This section makes a transition from studying external influences on a facility to understanding the facility’s internal organization and processes that are essential for patient care delivery. However, many internal structures and processes are influenced by external forces. For instance, the evolution of nursing homes (discussed in Chapter 6) has been driven primarily by external factors.

In this section of the book, Chapter 5 discusses the physical structures, such as building layout and design. Nursing home design has undergone a gradual evolution in creating settings that promote independence in a socially supportive living environment. In response to changing expectations about long-term care, current trends suggest a gradual transformation from traditional hospital-inspired facilities to contemporary architectural features with a more residential look and feel. Contemporary models of client-centered care are based on a philosophy that integrates physical layout and design with empowerment of the residents, families, and staff. Chapter 6 describes these emerging concepts and innovations. The remaining six chapters in this section represent the six main organizational departments that oversee the processes essential to delivering total care in a typical nursing facility: Chapter 7 covers social services; Chapter 8 explains medical and nursing care; Chapter 9 looks at recreational activ-
Chapter 10 discusses dietary services; Chapter 11 describes plant and environmental services; and Chapter 12 covers administrative offices. The organizational chart of a typical skilled nursing facility includes these functional departments as illustrated in Figure II-1. From a managerial standpoint, most facilities separate plant maintenance and housekeeping into two departments (as shown in Figure II-1), although they both have a common mission of environmental support.

In a mid-sized facility of 120 to 150 beds, each of these services is managed by a department head. Some of these managers are actually working supervisors. For example, depending on a facility’s size, a housekeeping supervisor may clean some rooms or polish floors but also supervise a crew of housekeepers. In spite of this organizational arrangement, in which qualified individuals are put in charge of different departments, the nursing home administrator has a “hands-on” role in coordinating and overseeing the integration of the clinical and adjunct processes. The various support services are adjuncts to the central nursing care process and must interface with clinical care using a multidisciplinary approach.

Building a multidisciplinary team requires the administrator’s involvement, and the administrator must develop an organizational culture of interdepartmental communication and cooperation to address patient needs in a holistic system of care. Materials covered in this section are intended to help administrators understand the purpose and function of each department. This knowledge will improve the administrator’s own effectiveness in managing the facility and should be useful in hiring qualified supervisors when vacancies occur.

In an integrated multidisciplinary approach to patient care, professionals who provide medical, nursing, social services, recreational activities, and dietary services share their observations, discuss clinical goals, and develop interventions in which a variety of services interface. Professionals in each discipline are aware of what others are doing to address the multifaceted needs of each patient. Developing an individual plan of care for each patient is a multidisciplinary effort. The overarching goal is to address all aspects of a patient’s needs without duplicating or disregarding any needed services. Often, problems and issues are addressed in committees, with service providers from all pertinent disciplines interacting and providing their professional inputs.

The Omnibus Budget Reconciliation Act of 1987 mandated that nursing facilities provide necessary care and services with the objective of pro-
motivating the highest practicable level of well-being for each patient. This section describes the process of fulfilling this mandate. Some of the most commonly provided services are listed in Table II-1.
Unlike other health care institutions, nursing facilities must combine both medical and social services. Although patients are admitted to skilled nursing facilities primarily to receive therapeutic interventions, these services must be delivered within a human context that emphasizes a home-like setting, personal choice, independence, dignity, and self-esteem as overarching factors that govern the clinical and socio-residential elements of service delivery. Achieving the appropriate blend of clinical and socio-residential services is the goal that guides the way in which the facility’s structures are developed and processes are implemented. Figure II-1 classifies nursing home services into their clinical and socio-residential components. When human factors are integrated into the two components, it creates a total living environment in which a person’s physical, mental, social, and spiritual needs are met.

**Table II-1** Types of Services Commonly Provided by Nursing Homes, either Directly or through Contracts.

<table>
<thead>
<tr>
<th>Service</th>
<th>% of all nursing facilities providing the service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental services</td>
<td>80.0</td>
</tr>
<tr>
<td>Help with oral hygiene</td>
<td>97.1</td>
</tr>
<tr>
<td>Hospice services</td>
<td>74.6</td>
</tr>
<tr>
<td>Medical services</td>
<td>96.1</td>
</tr>
<tr>
<td>Mental health services</td>
<td>79.7</td>
</tr>
<tr>
<td>Nursing services</td>
<td>99.5</td>
</tr>
<tr>
<td>Nutrition services</td>
<td>99.2</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>94.0</td>
</tr>
<tr>
<td>Personal care</td>
<td>96.7</td>
</tr>
<tr>
<td>Physical therapy</td>
<td>96.9</td>
</tr>
<tr>
<td>Podiatry services</td>
<td>89.2</td>
</tr>
<tr>
<td>Prescribed and nonprescribed medications</td>
<td>98.0</td>
</tr>
<tr>
<td>Social services</td>
<td>97.5</td>
</tr>
<tr>
<td>Speech therapy and audiology</td>
<td>93.5</td>
</tr>
<tr>
<td>Transportation</td>
<td>81.7</td>
</tr>
<tr>
<td>Equipment and devices</td>
<td>95.3</td>
</tr>
</tbody>
</table>

**Clinical Organization and Process Integration**

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**Overarching Human Factors**

- Personal preferences
  - Independence
  - Dignity
  - Self-esteem

---

<table>
<thead>
<tr>
<th>Socio-Residential Component</th>
<th>Clinical Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and Board</td>
<td>Amenities</td>
</tr>
<tr>
<td>Accommodation</td>
<td>Private rooms</td>
</tr>
<tr>
<td>- Privacy</td>
<td>Personal space</td>
</tr>
<tr>
<td>- Safety</td>
<td>Social space</td>
</tr>
<tr>
<td>- Cleanliness</td>
<td>Dining rooms</td>
</tr>
<tr>
<td>- Comfort</td>
<td>Layout</td>
</tr>
<tr>
<td>Meals</td>
<td>Décor and aesthetics</td>
</tr>
<tr>
<td>- Nutrition</td>
<td>Barber/beauty salon</td>
</tr>
<tr>
<td>- Choice</td>
<td>Gift shop</td>
</tr>
<tr>
<td>- Adequacy</td>
<td>Library</td>
</tr>
<tr>
<td>- Attractiveness</td>
<td>Chapel</td>
</tr>
<tr>
<td>- Palatability</td>
<td></td>
</tr>
</tbody>
</table>

**FIGURE II-2** Clinical, Residential, and Human Components of Nursing Home Services
Clinical, Social, and Residential Structures

