating decisions. It is essential for the residents and family to make their personal space feel like home, as they will endure a significant change in their lives during relocation. The opportunity for personalization supports the importance of one’s relationship with their environment to well-being, emphasized by Carp and Carp’s (1984) complementary/congruence model. More specifically, it will serve as a foundation for creating and maintaining meaning in the lives of the residents.

Residents have their own private bathroom and shower consistent with Kitwood’s person-centered care. Although many facilities have found that having communal bathrooms and showers helps to cut costs, the effects on residents are often not taken into consideration (Barrick, Rader, Hoeffer & Sloane, 2002; Sloane et al., 2004). Although this addition might be costly, the benefits it will have for the residents will be chosen in spite of the cost. Showering in an unfamiliar area outside of one’s own personal space is not supportive of a home-like environment. Residents also have the opportunity to personalize this space. For example, artwork from one’s home may be hung in the bathroom (Marsden, Briller, Calkins & Proffitt, 2001). Every aspect of these bathrooms is person-centered as they will be both personalized for the individual as well as support their needs and desires over an institutional nature. Receiving help to shower and/or use the toilet can be a very stressful and uncomfortable experience and thus developing a relaxing physical environment is very important. The toilet seat is a color that contrasts
with the floor and walls so that residents will be able to locate it (Briller, Proffitt, Perez, Calkins & Marsden, 2001). To ensure privacy, the bathroom has a door that can be closed and locked by residents. On the outside of the door a sign is placed that has both the words and pictures of a toilet and a shower. This sign is a darker color with white letters. The high contrast ensures the best possible visibility (Briller, Proffitt, Perez, Calkins & Marsden, 2001).

**Staff Relaxation Area**

Caring for residents with dementia can be an energy-draining experience. For the staff to be able to provide high quality of care and have the patience needed to work with PWD, it is important to provide an area for them to relax (Calkins, 1988; Cohen & Day, 1993; Cohen & Weisman, 1991). Whether a separate room for staff to retreat to has a positive or negative influence on the care provided has been the subject of debate for many years, and has yet to be resolved (Cohen & Day, 1993).

From personal experience interning at a dementia facility, in which a staff retreat area was not provided, I observed several negative consequences. Because the staff had nowhere to go during their breaks they would congregate in the day care center. Instead of engaging in conversations with the day care participants, the staff would use the time to talk on their cell phones, gossip, and converse with each other. Even the staff working in the day care actually began to ignore the participants due to conversations with those taking their breaks. These types of conversations could also be very distracting to the residents.

HHH will have a separate area for staff to relax in so as to ensure that the residents receive quality care from those staff members still working. A separate staff area will also ensure that the staff is able to relax and remove themselves from any stressors within the job. It is the intention for the staff to view the residents as friends (Bell & Troxel, 2001) or in other words, “empathizes with their situation, remains loving and positive, and is dedicated to helping the person feel safe, secure and valued” (http://bestfriendsapproach.com/about/about-the-best-friends-approach). Even still, caring for others all day long can become very tiring and stressful at times. Incorporating such an area into HHH will show the staff respect and understanding about the stresses of the
job. It will be emphasized that the purpose of this room is to allow the staff time to relax so that they are fully engaged with the residents the rest of the day.

The room has two areas, the first of which is a kitchenette with a couple of dining tables. The kitchen will have a refrigerator, a microwave, and stove for the staff to use during their breaks. The other section of the room is dedicated to relaxation. Comfortable chairs and couches are arranged around a fireplace with a television placed directly over the fireplace. The colors of this room are darker but home-like as to help the staff to relax while they are at work. Designing a room to allow the staff to relax will help them to come back after their breaks with more patience, and energy to provide a better quality of care. The use of this space will obviously be monitored so that it is used as intended and not abused.

**Semi Private/Semi Public Areas**

*Small Living Rooms*

In addition to the main living room, which is in a public area of the facility, there are two other small living room areas. Barnes (2006) found that offering different types of space was associated with greater well-being. Offering several different rooms with different levels of privacy accommodates more resident preferences and a greater range of behaviors. These smaller living rooms are for individuals who enjoy a more quiet and relaxed environment. Within these rooms there will be a small couch and a recliner along with a fireplace (Cohen & Day, 1993). These rooms are placed along the hallway between resident rooms and there will be no door to close so that residents who are wandering can always feel welcome to stop and relax. The placement of these rooms along the wandering path and the open door will increase their use. Of course it is still necessary for the use of these rooms to be emphasized by the staff members. It is possible that the rooms will not be used as intended if the staff does not initiate social experiences within these areas.

*Small Experience Areas*

The term activity will not be used within HHH due to the negative association it holds. In fact, as discussed previously “activities” are often used within care settings to keep residents busy. According to Edvardsson, Fetherstonhaugh and Nay (2010) and Phinney, Chaudhury and O’Connor (2007) the activities need to be meaningful therefore
they must be enjoyable, and support identity and belonging. In order to reject the stigma the word “activity” holds, HHH has “experience” areas instead.

In addition to the main experience area, there are two smaller areas. These are located along the hallway between resident rooms. The smaller rooms are used when just a couple of residents participate in experiences. Also if there is ever an experience going on that doesn’t interest a resident, she/he will have the opportunity to participate in something different in one of the smaller experience areas (Cohen & Day, 1993; Calkins, 1988). In addition to the designated experience areas there will also be life skill stations set up throughout HHH (Davis, Byers, Nay & Koch, 2009; Moschner & Greer, 2001). As discussed previously, these stations are supportive of both identity, and creating a purpose or meaning for the residents with dementia. Within HHH there will be an office station, a carpenter/workbench station, a nursery, a vanity/make up station and a sewing/laundry station. As it would be impossible to develop stations to accommodate all residents’ identities, these stations are considered an addition to the variety of experiences offered at HHH. The stations will be placed strategically around the facility and team members will encourage their use.

There will be three experience staff members including one director and two assistants. These team members, in addition to others, including but not limited to CNAs, RNs and administration, will be involved with experiences on a regular basis. The extra help during experiences will help to accommodate more individual desires and the various experience areas.

Dining Nooks

As there will often be residents who don’t want to or can’t eat in the main dining area due to feeling overwhelmed, or when their family comes to visit, a couple of smaller dining areas are set up around the facility adjacent to the central courtyard windows. These consist of one table with two to three chairs and will overlook the center courtyard so the residents can enjoy the outdoor view (Calkins, 1988). This option of a different dining experience supports a person-centered care model by putting the residents’ needs first.

Snoezelen Room
For those residents who are in the later stages of dementia, including the final stage, a program known as Snoezelen will be incorporated into HHH. Snoezelen is a program that uses various objects to engage the five senses. Lancioni, Cuvo and O’Reilly (2002) explained snoezelen as “…an opportunity to promote a general feeling of restoration and refreshment, which one obtains from engaging in pleasurable and stimulating activities that do not produce any pressure and can be enjoyed in full” (p. 175). Van Weert, van Dulmen, Spreeuwenberg, Ribbe and Bensing (2005) conducted a study on residents with moderate to severe dementia to determine whether snoezelen had a positive effect on their behavior and/or mood. In this study snoezelen was incorporated into 24-hour care and half of the residents had a snoezelen plan developed for them based on their preferences (particularly those regarding their senses) whereas the other half served as the control group. The plans were incorporated into the daily care and were evaluated through observation as well as video recordings. The results showed significantly less apathetic behavior, rebellion, aggressive behavior, and depression in the snoezelen group versus the control. In addition, significant improvements were seen in happiness, enjoyment, responsiveness to speaking, as well as talking more frequently, in the snoezelen group compared to the control group. These positive outcomes are promising in that snoezelen can improve the well-being of PWD in the middle to late stages of the disease. Therefore, a specific room is dedicated to this program, which focuses on sensory stimulation. The room has comfortable seating with a couch and a chair in support of a relaxing environment. There are colorful and interesting light objects placed around the room or hung on the walls. The goal is to create an environment that engages the various senses without overwhelming the residents.

