1. **INTRODUCTION -** The content of this brief should be considered as indicative and approached on the basis of an iterative process in partnership with key stakeholders. We anticipate that the requirements of the scheme needs to be developed alongside the master plan for the whole development so that the home responds to the site and vice versa.

   The fundamentals of good design are well documented and researched and the following does not seek to replicate the detail given in the following resources and others:

   - 'Excellence in Design: Optimal Living Space for People with Alzheimer's Disease and Related Dementias' - Chmielewski E, Eastman P. [2014]
   - Joseph Rowntree Foundation – Designing and Managing Care Homes for People with Dementia. http://www.jrf.org.uk/sites/files/jrf/1861348118.pdf
   - University of Stirling - http://dementia.stir.ac.uk/design [Good Practice in the design of homes for people living with dementia]
   - Dementia Care Matters – Butterfly Household Model of Care
   - Social Care Institute for Excellence – Dementia Friendly Environments

   Suffice to say we want to achieve best practice in care home design. Overall the purpose of this brief is to inform the design of a care home but the social care sector is complex and so the detail given also refers to other forms of available care and support that would in an ideal world be available to supplement current services. This is included as it does dictate the size of the home but may also be useful for the design team and MCC in determining the make-up of the wider site.

2. **BACKGROUND**:

   2.1. The proposed home at Crick Road will replace Severn View Resource Centre (SVRC). Sited in Chepstow, SVRC is a local authority owned and run building. In addition to a 32 bed residential home, the centre houses the Sth Monmouthshire Care at Home Team and a 6 days per week day service for older frail people and for older people with dementia.

   2.2. The home comprises 24 long term beds for people living with dementia, 2 short term beds (respite) for people living with dementia, 3 short term beds for older frail people and 1 long term bed for older frail people. The home also supports 2 step up step / down beds to support discharge and prevent admission from hospital.

   2.3. The home has reconfigured over recent years to support mainly people with dementia in response to an under provision in the independent sector. The home maintains a consistently good reputation and maintains near 100% occupancy.

   2.4. The home was built c1979 and although the layout is good, it has a number of significant weaknesses:

      2.4.1. Bedrooms are not en-suite. This is becoming increasingly unviable and there is the potential to be given a non-compliance order from CSSIW in due course.

      2.4.2. The layout is one of long corridors which is seen as poor practice in care home design; particularly in respect of people living with dementia due to difficulties in orientation and feelings of restriction.

      2.4.3. The home is on two floors, and this prevents ease of access to outdoor spaces.

2.5. Respite Services for people with dementia are supported on the same wings as those occupied by our long-term residents. Best practice would be to separate out the respite for people with dementia to avoid disruption to our long-term residents. Residential respite for people with dementia is significantly over subscribed.

2.6. In-house provision has a role to support the market. Demand and availability of long and short terms beds for older frail people [not living with dementia] suggests that this should not form part of future plans for the new build – further discussion required!

3. **OVERVIEW of DEMAND and BED REQUIREMENTS:**

3.1. **SERVICE REQUIREMENTS**

3.1.1. In terms of requirements the starting position is that MCC is seeking the re-provision of approximately 30 residential beds for older people living with dementia and a day service 6 days per week supporting 15 people per day. The limit is set according to revenue funding for staffing and the current provision. Exact requirements will need to be specified as we move through the design process. It is important to note that as it stands we must at least re-provide current services but this development allows an opportunity to explore the following:

3.1.1.1. The building design should through a well-planned environment support a more efficient staffing model. Although dependent on the funding mechanism for the new home, this efficiency may support an increased number of beds within the same financial envelope.

3.1.1.2. There is an under provision of high quality residential care for people with dementia. The potential to divert funding from independent sector placements to increase the number of beds provided should be explored.

3.1.1.3. Alternate funding options can be explored with funding and charging for rooms operating to different models of support.

3.1.1.4. Partnership arrangements could be explored with other not for profit providers so that there is some element of shared ownership that would allow an increase in the number of beds.