LEARNING MODULES

1. Institutional and residential dimensions. Clinical structure based on the sick-role model. Integrating clinical and socio-residential dimensions.
4. The clinical organization comprising nursing units, nursing stations, and furnishings. Assignment of patients to nursing units. Location and staffing of nursing stations. The function of call signals, medical records, and the pharmaceutical-storage room. Controlled substances and their security.
5. Social-aspects focus on the personal and private domains influencing the physical, mental, social, and spiritual aspects of a person’s life. Security, autonomy, and privacy as key factors in the personal domain.

continues
The physical characteristics of a nursing home influence the living environment which affects the patients’ sense of well-being. At least some evidence suggests that the physical environment can also affect social behavior and certain clinical outcomes. For example, in a pilot study, Brush and colleagues (2002) found that improved lighting and table setting contrast had a positive effect on food consumption and functional abilities of patients with dementia. When the environment provides too many stressors (discussed later in this chapter under Positive Stimulation and Distraction) and few opportunities to relax, dysfunctional behaviors are observed among patients with dementia (Rader 1991). Therefore, building layout, design, décor, furnishings and other amenities should be used to support clinical, residential, and social structures.

Unlike acute-care hospitals, a nursing facility is both a clinical and a social establishment. In the hospital, the sick-role model proposed by Parsons (1972) governs patients’ social relationships. The patient is expected to relinquish individual control to hospital personnel and comply with their directives. The sick-role promotes an institutional orientation to patient care, which is manifested in four ways: rigid daily routines; social distance between staff members and the patient; care
practices that lend to depersonalization, such as loss of privacy; and “blocking routines” that require patients to do certain things at pre-arranged times (Kruzich and Berg 1985). A social and residential orientation in patient care, on the other hand, is characterized by shared control between the patient and the facility personnel. Indeed, social and residential elements of long-term care extend beyond their immediate context of medical- and nursing-care delivery to a philosophy that embraces the idea that a long-term care facility is not merely a clinical setting; it is also a place that many people call home.

In a nursing facility, the clinical and social dimensions should complement each other, promoting effective clinical care and, at the same time, maximizing quality of life. The internal structures and processes must be designed to meet the needs of the residents and the needs of families and visitors. Striking the right balance between clinical and social aspects of care is not always easy, because traditional nursing home care has been based on an expert approach to meeting the physical and medical needs of patients (Collopy 1995). Well-meaning staff members are often ill-prepared to reconcile their own training and priorities with the fact that residents are entitled to make their own choices. As a result, caregivers may experience difficulty relating to residents because of this conflict (Chapman et al. 2003).

The clinical structure of long-term care is designed primarily to address the medical needs of patients. Although the clinical structure is associated with the sick role and the institutional dimension, it is irrational to think that this structure can be dispensed with entirely. For example, giving medications and other treatments in a patient population of any size requires certain routines based on medical directives. Medical examinations result in some loss of personal control by the patient. Necessary staff assistance with daily living activities does create some dependency. But, the clinical and socio-residential structures must complement each other.

The social structure is what lends a living and vibrant personality to a long-term care facility. The social structure includes numerous elements that promote individual satisfaction within a stable communal environment, in which people engage in individual pursuits and meaningful social relationships. The social structure encourages interaction, independence, engagement, activity, and leisure among the residents, while facility staff maintains its responsibility of oversight and support.
Individual rights are respected, but interventions are undertaken when necessary to promote the total well-being of all residents. Social structures also promote individual autonomy and decision-making, even when a resident’s decision-making capacity is limited.

The **residential structure** emphasizes making living arrangements homelike. A homelike environment is safe, clean, comfortable, and aesthetically pleasing, and it gives a reasonable amount of privacy.

### Integrating the Three Structures

The clinical organization of care delivery has been grounded in medical science, borrowing many of its salient features from hospitals. Medical structures are designed to facilitate efficient care delivery to a relatively large number of patients. Social structures, on the other hand, are largely based on a philosophy of holistic care. Residential structures emphasize architectural designs and interior décor. The extent to which social and clinical aspects are integrated varies according to the services a facility provides. Within the institutional continuum of long-term care (see Figure 1-5), social aspects are given greater emphasis in personal care and assisted living facilities, whereas clinical aspects get more emphasis in skilled nursing and subacute care facilities.

In all long-term care settings, the ultimate challenge is to deliver patient care while maximizing quality of life, which requires properly integrating human factors, the clinical component, and the socioresidential component to create a total living environment (Figure 5-1). Such an environment is holistic. It allows each resident’s physical, mental, social, and spiritual needs to be met, and it enables residents to live their lives as normally as possible. Modern architectural features also facilitate the delivery of clinical care in an environment of intimacy by allowing familiarity and bonding between caregivers and patients.

### The Holistic and Realistic Contexts

As described in Chapter 1, the objective of long-term care is to address a patient’s medical care needs within a delivery structure that integrates social, emotional, and spiritual support in a homelike physical setting. A
nursing facility should strive to achieve this objective for every patient, regardless of his or her physical or mental condition.

**Holistic Model of Health Care**

A holistic model of health care, as proposed by Shi and Singh (1998), emphasizes well-being: every aspect of what makes a person whole and complete. The authors propose that holistic health care incorporate four dimensions or contexts:

- physical (the human body in a medical context)
- mental (the mind in an emotional and behavioral context)
- social (emotional fulfillment in social relationships)
- spiritual (personal beliefs, values, and commitments in a religious and spiritual context)
The model of total living environment (Figure 5-1) suggests that a patient’s total needs should be evaluated and understood within the confines of the four dimensions of holistic health. Holistic long-term care then governs the clinical and socio-residential structures and aspects of care by promoting each individual’s quality of life through comfort, security, aesthetics, private space, personal independence, personal preferences, dignity, and self-esteem. Each patient is allowed to feel at ease and in harmony with the environment that has become the patient’s home. It means that the environment itself must promote healing of the body, mind, and spirit. Because a patient’s stay in a nursing facility generally involves an extended period of time, long-term care falls short of its objective if it does not have this holistic integration.

A nursing facility has a legal and moral duty to provide clinical care according to acceptable standards. Regulatory standards set a minimum quality threshold for clinical services. To a lesser degree, regulations also identify the main social components. But, in both areas, nursing facilities must go beyond the minimum requirements. The culture of nursing home administration suffers from paranoia of the regulatory system. Collopy (1995, 149) argued that the nursing home industry is often slow to respond and is largely reactive in the way that it invokes moral values, mainly to protect itself against possible regulatory sanction. Such a highly risk-averse stance mutes the providers’ own moral agency, so regulators and advocates for the elderly have seized the ethics agenda and have taken the initiative to prescribe minute regulatory details. Such a state of affairs will change only when the industry’s leadership asserts the values that are most desired by its clients.