All members of the team at HHH and interested family members will be trained on how to conduct a snoezelen experience for the residents. The main leaders of snoezelen will be the experience staff as well as the CNAs, although any staff or family members will have the opportunity to lead a snoezelen experience. The assistance of the majority of team members will make this experience possible. It is also important to note that experiences held within the snoezelen room do not necessarily have to be long and will typically be a one-on-one experience.

*Public Areas*
Indoor Wandering Path

Because of the open layout at HHH, the hallways will not be typical hallways, as they only have one side of walls. Where the other wall would be in a typical hallway it will open up to the dining, living, and experience areas. These hallways will be known as the wandering path, around the entire facility. Rather than the path merely being used for traveling from one area of the facility to another, it provides an interactive meaningful experience. The walls have 3-D objects hung on them that the residents can interact with. In order to encourage engagement, the objects must be interesting to the residents (Perez, Proffitt & Calkins, 2001; http://artlineltd.com/products/therapeutic-art).

The benefits of art for individuals with dementia has become a focus of study over the past several years. According to Basting (2006), although there have not been any definitive conclusions regarding the benefits of art for PWD, there are several studies that employ small samples that provide promising results (i.e., that art is beneficial for PWD). For example, Rusted, Sheppard and Waller (2006) found that PWD who participate in art therapy show steady improvement in calmness, mental acuity, sociability, and physical engagement over a 40 week time period. The art therapy group was compared to a control group who participated in recreational activities. The control group showed a drastic drop after the first ten weeks in all categories and a steady decline after that. On the other hand, the art therapy group showed a steady increase, signifying a more prolonged effect.

Kinney and Rentz (2005) highlight another example of how art benefits PWD by observing an art program known as Memories in the Making. Using the, Greater Cincinnati Chapter Well-Being Observation Tool, Kinney and Rentz observed the well-being of PWD during an art activity. The results showed that the PWD showed greater interest, pleasure, self-esteem, and normalcy, in addition to increased sustained attention. Although this literature does not specifically address the use of interactive art along the wandering paths it does highlight the general benefits of art for PWD.

Even though these objects are meant to be engaging for the residents, it is important for them to not be overwhelming, thus proper spacing along the walls is essential. The wall art/objects chosen are those that will not be a safety hazard to the residents. It will be important that pieces of these objects cannot be removed and become
a choking hazard. As a secondary precaution, the pathway wall art will be checked on a regular basis to ensure that it is intact and are not a hazard in any way.

Although it is the intention that the art/objects will initiate engagement on their own it is expected that stimulation by staff members will also be important in obtaining the most benefit from these interactive pieces. Even still, in order to obtain attention initially, the colors in the objects must be contrasting to both the floor and wall. The objects might include raised artwork or interactive objects such as a light panel or color wheel. It will be important to make these objects interesting without making them look child-like, in contrast to interactive wall art highlighted by Calkins (1988), which was reminiscent of what children play with when they are learning their shapes.

**Living Room**

The living room of HHH emphasizes both socialization and comfort. The colors of the room are bright warm colors and the furniture is large and comfortable. Couches, chairs, and tables contrast both the floor and walls to ensure the best visibility for the residents. There are recliners so that those residents who desire to nap in the living room may do so. Several warm, comfortable blankets are placed on the backs of chairs and couches for the residents’ use. These blankets will be washed every other day to ensure the utmost cleanliness. Often seating in care settings is set up in a line or in a big circle, making it difficult for residents to converse with others. Geboy (2009) discusses setting up areas of seating that are at ninety-degree angles to ensure that the residents will be able to socialize easily. Therefore the seating is arranged in several clusters of ninety-degree angles, with either two chairs together or a chair and a couch together. Having such opportunities for conversation and relationship building supports the core principal of creating and sustaining meaning in life. There is a working gas fireplace and a piano in one corner, consistent with a comfortable and home-like environment (Cohen & Day, 1993).

**Experience Areas**

The main experience area is located in a central location much like the main dining room. This area is used for experiences in which a large number of residents choose to engage. This area will have tables that seat no more than four people in order to avoid distraction and/or overstimulation (Geboy, 2009). These tables can be folded and
moved if the experience for that day does not require them. A television will be placed in this area yet it will not be used continuously as in many care facilities. The channels will be chosen by the residents and based on their interests.

_Dining Rooms_

There are two dining rooms in HHH, one on the left side of the central courtyard and the other on the right side. Both have several small tables within them. Small walls with live plants sitting on top of them divide these tables to both cut down on noise and stimulation (Calkins, 1988). Geboy (2009) claims that residents should be seated in groups of 4 to promote socialization. Any more residents at a table would be overwhelming and would likely result in withdrawal. Therefore, each table seats no more than four people (Geboy, 2009).

The tables and chairs are wooden, as this is likely similar to what residents had in their own homes. There are cushions on the seats and backs of the chairs to ensure comfort for the residents during their meals. The tables are covered with a tablecloth, and a placemat in a contrasting color will be set at each place. Consistent with person-centered care, residents will be able to choose the color placemat that they want. The plates are bright white and provide contrast from both the tablecloth and placemat. These contrasting colors will visually assist the residents (Calkins, 1988; Davis, Byers, Nay & Koch, 2009). It is also essential for the silverware to be a different color from both the placemat and plate so that residents can easily find it. Minimal silverware (typically only a fork or spoon, depending on the meal) will be provided to the residents at one time so that they don’t become confused or overwhelmed. All of these supportive additions to the meal tables provide opportunities for autonomy for the residents. Only providing the level of assistance that is absolutely necessary and allowing them to continue feeding themselves for as long as possible is respectful to their core personhood.

_Kitchen_

Directly off of each main dining room there is a small kitchen similar to the facility layout of the Corinne Dolan Alzheimer Center at Heather Hill built in Chardon, OH (Cohen & Day, 1993). These kitchens are accessible to the residents so that they may fix themselves a snack or get a drink at any point during the day. The residents will also be asked to help with food preparation and cleaning in support of creating and sustaining
meaning in their lives. The opportunity to assist those who are cooking is drawn from the Green House concept, and is supportive of a home-like environment and offers opportunity for occupation. According to Rabig, Thomas, Kane, Cutler and McAlilly (2006), the Shahbazim, which is the name for the primary caregiver at the Green House, does the cooking him or herself. The elders are able to either watch or help with the food preparation in these homes. All team members will be responsible for helping to cook meals, including nursing staff, experience staff, and the administrator. There will also be a registered dietician consultant as a part of the team to ensure that the residents receive the proper nutrition for their needs.

Due to the fact that the kitchen will be accessible to residents it is necessary to keep this area safe, and therefore precautions will be taken. There is a switch, which is disguised, that must be turned on before the stove or microwave will work. This will ensure that no foreign objects are put into a microwave and turned on and the oven is not turned on and forgotten about. In addition, objects in the kitchen that could cause harm to the residents if used improperly are placed inside of a locked cabinet. The lock will need to be hidden so as to not upset the residents more that they are locked out of something (Calkins, 1988). Allowing the residents to have access to the kitchen is not only supportive of a home-like environment but also creating and sustaining meaning in life, and the fact that identity remains beyond cognitive decline. Although some restrictions will be placed on the resident’s kitchen use to ensure safety, the restrictions are minimal and are not flaunted. The opportunity for autonomy it creates as well as its support of a resident’s identity is an essential addition to quality care.