3.2. **DEMOGRAPHICS**

3.2.1. Current demand can be confused or influenced by current practice, assessment and service provision. For example the threshold that someone is considered for residential care is influenced by:

3.2.1.1. The expectations of the family and the person and limitations placed as to perceived ability to cope. Risk averse approaches from family members may lead to residential care prematurely.

3.2.1.2. The current standards and practice of community based services. Support may be failing; not due to the abilities and needs of the person but as a result of inconsistent care and support.

3.2.1.3. The range of services currently provided within the community. It is often not a dramatic shift in need that requires a move to permanent care but a tipping point. This may be need for support during the night, carer breakdown, anxiety, disorientation etc… If enhanced community based services were available, the need for residential care may be delayed or even prevented.

In essence a demographic trend that shows a percentage increase in people over the age of 85 cannot be simply extrapolated on the basis of an average of number of people over the age of 85 in residential care.

3.3. **BALANCED PROVISION:** to ensure that residential care services are targeted and focused on need, they must exist within a balanced environment of provision.

3.3.1. Extra care / enhanced community provision**:** there is clear evidence of the need to provide enhanced provisions to people being supported in the community. Elsewhere in the county where such provision is available the number of residential placements per capita is significantly lower.

3.3.2. Critical in the development of services is the exploration of nursing involvement in providing services. The strategic agenda across social care and health is paving the way for ever closer working. Key questions include whether part of the home could include nursing provision and also whether specialist end of life services could be provided. Different legislative standards and requirements would need to be considered if this aspect of development gained momentum.

3.3.3. Critical also is to maintain the provision of step up step down beds to ensure avoidable admissions and prevent unnecessary placements to residential services directly from hospital. These could be included within the respite wing / household of the home.

3.3.4. Supportive models of care that work across service areas**.** An integrated model of support with staff working across service areas may be an option and further increase staffing efficiency as well as improving the experience of the person being supported.

3.4. **CONCLUSION.** For the purposes of informing the initial design and to allow for further discussions on funding we propose that the range of 30 – 40 bedrooms for people with dementia is utilised with 1 short-term provided for every 6 long term beds and 2 additional step up step down beds. As stated the specific requirements will be dependent on the revenue funding available and agreed. It is also dependent on other housing models such as extra care which may with the right facilities be able to support respite and step up / step down facilities. **NB** we currently have one permanent resident who does not have dementia. Although support for older frail people may not be part of future provision we would need to be able to accommodate this one person in the new home or within the extra care facility.

4. CARE HOME DESIGN

4.1. PRINCIPLES OF RELATIONSHIP BASED CARE AND OUTCOMES FOR RESIDENTIAL PROVISION.

4.1.1. Critical in the design of the home is that the form supports the approach and practice within care services. Below are the outcomes for our residential services. Practice is based solely on relationship centred care; that we are 'with' people and not doing 'to' or 'for' people. That our approach supports the identity of the person. All our teams have very comprehensive training and at the heart of this training is the philosophy of Prof. Tom Kitwood. The flower shown is an illustration of the key ingredients to well-being identified by Kitwood. For someone to live well, these elements must be consistently present. This is true of everyone, whether they have dementia or not. An additional ingredient of 'autonomy' needs to be considered and the home design should support spontaneity and choice – where to be, what to do, when to eat etc.. Overall, we know that you can live well with dementia and the design of any care home has to actively support these ingredients to be present.