The Realistic Context

Even though a total living environment of holistic care is an ideal that nursing homes must strive to achieve, numerous constraints keep the ideal from being fully attained. Inadequate financing is often a major constraint that limits a facility’s ability to obtain or use resources. Some constraints are patient centered. Examples include behavioral problems, such as frequent combativeness or screaming episodes, that can disrupt the environment. Therefore, the delivery of clinical and socio-residential services in nursing homes must also be placed in a realistic context. Patients in nursing facilities are in a clinical environment 24 hours a day,
seven days a week. Nursing facilities exist because of economic necessity. If it were feasible, almost every nursing home patient would choose to be cared for in a private residence by a private-duty nurse. The reality, however, is that unless an individual is very wealthy neither the individual patient nor the society can afford to incur the expense that private-duty care would entail. Expensive as it is, delivery of care in a nursing facility is highly cost-effective compared to private-duty nursing. From this perspective, the residential nature of a nursing facility should not be construed to mean that it is a private residence. It must, by necessity, provide services to a relatively large number of patients. In spite of suggestions to downplay or to criticize the institutional nature of nursing facilities, the fact remains that nursing facilities must function as organizations. As organizations, they must provide services as efficiently as possible, although focusing on efficiency will dilute social and residential aspects to some degree.

By its very nature, any group living arrangement, whether large or small, creates an environment in which small-scale conflicts of everyday life are likely to occur. First, respecting autonomy can be “vexatious because the conditions that bring elders into long-term care—confusion, dementia, wandering, and a host of diseases associated with being old—are such that the very capacity for choice and rational decision making is seriously compromised, if not absent” (Agich 1995, 113). In a relation of dependence, it may be quite natural for a caregiver to simply take over the care-delivery process. Yet, an effort must be made to return to the elder patient some of the responsibilities for his or her own health care in a caring and respectful way. Thus, a delicate balance exists between the clinical and social aspects of caregiving. The caregivers’ primary task is to help the patients reorient themselves in their effort to “make or remake their world,” which is an important but often overlooked aspect of adaptation to loss, pain, and suffering (Scarry 1985). However, there is no standard rule that can be followed to help people adapt to change in their lives. People try to adapt in their own unique ways through various interpretive efforts. The nursing facility, however, can provide physical surroundings and a basic sense of personal space to help the process of adjustment. Familiarity and closeness in the caregiver-patient relationship that is built on the foundation of respect for the patient can also help patients maintain their sense of identity despite the ravages of impairment (Agich 1995).
In a nursing facility, each resident’s desires, interests, and actions can directly affect the interests and legitimate expectations of other residents (Arras 1995). For example, patients who wander into others’ rooms, rummage through others’ belongings, dip their hands into other diners’ plates, make yelling noises, or display combativeveness disrupt the quality of life of other residents. To deal with such conflicts in an institutional setting, the facility must achieve an appropriate balance between the needs of these groups. Arras (1995) suggested that a model other than the one in which the patient’s best interest becomes the overriding goal is necessary. This alternative model is based on the notions of fairness, accommodation, compromise, and negotiation. Again, each situation is going to be different, but as a general rule, no one patient’s interests are legitimately outweighed by the competing interests of other patients.

**CLINICAL ORGANIZATION**

This section describes the clinical set-up in a traditional skilled nursing facility. Many newer facilities are being built using innovative design concepts to downplay the clinical structures, as discussed later in this chapter. The concept of a Green House, a sort of small, cottage-like structure, is presented in Chapter 6.

**Nursing Units**

A nursing unit or wing is a section of a facility that consists of a certain number of patient rooms served by a nursing station. Depending on its size, a facility may have clinically distinct nursing units, each providing a somewhat distinct level of care, such as rehabilitation, dementia care, or specialized care. Distinct nursing units can also be designated according to the type of certification (see Figure 3-3). To achieve staff efficiency, most clinical units are self-contained, having their own bathing rooms, dining or feeding rooms, and lounges for patients and visitors. An adequate number of clean linen closets should be located in the hallways of each nursing unit. An enclosed area or a hallway nook for depositing soiled linens should be located in the unit, with marked containers to ease sorting and to separate lightly soiled linens from those that are heavily soiled. When utility closets are easily accessible to staff, hallways are kept free of clutter and odors are kept to a minimum. An enclosed soiled-utility area
is ideal, because it can be equipped with a rinse tub to eliminate heavy wastes. Modern ventilation and waste-elimination systems are designed to keep odors to a minimum. Also, staff members ought to be trained in sanitation and odor control methods. Chemical deodorizers should not be used to mask odors.

A facility of 80 or more beds is likely to have more than one nursing unit. To the extent that it can do so, a facility should segregate patients based on clinical criteria. Distinctly separate specialized care units are often provided for subacute care or Alzheimer’s care. Such a specialized unit allows the facility to match staff skills to special patient needs. Restorative aides (paraprofessionals who follow up on rehabilitation therapies), for instance, are most appropriately stationed in the SNF unit where most of the Medicare patients are located. A separate nursing unit, however, is not feasible to have for every type of specialization. Several clinically complex services such as ventilator care, head trauma care, care for spinal injuries, and treatment for pressure ulcers and wounds can be located on one unit that is served by the same nursing station. On the other hand, neatly categorizing patients in terms of their needs for care is not always practical. Comorbidities often present a challenge to long-term care clinicians about where a patient with given health conditions can be best accommodated. However, facilities must give due consideration to each patient’s clinical needs as well as the patient’s quality of life. For instance, every effort should be made to segregate patients with cognitive impairments or behavioral problems from those who do not have such disabilities.

Some facilities focus on private-pay clients by furnishing a separate non-certified unit where the living environment is enhanced and amenities are upgraded. This type of segregation in a non-certified section allows a facility to provide upscale services to private-pay clients without discriminating against those on public assistance. It also shelters the non-certified section from certification surveys (see Chapter 3).

**Nursing Station**

The hub of clinical care is an appropriately located, adequately staffed, and well-furnished nursing station. This station can be regarded as a service center from where all nursing care is delivered to a certain number of patients, generally on an entire nursing unit.
Location of Nursing Stations

A nursing station should be centrally located, to enable the nursing staff to observe and supervise a certain number of patient rooms and to respond effectively to patient needs. A facility may have more than one station, depending on its size, acuity level of patients, and complexity of care. On the other hand, having too many stations would be inefficient, because each station must be individually staffed. As a general rule, a nursing station serves each clinical unit in a facility. The maximum distance allowed from a nursing station to the farthest patient room is generally specified in state licensure regulations.