Outside Areas

It has been suggested that outdoor areas/gardens can be very therapeutic for people with dementia in regards to their quality of life (Hernandez, 2007; Zeisel, 2007). Day and Calkins (2002) discuss the obvious increased access to sunlight, which can be important for obtaining vitamin D and sustaining one’s circadian rhythm. Research also shows that violent behaviors of PWD decreased in environments where outdoor areas were available and utilized (Mooney & Nicell, 1992). In support of the research, and the well-being of PWD, there are two separate outdoor areas for the residents to enjoy. During inclement weather inside areas will provide an opportunity for wandering.
**Central Courtyard**

The shape of HHH allows for a central courtyard with several entrances around the facility (Appendix 2). In order for residents to easily identify the entrances back into the building there are wooden pergolas at each door. These pergolas are decorated with flowers of various colors (Zeisel, 2007). Due to the fact that the walls of HHH naturally enclose this courtyard, residents will be allowed to come and go as they please (Cohen & Day, 1993). Within this courtyard there are several different areas for the residents to sit in the shade as well as a small walking path around the perimeter of the courtyard (Zeisel, 2007). There is also a shortcut path that branches off of the main path at a 90 degree angle and returns to one of the entrances to the courtyard. This provides another pathway for the residents to explore, yet this path will come out back on the original walking path so as to minimize confusion (Zeisel).

For those residents who enjoy gardening there are several raised flowerbeds to tend (Thelander, Wahlin, Olofsson, Heikkila & Sonde, 2008). In one corner of the courtyard there is a water fountain that runs down into a pool of water with fish in it. The residents have the opportunity to feed these fish on a daily basis and this will help to create meaning in their lives. The responsibility of caring for these fish fits into three of the four categories found by Phinney, Chaudhury & O’Connor (2007) to be meaningful for PWD. Caring for the fish can be considered a leisure experience, a chore, as well as an opportunity for social involvement. Not all residents will find this experience meaningful and that is why this is just one of many experience opportunities offered at HHH. For safety purposes there is a white fence placed around the pond. This fence is approximately 48 inches tall to ensure that a resident cannot climb over it. The pickets of the fence are vertical to inhibit climbing and placed 2 inches apart. This spacing allows for the residents to see through the fence but will not be large enough so that the residents might stick their hands or feet through the fence. In order to attract other wildlife, several different types of bird feeders are hung around the courtyard.

**Backyard Area**

In addition to the central courtyard there will be another large outside area behind the facility (Appendix 3). This area is fenced in with bushes, trees, and ivy hiding the fence. According to Calkins (1988), camouflaging certain areas that must be off-limits to
residents can be accomplished by continuing the wall paint color onto the door in order to limit its visibility to residents. This reasoning will be expanded to the outdoor area. Camouflaging the fence with greenery that blends in with the rest of the yard area limits the visibility of an escape. Cutting down on the visibility will also likely decrease the amount of stress felt in wanting to leave HHH.

Attached to HHH is a screened-in porch with comfortable seating for the residents. The seating on this porch follows the same rules as the living room and seating will be arranged at 90-degree angles to encourage socialization. Adjacent to the screened-in porch there is a patio. Several tables with umbrellas and a grill that will be used to cook out during warmer weather are set up here.

There is a walking trail around the perimeter of the yard area. A path down the middle of the yard serves as a shortcut from the main walking path as well as a new area for the residents to explore. There are several areas to sit around the walking path. Residents may stop and rest or just enjoy the weather. In addition to various benches and swings, there are also a couple of gazebos set up in this outdoor area. The yard is decorated with various colorful flowers, trees, and bushes.

Possible Constraints: Regulations and Budget

Each aspect of HHH’s design has a foundation in the three core principles: a) continuation of identity beyond cognitive decline, b) creating and sustaining meaning in life and c) creating a home-like environment. Due to the importance of each aspect of the design of HHH, to the quality of care for PWD, it will be essential to stay as true as possible to these ideas when the facility is developed. Of course it will be essential to abide by all state regulations for care settings. Therefore, adaptations to the design of HHH will be made in order to follow code regulations while still remaining as close to the original idea as possible so as not to lose the critical foundation in the three core principles.

The budget is an important aspect regarding the feasibility of opening HHH. Nationally, as of 2008, a nursing home with a brick exterior and load bearing walls cost approximately $99.86 per square foot. When contractor and architectural fees are included, this number increases to approximately $130 per square foot. Hart’s Home Away From Home is a single floor facility and will be approximately 25,000 square feet.
Thus just a rough cost of the frame of the facility as well as the contractor and architectural fees will be about $3,250,000. The facility will be built on an acre to an acre and a half of land. The large backyard area will be about half an acre total. There are many other costs that must be included in the budget, including furnishings, equipment and landscaping (Table 1).

An estimate of the cost of HHH can be compared to Eden Gardens, a proposal for a dementia facility in Canada (“Nanaimo travelers lodge,” n.d.). Many of the design ideas of this facility are similar to those of HHH and although it is proposed to be much larger than the size of HHH it can provide some insight into what the cost of HHH will be. The construction costs of Eden gardens, proposed to be three levels totaling approximately 125,000 square feet are, $19,200,000. Considering HHH is proposed to be about 20% of this, the cost should correlate accordingly. Thus this figure in addition to the information provided by Reed Construction data (http://www.reedconstructiondata.com/rsmeans/models/nursing-home) were both used when calculating the construction, contracting, and architectural fees for developing HHH. The landscaping costs of HHH were more similar to that of Eden Gardens because HHH will have two significant outdoor areas, lavishly landscaped with flowers, and bushes and furnished with many places to sit and enjoy the outdoors. In addition the continued maintenance of the outdoor areas will be essential. The furnishing costs proposed for HHH are also closer to that of Eden Gardens since there is a separate bathroom/shower for each resident, adding increased costs.

Table 1

<table>
<thead>
<tr>
<th>Hart's Home Away From Home Budget</th>
<th>Cost for 25,000 square feet</th>
</tr>
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<tbody>
<tr>
<td>Construction</td>
<td>$2,496,500</td>
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<tr>
<td>Contracting Fees</td>
<td>$624,250</td>
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<tr>
<td>Architectural Fees</td>
<td>$149,750</td>
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<tr>
<td>Furnishings and Equipment</td>
<td>$1,750,000</td>
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<tr>
<td>Landscape and Outdoor Areas</td>
<td>$500,000</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>$5,520,500</strong></td>
</tr>
<tr>
<td><strong>Total: 30 yr mortgage/5.5% interest Rate</strong></td>
<td><strong>$11,283,103</strong></td>
</tr>
</tbody>
</table>


The actual cost of building and developing HHH will also include purchasing land, insurance, and supplies for the facility including but not limited to food, cleaning
products, and bathing products. Funding for this facility will come from investors, fundraising, fees paid by the residents, as well as a mortgage. The mortgage amount will be spread out over approximately 30 years. Even if the entire building were mortgaged with no fundraising, the average cost of paying back this mortgage would be no more than $12,537 per year. This in addition to the cost of staff, the resident would need to pay about $68,804 per year (Table 2). Added to this amount would be the cost of food, staff training and supplies for the facility.

As of 2008, the average cost per year of private dementia care settings was $79,935 (http://www.nwhcare.com/service-cost.htm). Hart’s Home Away From Home would be competitive with this pricing when all costs are considered. The above numbers and tables serve more as a reference point as these numbers are not exact and there will obviously be fluctuation as well as additional costs. Although the cost of such a care setting can seem overwhelming, the quality of care provided to the residents is what is really important. The following section addresses the team at HHH who are the heart of providing quality care.

