

Worksheets

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Worksheet 1: Take a moment to think about your home

Please discuss in pairs and write down some of your thoughts on the questions below.

Question 1: How many homes have you had in your life? Which one was/is your favourite and why?

Please record your thoughts here:

Question 2: What does 'home' mean to you and how do you feel when you are at home?

Please record your thoughts here:

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Question 3: How does your home reflect who you are?

Please record your thoughts here:

Question 4: What is your favourite room/place in your home and why?

Please record your thoughts here:

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Worksheet 2: The experience of home environments for people with dementia

How might living in different home environments feel for a person with dementia? Look at your responses from questions 1-4 on **Worksheet 1** and relate them to the possible experience of a person with dementia.

Question 1: How many homes have you had in your life? Which one was/is your favourite and why?

Please relate your response to the experience of a person with dementia:

Question 2: What does 'home' mean to you and how do you feel when you are at home?

Please relate your response to the experience of a person with dementia:

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Question 3: How does your home reflect who you are?

Please relate your response to the experience of a person with dementia:

Question 4: What is your favourite room/place in your home and why?

Please relate your response to the experience of a person with dementia:

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Worksheet 3: Sensory environments

"Everyone needs sensory stimulation in order to comprehend the world around them. The only way we can get information into our brains is through our senses; sight, sound, touch, taste, smell and movement"[1].

It is essential to ensure that everyone with dementia has the opportunity to engage with their environment. Environments should be supportive, stimulating spaces that provide opportunities for the person with dementia to understand and connect with where they are. Some people may need additional layers of support offered to them.

Some people with dementia may begin to engage with their environment on a sensory level. It is essential that caregivers know how to help facilitate, guide and support them. "Caregivers need to ensure that the person at this activity level has the opportunity to experience a wide variety of sensations, and to carry out one-step tasks".[2]

The different environments that a person with dementia may find themselves in should be filled with opportunities for them to engage appropriately with location-specific objects, sounds, smells, images and tastes that can help them connect with where they are.

As some people with dementia may not be able to access sensory stimulating or calming activities independently, it might be beneficial for others to support them to engage with items in their environment – especially where there is the possibility for the person to be involved in activities that provide multi-sensory stimulation. Not only can the right level of sensory stimulation help to relieve stress and boredom, but opportunities to engage in appropriate shared activities can promote communication opportunities which can help to enhance a sense of comfort and well-being.

Many services that provide support for people living with dementia have developed multi-sensory rooms or environments that often include a range of specially adapted equipment designed to support someone with dementia to engage with their environment at a sensory level. It is essential for caregivers to be provided with training in how to effectively use multi-sensory opportunities and experiences. There should be clear guidance on how and when to use different forms of multi-sensory equipment.

A multi-sensory approach aims to reach individuals with dementia through movement and those sensory channels of vision, touch, hearing, smell and taste that are still intact.[3] This is achieved with a reduced dependency on higher cognitive processing. It is always worth remembering that people can have different experiences when exposed to similar sensory experiences, both good and not so good. This can be linked to life experiences, different levels of sensitivity, complex mental health conditions and other factors.

Often, sensory activity equipment will predominantly stimulate vision and touch.[4] However, it is worthwhile expanding opportunities (and the equipment used) to help stimulate the other senses too. Sensory environments should provide opportunities for both stimulation and relaxation. We must remember that if there is too much stimulation, a person with dementia can easily become overwhelmed. If there is too little, a person with dementia can lose interest in what is happening and/or their surroundings, and may withdraw from engaging.

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Worksheet 4: Sensory items

Every room to which the person with dementia has access should provide opportunities for multi-sensory engagement. Ideally these should be person-, room- and activity-specific in order to reinforce recognition of *who* the person with dementia is, to provide an understanding of *where* the person with dementia is, and for the experience to have purpose. For example, when dining, some people with dementia may benefit from having multi-sensory opportunities to help them understand and connect with the activity of eating.