Other areas of a clinical unit that may be adjacent to the nursing station include rooms for bathing and showering, special dining areas, and patient lounges, including the lounges designated for smokers. Of course, not all patient dining rooms and lounges must be in the vicinity of a nursing station—only those where supervision from staff is necessary. Also, not every type of specialized service requires a separate nursing station. Services for patients who need ventilators, head trauma care, spinal injury care, and treatment for pressure ulcers and wounds can all be provided from the same nursing station.

Staffing of Nursing Stations

Staffing is one of the most important issues in nursing homes. State licensure regulations often specify minimum staff-to-patient ratios, and facility administrators may tend to believe that those minimum standards represent adequate staffing levels. State standards set a minimum requirement, which is at best arbitrary, because it does not take into account the level of patients’ clinical acuity and other aspects of patient mix discussed above. Clinical load rather than state regulations should govern staff-to-patient ratios, and higher ratios are needed in specialized and heavy-care units (discussed in Chapter 14). Staff-hours per patient specify total staff hours for a given number of patients. Two additional staffing considerations are necessary:

- The skill-mix—the mix between registered nurses (RNs), licensed practical/vocation nurses (LPNs/LVNs), and certified nurse aides (CNAs)—must be carefully evaluated. Skill-mix considerations also include any specialized training, experience, and actual staff performance and productivity. For example, the staff may require spe-
cial training to adequately address cognitive and behavioral issues. Matching the skill-mix to patient needs is important, as indicated by a composite case mix based on patient assessment.

- Distribution of staff hours between the three main shifts—day, evening, and night—requires a proper balance. Generally, the day shift needs the heaviest staffing, and the night shift requires the least. But, different nursing units are likely to require different day-to-evening and day-to-night staffing ratios. Even within the same shift, certain time periods have heavier patient loads than others. For instance, the morning wake-up and grooming time, the lunch hour, and evening meal time generally require more staff assistance than at other times. The feasibility of adding staff hours to meet peak patient load demands should be assessed.

**Nursing Station Furnishings**

The layout and furnishing of a nursing station should enhance staff effectiveness. The station itself is an enclosed area, with a counter behind which nurses and other staff members perform administrative tasks. No one but authorized staff members should have access to the area behind the counter. Among other things, a nursing station’s furnishings must include three important components: a patient-call signal system, medical records, and a pharmaceuticals room.

**Patient Call Signals**

A call system is a critical component of a nursing unit. The system connects devices at all patient bedsides and next to all toilets to the nursing station. Ideally, it should also connect the station to the bathing-and-shower rooms, dining areas, and lounges located on a given nursing unit. The system enables the patients themselves and staff members working with patients to summon help when needed. Ideally, the system should have audio-visual as well as voice capabilities. A patient uses a sensory device—such as a call button—that sets off the audio-visual signal at the nursing station. This audio-visual signal consists of a light and a buzzer or bell to alert the staff that a patient is calling for assistance and also to identify the patient who needs help. A voice or “talk-back” feature is useful when the staff member attending to a patient needs to communicate with
staff members located at the station; this device saves time that otherwise will be spent walking back and forth from the nursing station.

**Medical Records**

Located at the nursing station, there must be a separate medical chart for every patient on the unit. The medical records must be readily accessible to all authorized staff members. Confidentiality, however, must be maintained at all times. Medical records are increasingly being automated by using computer-based information systems. Automation can greatly facilitate the tasks of keeping records up to date and retrieving them quickly. But keeping them secure and confidential is challenging (see Chapter 12).

**Pharmaceuticals Room**

The pharmaceuticals room, or “medication room,” as it is commonly called, should be quickly accessible from the nursing station. This room is locked to adequately safeguard all medications. A system that allows separate storage of medications for each patient should be used. The pharmaceuticals room is also commonly used to store nursing treatment supplies and a first-aid box. The room is furnished with a refrigerator for storing certain medications that require refrigeration. The room also contains a locked storage area for controlled substances that must be kept double-locked. A system must be in place to adequately account for all used and unused medications for each patient.

The prescription, dispensing, and use of **controlled substances**—narcotics, stimulants, depressants, hallucinogens, anabolic steroids, and chemicals—are governed by the Controlled Substances Act (CSA), Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970. Except as provided under the law, possession or use of controlled substances is illegal. Controlled substances are listed in Schedules I through VI of the CSA. Many of these drugs have a useful and legitimate medical purpose when appropriately prescribed by a physician, but their abuse generally has a substantial and detrimental effect on health and general welfare; hence the need for strict control of these substances. A facility must store controlled substances in a double-locked cabinet and implement proper recordkeeping and verification systems. Federal regulations also require all controlled substances to be destroyed—and that this destruction be duly witnessed—if an order for controlled substances is discontinued for any reason.
SOCIAL ASPECTS

Although a nursing facility is considered a patient’s home, it is also a community. The social aspects of long-term care entail the influences that the physical and social environments have on the patients’ physical, mental, social, and spiritual well-being. A positive environment is therapeutic for the patient, and it should also relieve the clinical infrastructure of pressures that might otherwise be imposed on it from social conflict or individual ill-adjustment. As mentioned earlier, clinical segregation plays a role in shaping the social environment, and it enables a facility to reach a better balance between the clinical and social domains. Segregating patients with severe dementia and those with behavioral problems from other patients is particularly important. A disruptive environment creates commotion and confusion and is unhealthy for those who prefer quietude and wish to engage in productive social, mental, and spiritual pursuits. The facility’s set-up should also make it easier for patients to explore their compatibilities with others and engage in social interactions in accordance with personal preferences. Thus the social environment has both personal and public domains.

Personal Domain

At a personal level, the main concerns people have are security, autonomy, and privacy. In coping with change, opportunities for introspection, a sense of personal space, and the respect of others may be more important for the patient than the ability to socialize with others.

Security

Security is a basic human need. It entails not only physical safety and psychological peace of mind but also the commonality rather than separateness of person (Parmelee and Lawton 1990). Security includes a variety of conditions that contribute to freedom from risk, danger, anxiety, or doubt (Schwarz 1996). A nursing facility is responsible for its patients’ personal security and the safekeeping of their belongings and private funds if the latter are deposited in a patient’s trust account that the facility manages. Security considerations often vary from one patient to another. A patient may have a tendency to wander out unnoticed, another may insist on wearing expensive jewelry that someone could remove or that could get lost, and another may hallucinate and imagine that someone is assaulting her. It can
be therapeutic for a patient to wander out into a protective environment, such as a fenced-in walkway. On the other hand, any major safety concerns should be incorporated into the patient’s plan of care, and they ought to be addressed by a multidisciplinary team of professionals, because the patient may require therapeutic intervention from trained staff.