Table 2

<table>
<thead>
<tr>
<th>Position</th>
<th>Salary</th>
<th>Cost to Facility</th>
<th>Number needed at HHH</th>
<th>Cost Per Year</th>
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</thead>
<tbody>
<tr>
<td>Administrator</td>
<td>$100,000</td>
<td>$200,000</td>
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<td>$200,000</td>
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<tr>
<td>Experience Director</td>
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<td>CNA</td>
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<td>Maintenance</td>
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<td>Outside Hire</td>
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<td>$30,000</td>
</tr>
<tr>
<td>Housekeeping</td>
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<td>Outside Hire</td>
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<td>$30,000</td>
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<tr>
<td>Registered Dietician</td>
<td>$50,000</td>
<td>Outside Hire</td>
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<tr>
<td><strong>Total Cost of Staff/Year</strong></td>
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<tr>
<td><strong>Total Cost for Resident/Year</strong></td>
<td><strong>$56,267</strong></td>
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</table>


Team at HHH

A quality care environment cannot be developed without the support of the entire staff. Laing and Buisson found that only-one third of care settings had provided specific training to work with PWD despite the fact that over half of the residents had dementia
This lack of training is detrimental to the quality of care both deserved and needed to properly care for PWD. In order to prevent an environment where the staff does not understand the particular needs of PWD, all staff within HHH, including the maintenance, management, and nursing staff, will receive extensive training prior to beginning work. The following sections include a discussion of staffing and its influence on quality of life, the characteristics that will be considered during the hiring process at HHH, the training procedure and materials for HHH, the overall organizational culture, and family as part of the team.

Quality of Life and Staffing

As previously discussed, quality care for people with dementia depends on the physical environment, and the social environment. The care staffs’ attitudes and behaviors toward people with dementia are key in creating a quality social environment (Fazio, 2008; Kitwood, 1997; Logsdon, 2000; McCurry, 2011; Robinson & Gallagher, 2008; Sixsmith, Stilwell & Copeland, 1993; Touhy, 2004). Kitwood’s theoretical framework of person-centered care serves as a foundation for a quality care staff. The focus of the staff must be on the person and not the disease. Sixsmith, Stilwell and Copeland (1993) emphasized Kitwood’s ideas, stating “Caregiving has to go beyond something that is simply ‘done to’ a dependent person towards a person-centered approach that recognizes the individuality, complexity and diversity of the dementia experience” (p. 999). By recognizing residents’ individual natures and incorporating them into daily care, the staff will be able to provide quality care (i.e., safety, privacy, choice, interpersonal relationships and comfort).

Although the research regarding a properly trained staff and its effects on quality care is minimal, it continues to grow (Bell & McGregor, 1995; Kwasky, Harrison and Whall, 2010; Sixsmith, Stilwell & Copeland, 1993; Teitelman, Raber & Watts, 2010). According to Bell and McGregor (1995), a person-centered style of care has had very positive effects on the residents in the care setting that they founded. In fact, “They consistently report that the majority of their residents do not end up in vegetation; a significant number stabilize and maintain relatively high levels of well-being despite having severe cognitive impairments” (Kitwood, 1997, p.61). More specifically,
Teitelman, Raber and Watts, (2010) found that social support, from both care setting staff and family caregivers, was very important for occupational involvement. Through in-depth interviews and observations of several residents with dementia, they found that a lack of such support could be very hindering to one’s well being.

One of the most significant ways that team members can support the well-being of people with dementia is by creating meaningful experiences. Edvardsson, Fetherstonhaugh and Nay (2010) says, “…person-centered staff should make efforts to involve residents in the completion of tasks to make them into meaningful moments” (p. 2616). Getting a resident to help with setting the table or sweeping the floor could fulfill their desires of contributing in a meaningful way to their environment. Residents with dementia actually claim that having the opportunity to engage in meaningful activities “…could provide feelings of being able to participate in and make a contribution to the life of oneself and others” (p. 2615). It is important to understand what each person’s routine was before he or she was living in a care setting, as not everyone is used to doing such chores and thus might actually be offended if such a request were made. The ability to create and sustain meaning relies heavily on understanding who the people are now as well as who they were in their past. This is not an easy task and thus staff must be trained to seek out this information through observations and conversations with the PWD as well as with the families. With the correct approach, a care team that creates meaningful experiences can be very beneficial to residents’ quality of life.

**Hiring Process**

The first step to developing a quality staff is the hiring process. Kitwood (1997) emphasizes that, “Great discernment is needed in the selection process. In many respects attitudes are the key. It is relatively easy to help a person to gain in knowledge and skill, but attitudes are often difficult to change,” (p.112). Determining the attitudes and characteristics of interviewees will be the goal of the interview process. The interviews at HHH will consist of standard interview questions and include additional components such as scenario questions and observations. The various interview strategies should ensure a much more rounded understanding of whom the interviewee is and whether or not they would be a quality addition to the team at HHH.
Caring for people with dementia can be a very stressful experience and there are certain personal characteristics that can be helpful. Qualities that will be sought out during hiring are patience, sensitivity, and a genuine love for older adults. According to Robinson, Reid and Cooke (2010), family members of PWD emphasize that qualities such as “personal interest in each resident, a sense of humor, caring, kindness, and respect for the residents as persons” (p. 498) are all essential to a quality relationship between staff and residents. Kitwood (1997) actually reduces the qualities needed down to one, someone who can be fully present. A caregiver must be able to look past the misconceptions and previous judgments of people with dementia and instead see them as individuals. This concept of being fully present includes many of the same characteristics mentioned above. To be present one must be caring, kind, respectful, and interested.

An interesting study by Gilson and Moyer (2000) looked at the relationship between personality characteristics (i.e., self-esteem, life satisfaction and perceived social support) and care staff’s empathy toward people with dementia. Results show that perceived social support was positively correlated with empathy scores indicating how important a supportive social environment can be. On the other hand self-esteem was negatively correlated with empathy. Gilson and Moyer attributed this finding to the idea that those with lower self-esteem are less self-focused and better able to respond to the needs of PWD.

**Scenario Questions**

Such qualities are easy to claim to have but in order to ensure that the interviewee does in fact hold these characteristics, the interview process will include much more than just asking questions. The interviewee will be given several different scenario questions to discuss how they would handle the situation (Kleshinski, Shriner & Khuder, 2008; Latham, 1989; Lemay, Lockyer, Collin & Brownell, 2007). Lemay, Lockyer, Collin & and Brownell (2007) determined that situation interviews were helpful in determining non-cognitive traits such as empathy, honesty, and responsibility. Latham (1989) claims that a situational interview is the only interview tactic actually grounded in theory. The theory, known as goal setting, is based on the idea that behavior is a result of one’s intentions and goals. Situational interviews “identify a potential employee’s intentions by presenting that person with a series of job-related incidents, and asking what he or she
would do in that situation,” (p. 171). In fact, Latham reviewed several studies that showed that this type of interview is reliable, practical and free from bias. In addition, it makes it almost impossible for the interviewee to know the perfect answer and thus provides insight into how valuable that person would be in the position.

A few examples of scenarios related to dementia care could include a resident asking about his/her deceased spouse, asking to go home or a resident who does not want to shower. Answers that reflect an understanding of the needs of PWD will be essential. According to Kitwood (1997) there is a cluster of needs of PWD: comfort, attachment, inclusion, occupation, identity, and love. Interviewees’ responses will need to show how they will comfort the residents who are distressed, and engage in meaningful conversations with the residents. The answers will also be analyzed to determine whether they would support the identity of residents, and most of all show them love. The answers to these scenarios, when analyzed using the needs of PWD, will give insight into whether or not the interviewee would be a positive addition to the care setting. Of course it is important to keep in mind that not every person interviewed has had dementia-specific training; therefore it will be essential for the interviewer to interpret their answers looking for aspects of patience and sensitivity even if the answers are not ideal.

*Observation Interviews*

Ideally, also included in the interview process would be observation of the interviewee with PWD (Kitwood, 1997). Because of the fact that HHH will be a new facility and the majority of the hiring process will be done before HHH opens, there won’t be residents yet living there. Therefore this opportunity for observation will be carried out when team members must be replaced. Observations are often used to assess job performance or quality of care provided, (Clancey, 2006; Shore, Lerman, Smith, Iwata & DeLeon, 1995) yet it seems that this tactic could be just as useful before hiring a person.