SERVICE OUTCOMES

- We promote a relationship based experience of receiving care and support that enables a natural life, promotes choice, control, independence and meets the social and emotional needs of the people we support.
- Improved listening and assessment. We understand 'what matters' and we know the person 'ordinarily'. In this context person centred support is only ever about the individual and founded on the persons individual needs for autonomy, inclusion, identity, attachment and comfort.
- Making it home. We recognise that "home" is different to us all and our homes reflect who we are as an individual. For those that live and stay at the home we will support the person to create a home and be at home; what comfort, security and individuality is to you. Shared areas will reflect the people who live in the home and their preferences.
- Services support the spirit of the person. We will place equal importance on the social and emotional well-being of the person as well as their physical well-being.
- Services support families, friends and other important people to remain involved they will feel involved and listened to and encouraged to actively advocate for their loved ones.
- The home looks, sounds and feels like a place for individuals to express themselves, have fun, make noise, be involved, be busy, find retreat and privacy and is at its heart whatever it needs to be to respond to how any person feels at any given moment.
- We recognise the importance of food and drink to a person's well-being. Meal times should be an occasion and be about so much more than just the food we eat.
- Maintaining connections with their local communities - to support people to maintain a sense of personal identity and inclusion in the local community. Communities will become more inclusive and

awareness of dementia will increase. We will actively seek opportunities to engage in the local community both through accessing the community and inviting community groups to visit regularly.

- The role of our teams develops. We utilise the skills of individual team members and they feel empowered, valued and their well-being improves. Individual team members are fully engaged and involved in developments.

4.2. **DESIGN CONSIDERATIONS**

4.2.1. **Overview -** Critical is on first approaching the care home what does it look, sound, smell and feel like. The tension between group living and it being an individual home must be reconciled in all aspects of the design. Typically, new build care homes can have a sterile, corporate [hotel] feel upon entry with reception, offices etc. Whilst there are practicalities of safety and security to resolve, a fence and security gate should not be the first thing that greets the person upon arrival. Reception and offices may need to be incorporated into shared areas (see below). Home style entrances are preferable that lead directly into the home and living areas. Coats and shoes would be more familiar as you enter a home, not a reception desk and adjacent offices. The home should be based on smaller households that are connected. People living with dementia can be overwhelmed by large spaces, too many people and too much noise. Smaller households mean shorter walking distances and better orientation which will increase the independence of the person. Smaller households will support person centred care and allow for 'flatter' staffing structures.

Each household should ideally have a separate external entrance and should include a large kitchen, lounge, dining room, shared toilet, fully equipped bathroom and quieter lounge area – this could be a snug. It is anticipated that the households would be linked but that there would be a shared area accessible from each household. Ideally each household would have no more than 8 – 10 en-suite bedrooms [8 per household is ideal]. En-suites will mainly have shower facilities but some incorporated baths would be beneficial. There is no need for separate toilet facilities for visitors and staff.

4.2.2. **Shared areas** within the home as a whole could include a Library, Hairdressers, Shop, Tea room and also have space for reception, office, staff welfare and administrative functions.

4.2.3. **Outdoors -** Access to safe secure outside spaces with different areas to allow for privacy and contemplation as well as socialisation. Ease of access to outside spaces is key to well-being; not only does it support people to connect with the world around them and give a sense of self and place, it is essential to physical well-being and sleep. The use of interconnecting paths should be considered, allowing the resident to roam to different areas. There should be natural flow to inside and outside areas so that the outside is accessible all year round. Toilet facilities should be provided outside. A detailed list of requirements for the garden has been prepared and can be shared with the design team. Ideally the home would be constructed at ground floor but 1st floor accommodation can be considered if there is direct access to outside spaces via roof terraces.

4.2.4. **Aspect –** There should be clear views of the outside (low cill heights) from as many places as possible.

4.2.5. **Orientation –** if a resident knows where they are, how to get somewhere and when they have arrived confidence will increase to move around the building. This will support greater independence and improved interaction within the home. Colour, light boxes, landmarks, destinations and specific features are all methods of orientation. Significant visual cues are key and consideration should also be given to using different smells to aid orientation.

4.2.6. **Personalisation -** It is not enough to state we encourage all residents to decorate their own room. This can be built in. Door furniture, colour schemes, memory boxes that are inset into walls as windows should help to orientate but areas of floor and wall space should be left to ensure that personalisation becomes almost a requirement. Shared areas should reflect the residents that are living there. There is a tendency to use front door furniture (knockers, letter box etc…) for bedrooms and this needs further discussion but this may run contrary to the household model.