**Autonomy**

Autonomy can be defined as “a cluster of notions including self-determination, freedom, independence, and liberty of choice and action. In its most general terms, autonomy signifies control of decision-making and other activity by the individual. It refers to human agency free of outside intervention and interference” (Collopy 1988). In any type of health care delivery, the patient assumes a dependent role in relation to the provider of care, as observed by Talcott Parsons (1972) in the sick-role model; the patient must concede some degree of autonomy. This dependence, however, does not mean that the patient should be made to give up all choice and decision-making. To the contrary, because health care by its very nature creates dependency, providers have an obligation to ensure the maximum preservation of patient autonomy. Patient rights, discussed in Chapter 3, are founded on both legal and ethical principles. Patient autonomy is the ethical principle governing patient rights. Therefore, any attempt to minimize patient autonomy is unethical. In this respect, the ethical principle goes beyond whatever is prescribed by law. On the other hand, a patient’s autonomy cannot be taken to an extent that it infringes on the rights of others.

Autonomy for patients also requires that they be allowed to personalize their living quarters with familiar things, and such personal items as radios, small television sets, family pictures, mementos, artifacts, plants, music, personal furniture, bed accessories, etc. For people with dementia, in particular, a link to the past becomes essential for exercising their remaining capabilities, because their long-term memory remains relatively intact until the later stages of the disease (Cohen and Day 1993). Emotions and memories from past experiences and events often stimulate conversation and social interaction. Although space is almost always limited, a display shelf in each room can help people personalize their space by displaying memorabilia and other items. Certain personal belongings may also pose safety concerns. For instance, too many electrical gadgets may overload the circuits and create a fire hazard. Long extension cords and floor rugs pose a tripping hazard.
Autonomy also means that a patient must be able to make informed choices. Although the nursing facility must encourage informed choice, it also has the responsibility to do what is in the patient’s best interest. Occasionally, conflicts may arise between a patient’s autonomy and the facility’s duty toward the patient. Such conflicts should be resolved by taking into consideration legal requirements, regulatory constraints, and ethics. Such situations are often not clear-cut. For instance, should a nursing facility use funds out of a patient’s trust account to purchase new glasses or new hearing aids after the patient has already broken or lost two or three of them? Such decisions can be best addressed in a multidisciplinary forum in which decision-makers take into account the patient’s wishes and past practices if the patient is unable to participate in decision-making. But, if the patient can participate, his or her wishes must be carried out.

Privacy

Almost all individuals require at least some privacy in terms of space, time, and person. In a health-care facility privacy of space is first determined by the type of accommodation: private or shared. Many facilities maintain a small number of private rooms for single accommodation. As a general rule, however, occupying a private room is considered a luxury for which someone has to pay more. Unless a medically determined need exists for private accommodation, public as well as private insurers do not cover it. So, in most instances, a patient must spend out-of-pocket funds if a private room is desired. Hence, for most patients, shared accommodation is the norm, which in most modern facilities constitutes double occupancy (rather than triple or quadruple accommodation). In these circumstances, privacy rests on how much physical space each individual has, including closet and storage space. Privacy also entails the need for intimacy (Westin 1967). Intimacy is a person’s privacy during visits with family, friends, and legal or spiritual counselors. Residents can also express their sexuality in a private environment if their intimacy is assured. Because privacy is generally compromised in a multiple-occupancy setting, the facility should provide secluded areas that may be used for intimate dining experiences with family and friends, for private visits, or for sexual intimacy. Even a recessed nook with a small table and two chairs can provide an area for private visitation.

Privacy of time is often compromised by clinical routines that are established for the sake of staff efficiency. However, such routines tend to
make patients’ lives regimented. In most nursing homes, wake-up and morning-hygiene chores must be completed before breakfast. Because assigning staff members to every resident at the same time is not possible, certain residents must wake up before others, and there may be little provision for patients to sleep in late. Meal hours are also generally fixed. Bathing and shower routines are scheduled ahead of time. Yet, within the parameters of such scheduled routines, patients’ individual preferences should be accommodated whenever possible. Privacy of time also includes the need for personal reclusion, that is, have time for oneself and be free from unwanted intrusion, to be alone for quiet reflection. For this purpose quiet and secluded spaces such as small libraries and chapels are highly desirable.

A disregard of privacy of person is dehumanizing. Privacy of person can be equated with dignity. Privacy of person should always be protected, because some aspects of privacy depend not on space or time but on the practices and processes of care delivery. A basic rule for facilities to follow is to treat every person with dignity, regardless of whether he or she can perceive indignities (Kane 2001). Knocking at the door before entering a patient’s room, closing the door for a patient while that patient is using the toilet, drawing privacy curtains during treatment, providing appropriate personal covering for a trip to the common bathing-and-shower area, providing proper grooming during a trip to the therapy room or dining room, and giving lap robes to female patients in wheelchairs are examples of how personal privacy is respected to preserve individual dignity.

Public Domain

Loneliness and isolation are common concerns among the elderly. Unless a person chooses to remain alone, opportunities must be provided for wholesome social interaction. The range of such opportunities depends on how well a nursing facility functions as a social community. The three most important experiences from this perspective are compatibility, the dining experience, and socializing.

Compatibility

Social interactions in the public domain are primarily driven by compatibility, because compatible relationships are something people naturally seek. The issue of compatibility first arises when a new patient is admitted to the facility and has to share a room with another patient who is a com-
plete stranger. Gender compatibility has been a long-established practice. Room sharing by two individuals of the opposite sex is permitted only in case of legitimate couples. Apart from such obvious types of compatibility, the main consideration in assigning a room to two people is how well the two individuals are likely to get along and engage in a meaningful social rapport. Compatibility is also an important consideration in other situations requiring social groupings, such as dining at the same table or participating in social and recreational events.

Relationship-building and bonding can be facilitated in several ways. Some nursing home residents assist other residents with simple tasks, such as escorting a friend to the dining room or assisting someone in a wheelchair. People who have disabilities of their own can find meaning in being helpful to others; it builds their own self-esteem. Nursing home residents can also develop such appropriate relationships with volunteers and staff members.