The observations will be held during a daily experience (activity) or mealtime. These observations will be informal and carried out as an opportunity for the interviewee to get to know the residents and other team members. Observations will be conducted to look for interactions that support the six needs of PWD (Kitwood, 1997). All team members will be asked to pay attention to interactions and will later be asked for their
opinion on whether or not they believe the interviewee would be a positive addition to HHH. Since the interviewees are not members of the staff and will be interacting with the residents, they will be required to sign a HIPAA privacy form before this aspect of the interview.

**Team Training**

The team at HHH is the heart of providing quality care. Without their support and proper training, the core ideas behind HHH cannot be carried out. Specialized training is not only correlated with more positive opinions of those with dementia (Kada, Nygaard, Mukesh & Geitung 2009), but it also is associated with improvement in various areas such as communication and resident behaviors (Beeber, Zimmerman, Fletcher, Mitchell & Gould, 2010). Thus specialized training as well as continued maintenance of this training will be a core component at Hart’s Home Away From Home. The Best Friends Approach by Bell and Troxel (2001, 2003) will serve as the core foundation of HHH’s training program. Supplemental training aspects are drawn from reviews of other training programs (Beeber, Zimmerman, Fletcher, Mitchell & Gould, 2010; Dijkstra, Bourgeois, Burgio & Allen, 2002).

Although there is a lack of empirical support for Bell and Troxel’s Best Friends Approach, it has continued to expand over the past twenty years. To date, they have conducted over 300 consultations and training sessions and their consultant list continues to progress. In fact, several Alzheimer’s Association chapters have adopted Bell and Troxel’s Best Friends Approach (http://bestfriendsapproach.com). The fact that such a well-known organization supports this approach and that the client base continues to expand likely indicates the benefits it has within a care setting for PWD.

The core idea behind the Best Friends Approach is that PWD are considered and treated as if they were best friends with the team members. Viewing the relationship in such a way will help to create a bond between the residents and the team that will increase the quality of care that is provided. It will also help the team to connect with those they are caring for in regards to seeing them as people instead of focusing on their disease. This idea relates back to Kitwood’s (1997) person-centered care, which has been shown to improve the quality of life of residents (i.e., decrease in agitation, aggression, and discomfort, and increase in sociability) (Curle & Keller, 2010; Geboy, 2009;
Hofland, 1994; Nijs, de Graaf, Kok & van Staveren, 2006; Reimer & Keller, 2009; Sloane et al., 2004). Even more specifically, person-centered care training has affected the quality of care provided by caregivers. This type of training has been shown to have positive effects such as better use of nonverbal communication, more assistance with tasks, increased conversation, and greater use of details from the residents’ life in their care (Beeber, Zimmerman, Fletcher, Mitchell & Gould, 2010).

The training of the staff at HHH will begin prior to the opening of the facility. The administrator, one RN, and the experience director will conduct the training. These staff members will attend a master’s trainer certification conference held by the Best Friend Approach Institute. This training costs approximately $895 per attendee and therefore will cost $2,685 plus travel costs (flight, hotel and food) for the three staff members to attend (Best Friends Approach Institute, 2011). The staff members who attend the training at the institute will be paid for sixteen hours of work ($619), as the training is two full workdays. This is based off of the highest paid employee’s (RN) salary apart from the administrator. The choice to base this off of the highest paid employee’s salary lies in the fact that each staff member will be attending the same training and thus each deserves the same pay. Since these staff members are certified they will then lead the training for the rest of the staff back at HHH. Staff members will also be paid for this training. Each of the staff will receive $387, calculated based on the salary of an RN, and the fact that the time commitment is equal to ten hours of a normal workweek. The residents’ yearly fees will pay for the costs associated with this training.

The training at HHH will be spread out over a week’s time period to minimize fatigue and or boredom. The same training topic will be offered twice daily, once in the morning and once in the evening, and each session will not last more than two hours to accommodate various schedules. The training sessions will cover topics such as types of dementia and how the disease progresses, the experience of dementia, how to be a best friend to someone with dementia, incorporating one’s life story into their care, and communication both with the residents and the families (Bell & Troxel, 2001; Bell & Troxel, 2003).

The topic of communication in particular has been included in many other training programs. Dijkstra, Bourgeois, Burgio and Allen (2002) evaluated a training
program that focused on communication with residents. This training consisted of a one-hour session, which included a hands-on portion to practice communication techniques and use of a memory book that was personalized for each resident. Dijkstra, Bourgeois, Burgio and Allen (2002) found that there were in fact improvements in the quality of care given by nursing assistants, such as an increase in the use of encouragement and cues. These improvements in quality of care resulted in an improvement in resident coherence.

Information from the training sessions is much more likely to be retained if the team members are active participants in the training (Bell & Kozlowski, 2008; Eckerman et al., 2002). Therefore, training at HHH will be interactive so the staff will retain information and use it within the daily care they provide. There will be skits regarding different scenarios that the staff might find themselves in with residents or their families (Appendix 4). These skits were developed based on personal experience and information provided by Bell and Troxel (2001, 2003). The skits will be done twice, once to show what not to do and a second time to show the correct way to react. The staff being trained will be asked to participate in these skits so that they may practice the concepts. In general the sessions will be much more than lecture and will include activities and discussions to increase engagement and therefore understanding of the ideas.

In addition, the team must have a way to reference the key points from each session throughout the day. Handouts on each topic will be provided at the HHH training sessions. In order to make these concepts even more portable and easily accessible, Bluethmann and Reed (2008) recommend the use of small laminated cards with the key concepts from each session. A metal ring will also be given to the staff so they can collect all of the cards and have them on hand for reference throughout the day.

Planning an effective training program is important although ensuring its ideas are actually implemented is an essential aspect. Beeber, Zimmerman, Fletcher, Mitchell and Gould (2010) actually contributed the failure of some training programs to lack of implementation. “A main challenge in the area is that many training programs are never translated into practice and therefore result in no improvement in dementia care” (p. 35). In response to this concern, it will be the administrator’s responsibility to ensure that all of this training is actually put into practice. At the onset of HHH it will be important for the administrator to spend a considerable amount of time engaged with the staff ensuring
the use of the learned techniques. In addition, the administrator will be expected to set an example of using these techniques on a regular basis.

In order to ensure the maintenance of this training program, refresher courses will be offered every six months to make certain that the tactics are being utilized in the care setting (Beeber, Zimmerman, Fletcher, Mitchell & Gould, 2010). These courses will be condensed versions of the full week sessions. If there has been any staff turnover, the new staff will be given a manual with all of the information covered in the initial training sessions upon their hire. To ensure that the new staff studies this information they will participate in an oral test to see how much they have retained. They will not be expected to have memorized aspects of the manual but instead asked questions which will indicate whether or not they understand the overall concepts of the approach. There will also be a mentoring program within HHH for new team members to pair up with current team members. Through this supportive relationship the new team members will be able to directly observe how care is provided at HHH while practicing the techniques learned in the manual, until they feel comfortable providing care on their own.

**Team Culture**

The organizational culture of staff has been found to not only be extremely influential on the quality of care (i.e., friendly conversations with residents, sufficient time for the residents, treat the residents with respect, call residents by their name, actively care for residents, staff and residents at ease with each other, nice and friendly atmosphere, and units make a lively impression) for PWD (van Beek & Gerritsen, 2010) but also on the satisfaction of the staff (Tourangeau, Cranley, Spence Laschinger & Pachis, 2010). Because of the fact that staff play such a significant role in creating quality of care, their satisfaction is extremely important. Therefore the organizational culture of the team will be a critical issue in the staffing at HHH.

