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How architectural design affords experiences of freedom in residential care for older people

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ABSTRACT

Human values and social issues shape visions on dwelling and care for older people, a growing number of whom live in residential care facilities. These facilities' architectural design is considered to play an important role in realizing care visions. This role, however, has received little attention in research.

This article presents a case study of a residential care facility for which the architects made considerable effort to match the design with the care vision. The study offers insights into residents' and caregivers' experiences of, respectively, living and working in this facility, and the role of architectural features therein.

A single qualitative case study design was used to provide in-depth, contextual insights. The methods include semi-structured interviews with residents and caregivers, and participant observation. Data concerning design intentions, assumptions and strategies were obtained from design documents, through a semi-structured interview with the architects, and observations on site.

Our analysis underlines the importance of freedom (and especially freedom of movement), and the balance between experiencing freedom and being bound to a social and physical framework. It shows the architecture features that can have a role therein: small-scaleness in terms of number of residents per dwelling unit, size and compactness; spatial generosity in terms of surface area, room to maneuver and variety of places; and physical accessibility. Our study challenges the idea of family-like group living. Since we found limited sense of group belonging amongst residents, our findings suggest to rethink residential care facilities in terms of private or collective living in order to address residents' social freedom of movement. Caregivers associated 'hominess' with freedom of movement, action and choice, with favorable social dynamics and with the building's residential character. Being perceived as homey, the facility's architectural design matches caregivers' care vision and, thus, helped them realizing this vision.

Introduction

Worldwide, the number of older people is rising (United Nations, Department of Economic and Social Affairs, 2015). Because health status typically declines with advancing age, the need grows for long-term care, like provided in residential care facilities (United Nations, Department of Economic and Social Affairs, 2015; Van den Bosch et al., 2011). Ideally, these facilities meet contemporary care visions.

Societal discourses on dwelling and care for older people reflect an evolution from a medical to a social model (Declercq, 2000; Elf, Fröst, Lindahl, & Wijk, 2015; Mens & Wagenaar, 2009; van der Kooij, 1987). Originating in early 20th century modernism, the former takes a rational, objective, functional and pathological approach to care. Older people are categorized based on medical parameters or care needs. This model is associated with patronizing, stigmatization, institutionalization, exclusion and lack of recognition of personal characteristics, values and perspectives. The corresponding architecture lacks places relating to residents' daily life: "in a classical nursing home, people do not dwell" (Mens & Wagenaar, 2009, p. 79, authors' translation). By contrast, the social model emphasizes people's autonomy, individuality, community integration and participation, normalization, and home (versus institution) (Declercq, 2000; Mens & Wagenaar, 2009). Increasing attention goes to older people's experiences. The ongoing refutation of a purely medical model evidences an emancipation process of older people who want to avoid institutionalization (i.e., avoid subjection to institutional rules and routines, and to restrictions of activities, mobility and social contacts), and instead want their voice to be heard, continue their own daily lives, and stay involved in society as much as possible

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(Mens & Wagenaar, 2009). The physical environment plays an important role in realizing care visions (Elf et al., 2015; Kearns, 2007; Martin, Nettleton, Buse, Prior, & Twigg, 2015; Mens & Wagenaar, 2009; Van Steenwinkel, Verstraeten, & Heylighen, 2016).

Theoretically, environmental gerontology puts forward several models to develop understandings of relations between people and their physical environment. The competence-press model (Lawton & Nahemow, 1973), for example, plots the press exerted by the environment (broadly defined) that older people can manage in relation to their competence level. Another model by Parmelee and Lawton (1990) suggests that at the heart of person-environment relations in late life lies the dialectic of autonomy and security (following citations, see Parmelee & Lawton, 1990, p. 465–466). They define autonomy as "a state in which the person is, or feels, capable of pursuing life goals by the use of his or her own resources", and which implies "freedom of choice, action, and self-regulation of one's life space – in other words, the perception of and capacity for effective independent action". Security is "a state in which pursuit of life goals is linked to, limited by, and aided by dependable physical, social, and interpersonal resources." Security includes physical safety, social support, and peace of mind, for example, being free "from risk, danger, concern, or doubt."

Besides a focus on processes (like environmental stress, and competence), increasing attention goes to 'place' as a "key integrative construct in conceptualizing both the environments occupied by older persons and older person's interaction with these environments" (Wahl & Weisman, 2003, p. 625). A well-known model of place by Weisman et al. (Weisman, 1997; Weisman, Calkins, & Sloane, 1994; Weisman, Chaudhury, & Diaz Moore, 2000) considers the people studied in their physical, social, and care organizational context. Diaz Moore (2004, p. 298), following Gubrium (1978), defines place as "a milieu comprising a physical setting within which activities occur – which can be thought to be carried out by people of various social groups – and having inherent yet largely implicit socially shared understandings that enable effective coaction". In connection with the meaning of places in late life, the concepts home, identity, and privacy are well-researched (e.g., Rowles & Chaudhury, 2005).