**Dining**

In the social context, dining is more than just something done for physical sustenance and good nutrition. Dining can provide opportunities for people to interact with others in a social setting. Seating arrangements should be such that they create opportunities for those who can socially interact. Of course, a patient’s clinical condition will determine to what extent interaction is possible. For patients who require feeding assistance or who may have other special needs, dining may become a clinical event, but staff interaction can still help make it a social event. To the extent possible, clinical dining areas for those who cannot eat on their own should be separated from social dining areas, so that those who are able to dine in a social setting can enjoy the dining experience without interruption or distraction.

The dining environment should be relaxed. Comfortable chairs, tablecloths or placemats, cloth napkins, table center-pieces, and soft music contribute to a relaxed and enjoyable experience. A facility should also have some special tables to accommodate wheelchairs, but ambulatory and wheelchair patients should be allowed to sit and dine together.

**Socializing**

Socializing often depends on an individual’s capacity to interact with others. Well-planned facilities offer varied spaces where people can spend time in the company of others. Effectively managed facilities offer numer-
ous daily opportunities for patients to socialize according to their personal interests. Social events also enable patients with dementia and other limitations to receive sensory stimulation by just being present. Events should be held in both interior and exterior spaces. Interior spaces include lounges, dining areas, craft and game rooms, and chapels. Exterior spaces include courtyards, patios, balconies, terraces, vegetable and flower patches, gazebos, and the spaces around bird feeders and fountains. The building’s design should permit all residents easy access to the exterior. The outdoor spaces should have appropriate seating arrangements so that the patients can spend time relaxing, socializing, and simply enjoying the surroundings. Interior spaces should be comfortable and pleasing, with appropriate furniture, lighting, fixtures, and décor that allow people to associate with one another in pleasant surroundings. Modern facilities also have spaces such as mini-malls, ice cream parlors, and barber and beauty shops where residents can enjoy in similar fashion some of the social activities they once pursued.

**RESIDENTIAL FEATURES**

‘Homelike’ is the buzzword often used in discussing the residential context of long-term health care facilities. Indeed, the design of the residential structure should be founded on the home concept. To be realistic, though, one should also take into account the clinical domain. The point is that patients are admitted to nursing facilities only because they have clinical needs. The clinical and residential elements of care, therefore, must complement each other. Otherwise, residential features that detract from a high level of clinical care, particularly in subacute care settings, can be counterproductive.

A pleasant and comfortable environment is necessary for maximizing the patients’ quality of life. A homelike environment is achieved by a facility’s structural design, furnishings, décor, and a proper emphasis on the social structures discussed earlier. This section will address some of the physical features necessary for creating a residential environment. Most of the design features that will be addressed are particularly applicable to planning a new facility or remodeling or expanding an existing one. Other elements of residential-structure design can be incorporated into existing facilities with little expense. In addition, the safety and accessibility features that the nursing facilities’ buildings must have are governed by laws with which the nursing facilities must comply.
For people with dementia, in particular, small groupings of residents in a setting that resembles a home—and not a large institution—provide a more effective therapeutic setting. The smaller scale of the living quarters reduces the stress that such patients may experience from the overwhelming effect of being placed in complex, unfamiliar surroundings. The medical character of the facility can be further deemphasized by eliminating the traditional nursing station and creating more shared spaces for social contact (Cohen and Day 1993). Large institutions can often modify a section of the main building to create a smaller, self-contained unit with its own kitchenette and common room, which can serve as a multipurpose room for dining, activities, and socializing.

**Residential Designs**

The average size of a nursing facility has increased by 40% from 75 beds in 1973 to 105 beds in 1999 (National Center for Health Statistics 2002). Although the larger size creates operational efficiencies, it detracts from a residential environment. In response, some innovative architectural plans have emerged. Modern residential designs promote privacy and neighborhood social activities. Increasingly, in new constructions, private rather than shared rooms are in vogue, to give patients more personal space. In addition, current architectural designs no longer feature the traditional long corridors that are lined with rooms on both sides, which often get cluttered with all kinds of barrels and carts and create an institutional look and feel. High-pitched roofs, varied plan configurations, and the connection of indoor to outdoor spaces can make a building seem more like a condominium than a nursing home (Nursing home architecture 1997).

**Cluster Arrangement**

The cluster design is gradually replacing the traditional corridor design in modern nursing home architecture. The design places decentralized self-contained clusters within the larger clinical units, creating relatively small residential groupings. Even though a nursing station is present, the design helps de-emphasize it. The cluster concept is sometimes called “neighborhood living,” and the clusters may be called “household clusters.” Each cluster functions as a residential unit or neighborhood, with its own living room and a room for various activities and for dining, surrounded by resident rooms (Dunkelman 1992). Seating configurations are designed to
create intimate social spaces. The design allows for plenty of windows for natural lighting and a somewhat panoramic view of the exterior. Clusters also tend to offer better flexibility in segregating residents than traditional layouts do. For instance, patients requiring heavy care could be accommodated in the same cluster.

Clusters are typically designed for between eight and twelve residents, and three or more clusters are grouped together for staffing efficiency (Browning 2003). For example, Figure 5-2 illustrates three nine-bed clusters, totaling 27 beds. High construction costs for clusters present a major challenge to facilities although better functional efficiencies are often gained. By decentralizing staff and services and giving staff members quick access to utilities, a cluster layout can make employees more productive and the delivery of care can be improved. Small nurse-aide stations—generally no more than a desk and chair—enable the staff to be in close proximity to residents, allowing for prompt attention to their needs. In Figure 5-2, each of the three clusters has its own nurse-aide station. The self-contained clusters also have their own bathing rooms, linen closets, and soiled utility closets. Staff members can function more efficiently, because this arrangement shortens walking distances and saves time. Services are brought to each cluster, instead of transporting residents to the nursing station, dining room, or therapy room (Dunkelman 1992). A group of permanent caregivers assigned to each cluster can also provide opportunities for interaction and bonding between caregivers and residents.