According to van Beek and Gerritsen (2010), there are four different types of staff organization, including clan, adhocracy, hierarchy, and market. A clan type organization is the most flexible and creates a group attitude with “a strong cohesion, participation, and a sense of ‘we-ness’” (p. 1275). An adhocratic organization is one that can quickly adapt to change, and a hierarchy is one focused on structure and rules. On the contrary, a market staff organization focuses on profit, competitiveness, and productivity. Through
surveys and observations, van Beek and Gerritsen found that a clan type organization had a positive correlation with both the perceived and observed quality of care measures (i.e., personal individual care, creating a nice and friendly atmosphere, and supporting residents emotionally). Therefore, this is the type of culture that will be created in HHH as it would have the most benefits for a dementia care setting and the quality of life for the residents.

Work environments have also been found to be associated with job satisfaction and job turnover. Tourangeau, Cranley, Spence Laschinger and Pachis (2010) surveyed staff members regarding perceived organizational support and work group cohesion. Work group cohesion in this study focused on “employee perceptions related to the nature and goodness of their work relationships and the level of commitment and identification experienced as part of a team” (p.1064). The measure of organizational support was included in order to determine how receptive organizations were to employee contributions and how concerned the organization as a whole is for the employees’ well-being. Results showed that higher job satisfaction was associated with greater perceived organizational support and stronger work group cohesion. Regarding job turnover, lower work group cohesion was associated with a greater intent to leave one’s job. This study signifies how important a clan organizational culture can be to the satisfaction of employees.

This clan culture will need to be put in place at the beginning so that it becomes ingrained in the functioning of HHH. The first step in incorporating a clan type atmosphere is to refer to the staff as more than just the staff but as a team that works together in order to accomplish quality care for the residents at HHH (Kitwood, 1997). To maintain a clan culture, daily meetings will be held between management and the nursing and experience staff to promote conversation about issues either with the residents or with the facility, and also to create an atmosphere where all staff feels free to bring any suggestions for improvement to the entire group. These meetings will be held at shift change so that night and day shift teams can correspond about the residents and the previous shift. Only half of the team members will be able to attend the daily meetings as the other half will need to be with the residents during this time, therefore the team members will switch every day. All other staff, including housekeeping,
administration, and maintenance, will be welcome at daily meetings if they choose to attend but will be required to attend meetings once a week so that all staff can come together and discuss issues and/or suggestions regarding HHH. Although attendance at the weekly meetings is required, they are not led by the administrator but instead are relaxed and open discussion opportunities. The lines of communication will remain open at all times to ensure that a hierarchical feeling is minimized and instead the entire staff feels equal to one another. (Tourangeau, Cranley, Spence Laschinger & Pachis, 2010).

**Family: Part of the Team**

It is important to note that family will also be considered a part of the team at HHH. According to Gaston (1994), “What is most important is the message that is communicated: Families are an integral member of the caring team. They are invited to become members of a new, extended family” (p. 77). Not only can family members help to provide better care for the residents (O’Neil, 2009) but also their inclusion can be beneficial to both the team at HHH and the family members (Davis & Curtin, 2011). O’Neil discusses how necessary it is to obtain details about the residents’ lives in order to provide person-centered care. The best way to obtain this information once the residents are no longer able to express themselves verbally is from family. In fact, O’Neil discusses that the more family members who are included the better as each person provides a new perspective on who the PWD is, thus providing more insight into how to provide the best care.

Davis and Curtin (2011) address how incorporating family into the care setting can be beneficial to both the team and family, in that it minimizes the amount of stress held by either group. It also provides a role for the family members after placement of their relatives. If those family members who are interested are welcomed to remain a significant part of the lives of the residents it will help with the transition process for both the resident and family. According to Maas et al. (1994, 2004), staff may actually be able to aid in this transition process through open communication about the resident and the care they are receiving, and allowing family to play a significant role in the care of the resident. Family assistance in the care of the residents, as well as a positive relationship between staff and family, can both decrease the occurrence of caregiver burden among the staff (Abrahamson, Suitor & Phillemer, 2009).
Families as a part of the team also have the opportunity to help with the experiences at HHH. Not only will this help to further create a positive bond between family and HHH it will also prove beneficial to the experience programming. Family will be able to offer specific talents and new ideas for experiences (Gaston, 1994). Although all input and assistance from family members will be welcomed it will be necessary to ensure that these experiences follow the basic principles and guidelines of HHH. In order to ensure that family members understand and can implement these concepts within HHH they will be invited to attend training sessions.

Overall, the inclusion of family in the team at HHH not only will benefit the residents but the staff and families as well (Baker, 2007). Families will be welcome within the facility at any time, and there will be an open line of communication between the team members and family regarding the residents. This communication and open door policy should help to create an extended family bond between residents, team members, and family. In order to ensure the privacy of the residents, those family members who wish to discuss medical issues must be designated on HIPAA forms signed by the resident or the family member must hold a power of attorney.

Thinking of oneself as part of a team is a significant factor in creating a positive experience for the staff (Tourangeau, Cranley, Spence Laschinger & Pachis, 2010), and a predictor of showing more empathy to the residents with dementia (Gilson & Moyer, 2000). This decision to implement a group-oriented culture is also supportive of avoiding caregiver burden within HHH. The following section further discusses caregiver burden and other ways in which to minimize its occurrence.

**Avoiding Caregiver Burden**

Caregiver burden is a significant concern when caring for people with dementia, and because of the importance of continuity and retention of staff to the care of PWD, preventing this burden is incredibly important. Although one’s psychological characteristics may play a role in how this stress is handled it is not the sole factor (Andrén & Elmstahl, 2007; Cantor, 1983; Donaldson & Burns, 1999; Donaldson, Tarrier & Burns, 1998; Kim, Shin & Yoon, 2001; Papastavrou, Kalokerinou, Papacostas, Tsangari & Sourtzì, 2007). Barber and Iwai (1996) examined how demographic characteristics, workload and caregiving involvement, work environment characteristics, and social

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support were associated with staff burnout. In this study the demographic characteristics included age, sex, education, experience, and self-esteem. A survey of primary care staff for those with dementia (i.e., nurses, nurse aids, social workers) revealed that the greatest predictor of staff burnout was characteristics of the work environment. The best predictor was role conflict, followed by role ambiguity. Barber and Iwai state, “Chronic role conflict and role ambiguity are demoralizing and tension-provoking, and often result in lowered self-esteem and increased feelings of futility and powerlessness” (p.111). Preventing this at HHH will be a priority, as it seems to be such a significant predictor of staff burnout.

Therefore from the onset, responsibilities of each staff member will be made clear. Although a team-like atmosphere will be created and maintained at HHH, there will be job descriptions for each team member, similar to a traditional job, yet the description for all positions will include common key tasks associated with the provision of person-centered care. For example the nursing staff will have traditional responsibilities but they are also expected to help with experiences and cooking meals. In addition to designing and leading experiences, the experience staff will help with cooking meals and various other responsibilities if other team members are in need of help. The administrator will have a much more hands-on role in the daily life of the residents and will help with experiences, care, and cooking. Regardless of the expanded job descriptions, it will be made clear from the onset what team members’ duties are. Meetings will be held periodically to assess how well each person is handling her/his tasks and to make sure there is no misunderstanding in job assignments. By making roles clear, and making sure the team members aren’t becoming unnecessarily overwhelmed, it should reduce the possibility for role conflict and role ambiguity. The importance of reducing role conflict and role ambiguity is also supportive of a clan culture.

**Experiences**

**Overview**

What are often known as activities in care settings will be termed experiences within HHH. Activities in a typical care setting are designed to keep the residents as busy as possible and often are not developed with the individual personalities and interests in mind. The idea behind typical activities can be detrimental to creating a quality care
environment. In fact, offering activities merely to keep the residents busy is in opposition to all three of the core principles upon which HHH is based. These types of activities don’t consider what is meaningful for the residents or their unique interests. The first step to not allowing the detrimental aspects of the concept ‘activity’ to become a part of HHH will be to call the activities experiences instead. Yet, to truly avoid the negative effects of this term, more than just the term will need to change. The core ideas behind these experiences will be different.