However, theories within environmental gerontology have been criticized for being not very productive (Wahl & Weisman, 2003, p. 626). The worldviews underlying these theories may hamper research innovation and compatibility of knowledge with design practice (Diaz Moore & Geboy, 2010; Schwarz, 2012; Wahl & Weisman, 2003). Indeed, Schwarz (2012, p. 6) notes, by emphasizing a positivistic approach, environmental gerontology focused on predictive, context-independent theories that fail to offer insight into the role of the physical environment as a contextual element in the aging process and in older people's experiences.

In line with Schwarz (2012) we recognize the potential of studying cases that are connected with their context, to develop in-depth understandings of how and why older people experience and negotiate their physical environment the way they do. Such understandings should not aim to be predictive, since people have certain degrees of freedom in making sense of and negotiating their environment. The environment thus has no deterministic force. The understandings developed can help to gain insight into and anticipate similar situations and envision alternative futures (Flyvbjerg, 2011, p. 312; Geertz, 1993, p. 26), and can in this way be relevant to architectural design research and practice.

This article presents a case study of a newly-built residential care facility for older people – referred to as Heather House (pseudonym) – for which the architects made considerable effort to match the design with the care vision. We aimed to gain insight into residents' and caregivers' experiences of, respectively, living and working in Heather House, and the role of architectural features in these experiences.

Methods

The first author collected data and analyzed them in collaboration with the second and third author, and is henceforth referred to as "the researcher."

Because we aim to articulate an in-depth understanding of architecture's role in people's experiences, the research consists of a case narrative with a critical realist and constructionist (Crotty, 1998) approach. Two data gathering techniques were used: participant observation and in-depth, semi-structured interviews with residents and caregivers. For interview preparation and for contextual information, data concerning design intentions, assumptions and strategies were obtained from the design brief, and architects' design contest submission, and through a semi-structured interview with them, and observations on site.

Setting

Heather House is a residential care facility for people with physical impairments, psychosocial problems, dementia, and psychiatric problems due to old age, in use since May 2014. It is located in a multicultural garden suburb, and includes four dwelling units for eight residents each. During one week, four nursing assistants individually manage one dwelling unit. Per four dwelling units there are five nurses, one occupational therapist, and four cleaners. Additionally, help is offered by interns (about five per year), and family members. Residents can use a paid service from a non-profit organization, e.g., to assist in activities or transportation.

Heather House was selected for its contemporary care vision and its innovative architectural design. Its care vision aligns with 'small-scale, normalized living', a well-known concept in Flanders, Belgium, denoting a housing and care type where six to 16 people, with professional guidance, form a household in a for them familiar and homey environment, which is architecturally and/or socially integrated in the neighborhood (Van Audenhove et al., 2003). In their care vision, directors of Heather House emphasize normalization, integration, participation, and family-like group living within a household. They aim to house eight people per dwelling unit in a familiar, homey environment that offers common places and ample privacy. They aim to offer an environment that compensates for residents' impairments, supports them in conducting homey activities and moving independently and safely, affords social freedom of movement, and integrates residents in the neighborhood. According to the care vision, residents' daily life is not bound by fixed care tasks, rather, much can be chosen and decided by themselves.

The architects took as the starting point for their design dwelling (rather than care logistics). Each dwelling unit consists of well-lit dwelling places compactly clustered around a patio in an open plan (i.e., a continuous space without doors) (Fig. 1b, c). Two adjoining private rooms – designed to be little houses in themselves, with an entrance, sitting corner, bedroom and bathroom (Fig. 1d) – give way to an entrance, living room, hobby room, or kitchen-dining area. These common rooms are scaled to accommodate eight residents, each with a stroller and wheelchair. Four of these dwelling units are grouped in two building blocks of two floors high, connected with a bridge on the first floor. Their front doors face each other. The basement contains a bathroom for residents, and staff's utility and storage rooms. A garden path connects the garden gates, (front) doors and terraces (Fig. 1e). To integrate Heather House in the residential area, the building stands along the street (rather than drawing back from it), and its façade is articulated into smaller parts with pitched roofs, and varying windows (Fig. 1a), like the neighboring houses. Additionally, the site and building include residential elements like an hedge, garden path, garden gate, and front door with a lamp.