Nested Single Rooms

To counter the high cost of constructing private rooms, the architectural firm of Engelbrecht & Griffin (now named EGA, PC) pioneered the design of nested single rooms. Cost is conserved by efficient use of space. Although nested rooms are much smaller than regular rooms, they are self-contained bedrooms with their own private half-bathrooms that have a toilet and a sink (Figure 5-3). Nested single rooms offer privacy, and when they are placed in a cluster setting, they can also provide opportunities for socializing through “neighborhood living” arrangements (Figure 5-4). Easy access to common lounge areas in the vicinity of the rooms encourages residents to get out of their rooms to meet and converse with familiar neighbors, and provides a comfortable setting for visiting with family and friends.
FIGURE 5-2 27-Bed Wing Plan in a Cluster Arrangement of Private Rooms

Source: PDT Architects/Planners, Cincinnati, Ohio. Designed by Mark B. Browning, AIA, for Cedar Village, Mason, Ohio. Reprinted with permission from Mark B. Browning.
Safety

Safety is a paramount concern in all living environments. But safety is especially important in long-term care facilities because these facilities house residents who have various degrees of disability. In building design, safety requirements are primarily governed by federal, state, and local...
FIGURE 5-4  Partial Floor Plan of Cluster Scheme

Source: EGA, P.C. "Designs for Living." Reprinted with permission from EGA, P.C.
codes and regulations. Among these, the Life Safety Code of the National Fire Protection Association (an international private non-profit agency) provides the most comprehensive set of rules. The Code has the force of law; so total compliance is necessary. It addresses construction, protection, and occupancy features that are necessary to minimize danger to life from fire, including smoke, fumes, or panic. Fire barriers; fire resistance ratings of walls, doors, and ceilings; and other construction features are minutely detailed in the Code. Flame-retardant standards for furnishings, curtains, and upholstery are specified. The Code requires that waste baskets and trash cans used in the facility be made of non-combustible materials or that they have Underwriters Laboratory or Factory Mutual product markings. The Code establishes criteria for means of egress, as well as written plans for evacuation and relocation to areas of refuge within a building and for evacuation from a building. The Code specifies installation, maintenance, and testing of safety equipment such as emergency generators, sprinkler systems, smoke detectors, fire alarms, fire doors, and exit signs. It sets standards for air conditioning, heating, ventilation, and electrical systems. It also outlines minimum requirements for fire drills that facilities must conduct on a regular basis. Publications by the National Fire Protection Association include a Life Safety Code Handbook, which contains not only the text of the Life Safety Code but also supplementary interpretations in the form of commentaries, examples, and illustrations.

Safety of residents is determined by many factors other than building requirements. These are common safety considerations that staff members must remember at all times:

- The elderly are particularly vulnerable to falls. Great caution and vigilance needs to be exercised around wet floors, power cords, fallen objects, and throw rugs.
- Potential hazards should be eliminated or closely monitored. Access to products such as drugs, lotions, and ointments on medication and treatment carts should be adequately supervised. Patients could also gain access to other unattended toxic substances, such as cleaning chemicals left unattended on housekeeping carts, or sharp objects, such as certain maintenance tools.
- Access to areas such as the kitchen, mechanical rooms, and laundry are generally prohibited. However, kitchen and laundry areas can provide stimulating and meaningful engagement for some patients,
including those with dementia. With some supervision, cooking or laundry activities can add to patient’s quality of life, particularly when smaller kitchenettes are included in the facility’s design.

Not all nursing homes are located in safe neighborhoods. The administrator must evaluate external security concerns, which include protecting residents and their property from intruders. To the extent that patients can feel safe and secure, they can choose to spend time indoors and outdoors.

Accessibility and Wayfinding

Nursing home buildings and facilities must be accessible by individuals with disabilities. A **disability** can be a physical or mental impairment that substantially limits one or more major life activities. Accessibility for disabled people is required under the Americans with Disabilities Act (ADA) of 1990. The legislation is a general civil rights law designed to protect the rights of handicapped people in all aspects of their lives, including employment, recreation, and their use of buildings and facilities. The ADA also covers access to transportation and communication. ADA prohibits discrimination in public accommodations (i.e., businesses open to the public) on the basis of disability. Although the law does not specifically mention nursing facilities, health care establishments fall within the category of public accommodation. The law requires that certain adaptations, whenever necessary be made to provide access by the disabled to such public accommodations. For example, there should be no architectural barriers that might prevent access to the building from sidewalks and parking areas. Inside the building, barriers to accessibility should also be removed. Examples of things a facility can do to make its services accessible include positioning telephones, water coolers, and vending machines so that they are easy to reach and use; installing elevator control buttons with raised markings; using flashing fire alarm lights; installing raised toilet seats and grab bars in the bathrooms, and allowing enough room to maneuver a wheelchair; and avoiding high-pile carpeting that makes steering a wheelchair difficult.

The ADA also requires facilities to provide auxiliary aids for effective communication. Such aids include interpreters, telecommunication devices for the deaf, audio recordings, and large-print books and publications. However, the facility is not required to provide personal devices and services such as eyeglasses and hearing aids (American Association of
Retired Persons, undated). Any segregation of patients within the facility should be based on clinical factors, not on a person’s disability, because segregation based solely on disability is discriminatory. Another law, the Fair Housing Amendments Act of 1988, prohibits disability-based discrimination in public and private living quarters. The American National Standards Institute (ANSI) has published detailed design specifications for accessibility (see ANSI 1986).

Due to a decline of various senses, residents in nursing homes are often susceptible to disorientation. Sameness and repetition—similar layouts, regular pattern of doors, and similar furniture throughout a facility—are the common sources of disorientation (Drew 1992). **Wayfinding** is the term used to describe features that can help people find their way through a large institution with relative ease. Orientation involves much more than use of signs. In addition to clear and readable signage, wayfinding can be facilitated by using a variety of means such as employing different color schemes and patterns in different sections of the facility; color-coding handrails; varying furniture styles; varying layout and arrangement; using pictures, photographs, tapestry, hanging quilts, and window displays; and placing public accessories such as telephones and water coolers in planned locations. Pathways for wandering, residential kitchens and laundries, and contained outdoor gardens are particularly helpful in caring for patients with dementia (Regnier 1998). On the other hand, doors leading to utility rooms and areas not meant for residents should be painted to blend with the adjacent walls.

**Positive Stimulation and Distraction**

In long-term care facilities, chronic understimulation and lack of positive distraction for patients can pose a substantial threat to wellness (Ulrich 1995). A nursing facility should be organized to function efficiently but design and décor should also promote health by creating physical surroundings that are psychologically and emotionally supportive for patients, visitors, and staff members. Supportive surroundings help reduce stress.