4.2.7. **Noise and Acoustics -** careful consideration needs to be given to the acoustics within the home. As part of practice development senior staff undertake observations of interactions within the home – i.e. they will sit and passively observe. Levels of noise and associated disorientation and distress are key themes in the feedback from these observations.

4.2.8. **Couples –** Consideration needs to be given to providing rooms that can be converted to accommodate a couple to ensure people can stay together

4.2.9. **IT access –** is now essential for all residents especially as we develop access to social media. Phones must also be provided in each room. The home should have Wi-Fi.

4.2.10. **Alarm call system -** can support the efficient running of a home and help to keep residents and staff safe. Call monitoring functionality can be extended beyond alerting for emergencies and calling for assistance. The system must also be compatible with internal and external use. Use of smartphone technologies should be considered.

4.3. **VISITORS –** Residential homes can isolate relatives and visitors – families will question their role and purpose in the support of their loved ones when they come to live in a residential home. The design must incorporate:

4.3.1. A sense that visitors are part of the home and feel comfortable to be active participants in the life of the home. This supports them to have purpose when visiting.

4.3.2. Both inside and outside there needs to be areas for visitors to spend time alone with a resident. This should also include private dining space so that families can have a meal together.

4.3.3. Families and visitors should also have access to training and information resources. This is particularly important for families of people attending the home for respite.

4.3.4. Ideally the home would provide guest accommodation for families visiting from far away or when their loved one is unwell or at the end of their lives.

4.3.5. The Outside space should include a children's play area to encourage all members of the family to visit the home.

4.4. **ANCILLIARY SPACES**

4.4.1. Sufficient storage spaces must be built into the home. Sluice rooms must be anonymised wherever possible to avoid unwanted access by residents. Location and storage of delivery to large bulk items (incontinence products) needs to considered.

4.4.2. Car Parking should be adequate but should not impose on free access to external spaces.

5. **COMMUNITY CONNECTIONS**

5.1. A fundamental of the project is to connect the home with the wider community. The day service could also be available as a community resource / centre, shared areas within the home could invite people in; whether to use the tea room, shop or library.

5.2. Access to public transport has been highlighted as key in consultation with resident's families.

5.3. Joint areas could be considered. One idea proposed is that there should be a crèche on the wider site with outside spaces shared between the home and the crèche. The potential for older people to be with children can have significant benefits for both.

6. **MANAGEMENT AND STAFFING**

6.1. As discussed there are clear benefits to residents if they are supported by a staff team who feel supported themselves.

6.2. Clearly the home must accommodate some management and administrative function and further debate is required as to how this is best accommodated. Anything resembling a work station must be avoided in the home areas but there needs to be infrastructure which allows staff on the residential units to maintain files, store medication and access resident information. Paper free systems are currently being introduced across direct care services so a lap top is sufficient in each area.

6.3. Areas must be created for professional consultation and discussion – the home needs to invite in reach.

6.4. One key aspect of quality in care provision is the stability of the staff group. High retention allows for skills development and organisational investment in each team member. The built environment must support this. In addition to all aspects of comfort that exist for residents apply equally to staff. In addition the following should be considered:

6.4.1. There needs to be a quiet area for staff to withdraw to. In dealing with behaviour that can challenge staff can experience high levels of stress – this room can be linked to resident and visitor quiet areas – rooms for relaxation, contemplation etc….

6.4.2. Access to on-site training facilities which support continuous improvement and self-directed learning. One proposal under discussion is to establish the care home as a site to develop best practice in supporting people with dementia. This could include full

on-site training facilities as well as opportunities to develop apprenticeships and placements.

7. **CONSULTATION -** Before detailed designs are produced there is a clear need to undertake further consultation with a wide range of stakeholders. This should include people living with dementia, Families, Integrated Services Teams, Aneurin Bevan University Health Board Colleagues, Direct Care Teams and specialists in supporting people with dementia.