The experiences at HHH are a key aspect of the social environment for PWD and thus it is essential that they be given specific attention. Drawing upon the theoretical foundations of HHH, and the three core principles, all of the experiences at HHH will follow certain guidelines. In conjunction with these foundational ideas, the experiences at HHH are supported by Bell and Troxel’s Best Friends Approach (2001, 2003) and Lokon’s (2010) Opening Minds through Art. Both staff and family will be educated about and encouraged to lead and engage in experiences that embody the key guidelines that are discussed below. These guidelines are that experiences must: a) be appropriate, b) allow for self-expression, c) be meaningful, and d) offer a wide variety of experiences.

*Experiences Must be Appropriate*

Developing experiences that are both age- and disease-stage-appropriate is very important to the well-being of PWD (Buettner & Fitzsimmons, 2003; Jarrott & Gigliotti, 2010; Lokon, 2010; Mahoney, 2003). Often activities within care settings include coloring pictures, or putting together puzzles made for children that have very few and large pieces. Not only must experiences be age-appropriate but they also must be stage-appropriate. There should be no right or wrong way to complete the experience and this allows the residents to succeed no matter what their capabilities. An observation study by Mahoney (2003) determines how beneficial age- and stage-appropriate activities are for PWD. Through observations of residents with dementia, Mahoney found that activities more specifically tailored to the residents initiated greater positive emotions, and kept the residents interested longer. Social interaction also increased during the age and stage specific activities. In addition, Mahoney saw fewer negative emotions and agitation. Providing such experiences that all PWD can succeed at is supportive of their personhood.
Experiences Must Allow for Self-Expression

Providing opportunities for self-expression within experiences is extremely important to support the well-being of PWD. While much of the literature regarding self-expression deals specifically with creativity (Abraham, 2005; Allan & Killick, 2000; Cohen, 1998; Cohen, 2006; Phillips, Reid-Arndt & Pak, 2010), Krause (2007) expanded this to include any range of activities or hobbies that allow older adults to express their abilities. Krause used secondary data analysis to determine that, “…self-expression is associated with few symptoms of depression, because older people who are able to use their talents are more likely to derive senses of meaning in life, and they are more likely to feel grateful for the things they have received in life” (p. 203). Providing opportunities for self-expression seems to be incredibly important to the well-being of PWD.

In support of self-expression, providing choices will be an important aspect of the experiences at HHH. Residents will always have the choice to either participate in the experience or not. Beyond this initial decision, experiences will allow for choices throughout, and will incorporate the interests and hobbies of the residents. Providing opportunities for the residents to express who they are will be a focus at HHH.

Experiences Must be Meaningful

As previously discussed meaning in life is an essential aspect of creating a quality care environment (Edvardsson, Fetherstonhaugh & Nay, 2010; Harmer and Orrell, 2008; Phinney, Chaudhury & O’Connor, 2007). Merely keeping residents busy with an activity is not going to address the need for meaningfulness. The activity must either contribute to others and their environment or be enjoyable for the residents. The key is to structure the daily activities around the preferences of the residents and for the staff to remain proactive in making every task of the day meaningful.

Mealtimes, showering, and dressing are all tasks that must be accomplished each day and it is up to the team at HHH to make these tasks meaningful for the residents. Instead of using mealtimes to get other tasks done, or viewing shower time as an assembly line of residents (Briller, Proffitt, Perez, Calkins, & Marsden, 2001) these tasks should be used as an opportunity to engage in meaningful conversations. The key is to view these less as tasks and more as experiences. Kitwood’s idea of looking not at what
is done but instead at how something is done is critical here (Fazio, 2008). It is the process that is important.

The conversations should also be incorporated into other experiences within HHH in order to make them meaningful. These personal interactions in addition to incorporating the various interests, hobbies, and identities of the residents will help to create meaningful experiences. Referring back to Phinney, Chaudhury & O’Connor (2007) there seem to be four categories of meaningful experiences including leisure and recreation, household chores, social involvements, and work-related activities. Due to the fact that each person is unique, experiences from each of these categories must be offered. Without a wide variety of experiences it will be impossible to create meaningful experiences for each resident. In fact, variety is the fourth and final guideline for the experiences at HHH.

*Wide Variety of Experiences*

Kitwood’s principle of occupational diversity addresses the importance of offering a variety of occupations. The higher the occupational diversity, the better the range of activities and thus the better the facility is at satisfying the psychological needs of PWD. Offering the same experiences day after day and week after week might not seem to be a problem for individuals who have a difficult time remembering what they have done the day before. Although it is debatable what PWD will remember from day to day, it is not debatable that the team members must be interested in the experience in order for the residents to become engaged. If the team members leading the activities are bored because they do the same things day after day, they will likely pass that sentiment to the residents.

From personal experience of interning at a dementia care setting, an exercise program was offered every day and the exact same routine was done. The staff seemed very uninterested and the majority of the residents sat in silence through the entire experience of exercise. If the staff had even just smiled or portrayed an attitude of enjoyment more residents would have become engaged in the experience and likely have enjoyed it more. Therefore in order to avoid this situation the experience directors at HHH will be in charge of continually coming up with new and enjoyable experiences. Obviously some experiences will be recycled but for example an exercise program that is
done daily will need to be diversified with new music and new moves. HHH will provide a variety of experiences including but not limited to daily tasks, outings, visual art projects, and spontaneous and nighttime experiences. A few of these types of experiences are highlighted below.

The Best Friends Approach emphasizes that one of the benefits of having a best friend is experiencing the unplanned aspects of life with them. This idea is applied to the experiences in that they are meant to be fun, and spontaneous. Although the concept of using spontaneous experiences has not been empirically studied, there is some literature in addition to the Best Friends Approach that suggests its benefits (Alzheimer’s Association, 2010a; http://www.alzny.org/caregivers/activity.asp; http://www.in-the-moment.com).

Theoretically, any object lying around can be formed into an enjoyable experience with some creativity and practice. A few examples of such spontaneous experiences are to make up a funny rhyme, blow bubbles with bubble gum, or smell a fragrance together (Bell & Troxel, 2001). Spontaneous experiences don’t have to be long or complex and often need minimal to no supplies in order to be carried out.

Even though all team members will be encouraged to incorporate spontaneous experiences throughout the day, the specified experience team members will be the leaders. In addition to the planned daily experiences, these team members will spend time enjoying the spontaneous aspects of life with the residents. This will remove the pressure of having to plan experiences to take up the entire day, and therefore make it less of a requirement and more enjoyable. Since coming up with these experiences has to happen at the spur of the moment, it will need to become second nature for the team members. Therefore, practice designing these types of experiences will be a key aspect of training and refresher sessions. Whereas spontaneous experiences are essential to quality programming planned experiences are just as important.

Outings will also be an important aspect of the experiences at HHH. Without experiences where the residents are able to leave the facility, life can become boring and meaningless. It is essential to keep in mind that before the person moved into this setting they were likely able to come and go, as they wanted. Losing such a privilege can be extremely detrimental to one’s quality of life therefore it will be a significant aspect of
the experiences at HHH. Such outings will include visits to local parks for picnics, trips to a local zoo or museum, and going out to eat at a restaurant. The key to making these outings possible for all PWD, despite the stage of dementia, is individualized attention. The majority of the team at HHH will attend these outings thus allowing each PWD to receive the attention needed to enjoy this outing as well as to make it a safe experience. Even still, those in the most advanced stage of dementia will not be able to participate in most of these outings but this will be determined on a case-by-case basis. As every person at HHH deserves the same quality of care regardless of the stage of dementia, those in the latest stages will have sensory experiences particularly in the snoezelen room.