A psychologically supportive environment—also called an enhanced environment—is one that provides a moderate degree of positive stimulation and distraction. If the degree of stimulation caused by sounds, intense lighting, bold colors, etc., is too high, the effect can be quite stressful. On the other hand, prolonged exposure to low levels of environ-
mental stimulation can lead to boredom, negative feelings, and depression. In the absence of positive distractions, patients begin to focus on their own problems and end up increasing their level of stress. Positive distractions elicit good feelings, hold attention, and generate interest. Happy faces, laughter, people passing by, pets, fish in aquariums, birds, flowers, trees, plants, water, pleasant aromas, and soothing music can all be positive distractions. Negative distractions, on the other hand, are stressors. They simply assert their unwanted presence because it is difficult to ignore them. Visual stimulation from pictures, artwork, and television-watching can be positive for patients, but abstract art and uncontrolled loud noise from television are negative distractions. Other loud sounds, such as frequent paging over the intercom, are also distressing. Modern wireless communication devices, such as portable pagers, reduce institutional noises and enhance staff efficiency.

**Aesthetics and Comfort**

Light and color play a role in more than just the illumination and aesthetics of a facility. They also influence patients’ sleep, wakefulness, emotions, and health. The proper aesthetics are necessary to promote a sense of well-being, but aesthetically appealing surroundings are not necessarily comfortable. Aesthetics and comfort must be integrated.

**Lighting**

Natural sunlight is known to have positive effects on overall health. Facility design should incorporate as much natural lighting as possible, while also incorporating artificial light. Patios and porches provide residents with a place to be outdoors and enjoy direct sunlight. Windows, skylights, atriums, and greenhouse windows can be used to bring some of the natural daylight indoors. Low windows in patient rooms, lounges, and corridors allow residents to see the exterior grounds from their beds and wheelchairs. Window treatments should be used to regulate sunlight and minimize glare. Horizontal mini-blinds are generally preferable to vertical blinds, but light-filtering pleated shades are considered even better. Valances can be added to create a homelike look.

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1For much of the information in this section, the author is indebted to the excellent work by Elizabeth C. Brawley 1997. See References.
Lighting needs of the elderly are quite different from those of younger people. As their sight and visual acuity decline, the elderly require higher levels of illumination; glare must be minimized, however, because many patients are not able to modify their environment to avoid glare. Poor lighting and glare can lead to depression, agitation, confusion, and falls. A facility can ensure proper lighting for patients and also enhance the homelike feel by using chandeliers, wall sconces, recessed lighting, table- and floor-lamps, and other light fixtures. In resident rooms, night-lights are essential. Along with clear pathways to the toilet, night-lights can facilitate safe trips to the bathroom and help patients avoid falls.

Color
Colors can help lift spirits and create cheerful and soothing environments. Colors used in health care settings have changed dramatically in recent years. Traditional colors such as white, bold yellow, beige, and green are no longer considered appropriate. More pleasing and stimulating colors have now become popular, colors such as soft apricot, peach, salmon, coral, soft yellow-orange, and a variety of earth-colored tones. Patterns and colors in wallcoverings and decorative borders can liven up some otherwise unexciting areas. Bedrooms, bathrooms, dining rooms, living rooms, and alcoves are all appropriate places where wallcovering can enhance residential quality. Coated wallcoverings can be used in areas such as hallways, where soiling is a serious problem. Handrails are necessary in hallways and other areas, but with a natural wood finish, they help maintain the residential look.

Colors are also used to promote safety. Aging reduces a person’s ability to distinguish colors. To compensate for this reduced visual function, high-contrast colors should be used. For example, the color of grab bars in the toilet should contrast sharply with the color of the wall, to ensure maximum visibility. Countertop colors should stand out strongly from those of floors. For many nursing home residents, being able to use the toilet may depend on being able to locate it. In a totally white bathroom, some patients will find it difficult to distinguish the toilet from the floor or the adjacent wall. Colored toilet seats create visible contrasts against the surroundings and can facilitate locating the toilet. Conversely, a colored wall can provide visual contrast against a white toilet. For patients with Alzheimer’s, however, sharp color contrasts and patterns can be disturbing. Pastel colors tend to work best for these patients (Kretschmann 1995).
Furnishings

Carpeting adds warmth and softens sounds. It also provides cushioning against falls and can prevent serious fractures of the hip or wrist. Today’s high-performance carpets, which are resistant to stains and odors, are also cost-effective. New carpets are treated with a vinyl moisture barrier and an antimicrobial coating (Yarme and Yarme 2001). Proper installation and regular maintenance can make carpeting last for several years. Of course, carpeting is not appropriate for all areas in the building. Slip resistant tile is by far the most widely used flooring material. Resilient flooring with low sheen can be used in certain high-use areas without creating an institutional appearance. For example, these hard-surface floorings also come in beautiful wood-grain patterns that add a homelike touch. Also available are new soft-surface floorings that are made of easy-to-maintain sheet vinyl material with a dense, soft, carpet-like surface and a cushioned backing. These materials have been tested to ensure that they reduce injuries from falls (Yarme and Yarme 2001). Highly-polished and buffered surfaces are not recommended for the elderly, because they produce glare, appear wet or slick, and can be a source of anxiety and confusion.

A variety of furniture is now available that is specifically designed for long-term care facilities. Lounge chairs, sofas, and rocking chairs can add charm and variety as well as comfort. Use of upholstered furniture has actually become quite common. Some manufacturers are producing foam cushions that are soft enough to be comfortable and yet firm enough for residents to rise easily from chairs and sofas (Child 1999). Brawley (1997) comments on several enhancements in high-tech finishing of upholstery fabrics. These include soil- and stain-resistant finishes, lamination with vinyl, fluid barriers, and anti-microbial finishes. For nursing home use, these fabrics must also be flame-retardant. “Super fabrics,” such as Crypton, have built-in stain and moisture resistance and have been tested for fire and microbial resistance. These new fabrics have replaced vinyl coverings for chairs and sofas, and a range of colors, textures, and patterns are now available to enhance the residential environment in nursing facilities.

CONCLUSION

The delivery of long-term care in the nation’s nursing facilities continues to evolve as the holistic model of health care delivery transcends the sick-role
model as the basis for delivering care. As the sharp differences between acute care and long-term care are recognized and acknowledged, innovative approaches increasingly are being used to integrate the clinical organization of care with its social aspects and residential features. In fact, the residents’ quality of life cannot be maximized without integrating a number of factors that include clinical care, an environment that respects and promotes the personal domain, opportunities for compatible social relationships, and various aesthetic features that enhance the residential environment, with due regard for safety and positive stimulation. The next chapter describes some emerging concepts that in some ways build upon the concepts discussed in this chapter and in other ways go a step beyond.

DISCUSSION QUESTIONS

1. What actions can a nursing home administrator take to integrate the clinical and social structures in a skilled nursing facility?

2. Discuss the integration of clinical, social, and residential elements necessary for creating a therapeutic environment for patients with Alzheimer’s disease.

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