Often overnight hours are ignored in regards to experiences for the residents, due to the lack of experience staff available at this time. In support of person-centered care, and occupational diversity there will be experiences offered throughout the night contingent upon residents’ needs and desires. These experiences will focus on relaxation and quality interactions. Anderson (2008) observed a special care unit that did offer night activities, and found that they included: interactions between staff and residents, television, music, reading (magazines or books based on abilities), and eating and drinking. While all of these will be options for nighttime experiences at HHH, interactions will be a key aspect. Residents won’t be given a magazine or set in front of the television and expected to engage themselves. Instead, members of the team will use this time to engage in meaningful conversations, or just enjoy each other’s company during the quiet hours of the night.

Conclusion

Although the quality of care for PWD has received attention for well over 20 years, there is still much progress to be made (Calkins, 1988; Kitwood, 1997; Koren, 2010; Power, 2010; Rader, 1995; Thomas, 1994). Unfortunately, many facilities that provide dementia care do not take the literature into consideration nor do they adapt all aspects of the care setting for PWD. There is a considerable amount of literature both theoretical and empirical that, if integrated properly, should result in quality dementia care; that is, care that provides security, privacy, choices, comfort, personal relationships, and is individualized. At its core, HHH is founded upon Lawton’s person-environment fit
theory and Kitwood’s person-centered care, which together emphasize how important both physical and social environments are to positive behavioral outcomes.

Specifically, HHH is grounded in three core principles. The development of these principles integrate literature over many years and include the idea that there is a continuation of identity beyond cognitive decline (Caddell & Clare, 2010; Cohen-Mansfield, Golander & Arnheim, 2000; Fazio, 2008; Fazio & Mitchell, 2009; Jennings, 2009; Myser, 2007; Sabat, 1992; Sabat, 1999; Sabat, 2002; Small, Geldart, Gutman & Scott, 1998; Tappen, Williams, Fishman & Touhy, 1999; Touhy, 2004), creating and sustaining meaning in life (Harmer & Orrell, 2008; Phinney, Chaudhury & O’Connor, 2007; Edvardsson, Fetherstonhaugh & Nay 2010; Netten, 1993), and creating a home-like environment (Cohen-Mansfield & Werner; 1998; Robinson, Reid & Cooke, 2010; Verbeek, van Rossum, Zwakhalen, Kempen & Hamers, 2008). Everything in HHH including the experiences, team training, physical environment and role of the family is designed with these ideas in mind. HHH is founded on the idea that improving dementia care takes a lot more than just painting walls or buying new art supplies but instead the change must be integrative. A personalized and home-like physical environment must be accompanied by specialized training for the team, in addition to providing meaningful, appropriate, and individualized experiences. Through integrative changes and a foundation in both theoretical and empirical literature, Hart’s Home Away From Home can provide the quality of dementia care that has been sought for so long.
Appendix 2
Appendix 4
Skill #:1
No Knack

**Resident:** Where is my mother? I need to find my mother. She just lives across the way over there.

**CNA:** Your mother is dead. She doesn’t live over there.

**Resident:** Liar! Why would you say something like that? I just saw my mom yesterday.

**CNA:** There is no way you saw her yesterday she is dead. Why can’t you remember that?

**Resident:** (Begins to cry, and get angry) What...why are you saying that? I want to leave. How do I get out of here?

**CNA:** You can’t leave you live here. That door is locked you can’t go out.

**Knack**

**Resident:** Where is my mother? I need to find my mother. She just lives across the way over there.

**CNA:** Oh she does? I didn’t know that. Tell me about your mother are y’all very close?

**Resident:** Yes very close. Now let me out this door I need to go find her.

**CNA:** Let’s go a different way. Walk with me and tell me about your mother.

**Resident:** She is very nice and has always been a very good mother to my sisters and me.

**CNA:** How are your two sisters Judy and Carol?

**Resident:** They are wonderful. But I really need to go find my mother?

**CNA:** How is your daughter Annabelle doing? Sit and tell me how her job as a pilot is going?
Skit #2
No Knack

Resident: I want to go home.

CNA: Your home is here. This is where you live.

Resident: I am not sure what you mean. I don’t live here I have a house on Signal Mountain.

CNA: You don’t live there anymore. When your husband died you had to move down here with us.

Resident: My husband died!!!? When? I just saw him yesterday. (Starts hyperventilating, and crying).

CNA: Your husband died five years ago! Why don’t you remember this?

Resident: I don’t know what you are saying? I need to go find my husband. He is not dead.

CNA: Please just go sit down I have work to do.

Knack

Resident: I want to go home.

CNA: Tell me about your home. Have you lived there long?

Resident: Yes I have can you please let me out so that I can go home.

CNA: You used to live in Nashville didn’t you?

Resident: Yes, Yes Nashville. I lived there.

CNA: Your son Michael still lives in Nashville right? How is he doing?

Resident: Oh how sweet of you to ask. He is doing fine thank you.

CNA: Tell me how was it living in a household where you lived with all males, your two sons and husband.
Skit #1
No Knack

**Family Member:** That lady over there is wearing my mother’s shirt. I bought that for her!

**CNA:** Well we are just trying to do our job here. We can’t do everything!

**Family Member:** We are paying a lot of money to have my mother here and I expect you to keep my mother’s clothes on her and off everybody else.

**CNA:** You have no idea what it is like to deal with these residents all day. I do the best I can.

**Family Member:** Well next time I come I expect to see no other residents with my mother’s clothes on them.

**CNA:** You need to understand that it doesn’t matter to her. She is gone. She has Alzheimer’s remember?

Knack

**Family Member:** That lady over there is wearing my mother’s shirt. I bought that for her!

**CNA:** I understand your concern. Our main goals here at Hart’s Home Away From Home include having compassion for the individual and respecting their dignity as a person. This particular resident found that shirt in their closet, I suppose it got hung their accidently. There was no need in embarrassing the resident and telling them it was not their shirt. We decided it would work better to just get the shirt back at the end of the day.

**Family Member:** You should have taken the shirt off of her. I don’t like other people wearing her clothes.

**CNA:** I want you to know that I do understand your concern. If you have more questions about our values here at HHH, I know the administrator would be more than willing to discuss it with you.
Skit #2
No Knack

Family Member: Why is my wife still in her pajamas? I want her up and dressed at 9am.

CNA: We have a lot to do in the mornings and with all of the residents we have to deal with, your wife is not our only priority.

Family Member: I want you to promise me that the next time I come in that you will have her up and ready at 9am.

CNA: You need to know that your wife is very difficult to deal with and because she has Alzheimer’s she isn’t here anymore. It doesn’t matter to her when she gets dressed. You need to learn to be okay with that too.

Family Member: My wife wants to get up and be dressed at 9am. That is what she has always wanted.

CNA: Well we are doing what we can. I need to go get some work done now.

Knack

Family Member: Why is my wife still in her pajamas? I want her up and dressed at 9am.

CNA: I understand your concerns. Here at HHH we work to respect the individual and their desires. Most mornings your wife is not ready to get dressed before 9am. We allow her that choice and when she is ready we help her get ready.

Family Member: She doesn’t know what she wants. She has Alzheimer’s.

CNA: I understand how you feel but although your wife has Alzheimer’s we still work to allow her as many choices in her day as possible. One of these choices is when she would like to get out of her pajamas.

Family Member: She doesn’t know how to make that choice.

CNA: I do want you to know I hear what you are saying and I understand. I would like to encourage you to talk to the administrator and he can work to accommodate your concerns or we could all sit down and try to work out a way to make both you and your wife happy.
References


Basting, A.D. (2006). Arts in dementia care: ‘This is not the end…it’s the end of this chapter.’ *Generations, 30*(1), 16-20.