Things to consider in this example might be a plain fabric tablecloth with contrasting-coloured napkins, cutlery and crockery. The crockery should be a contrasting colour to the food served – for example, light-coloured foods such as mashed potato can be served on dark-coloured plates and vice versa.[5] Blue plates are useful as no blue foods occur in nature. Appropriate cooking/food smells should be present, and a range of food tastes and textures should be available.

Multi-sensory experiences can be provided through daily care routines (e.g. getting dressed, dining, having a bath), through environment/room-specific activity (e.g. fruit tasting in the dining room, turning the pages of a newspaper in the lounge, smelling the flowers in the garden) and through activity-specific opportunities (e.g. using familiar scented polish when cleaning, kneading dough with bare hands, singing along to familiar songs).

What sensory items would you try to provide in the following rooms?

Room 1: Bedroom/hospital bed area

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Room 2: Lounge/day lounge

Please record your thoughts here:

Room 3: Dining room

Please record your thoughts here:

Room 4: Bathroom

Please record your thoughts here:

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Worksheet 5: Sensory change experiences

Along with cognitive difficulties, many people living with dementia can also experience changes in sensory perception.

Taste

Some people may no longer enjoy their favourite food and drinks as these may not taste the same and/or the texture may feel different in the person's mouth. In some cases, the taste of food and drink can become so altered that it can taste rotten, rancid or chemical. This can be quite distressing and disconcerting. Eating and drinking can become more difficult if the person no longer enjoys it.

If a person with dementia is experiencing this, it is recommended that they are supported to have regular dental check-ups to rule out other causes such as tooth decay. Some people who having an altered taste experience due to their dementia may be less inclined to engage in dining activities.

Question 1: How would you support a person with dementia with dining if they were having an altered taste experience?

Hearing

Some people with dementia may become distressed by some of the sounds and noises that they hear. These sounds can even become painful (hyperacusis). In cases of people with hyperacusis, it's not unusual that everyday noises such as barking dogs, someone chewing, a vacuum cleaner, a boiling kettle or a flushing toilet can become physically unbearable. Communal living environments, restaurants, hotels, shopping centres, hospitals and other public spaces can become very difficult places for people with hyperacusis.[12]

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In contrast, some people with dementia develop an increased liking for environmental sounds and music. A US research study recorded an increase of 48% in musicophilia (liking for music) among a group of people with dementia[13].

Question 2: How would you support a person with dementia who has been diagnosed with or may have the symptoms of hyperacusis?

Smell

People with dementia may become distressed by changes in their sense of smell. Some may experience olfactory hallucinations or 'phantom smells' such as perfume, smoke, rotting food or cat urine. These smells can be very confusing and may lead a person to no longer trust their own sense of smell, or to become fearful of what they perceive to be happening around them.

Although people with dementia who experience olfactory hallucinations detect smells that aren't present in their environment, there could be other explanations for this experience. It could be provoked by a mental health condition, a physical illness (fever, seizure, migraine, infection, etc.) or anything which may cause delirium[14].

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Question 3: How would you support a person with dementia who can smell smoke and is convinced that there is a fire (be mindful that there might actually be a fire that you are not yet aware of, so your responses need to reflect this)?

Sight

Some people with dementia may experience visuo-perception or spatial awareness difficulties. This can be where the person experiences misperceptions, misidentifications and/or hallucinations.

Misperceptions could be when a person with dementia sees one thing and interprets it as something else. For example, mistaking coats on a hook on the back of a door for a figure standing in the doorway, or mistaking blue flooring for water[15].

Misidentifications could be when the person with dementia has difficulty with identifying specific objects and/or people. For example, mistaking their daughter for their wife, thinking their reflection in the mirror is another person (and possibly being frightened), thinking that voices on the radio or television are from people in the room with them[16].

Hallucinations could be when the person with dementia experiences something that is not really there. It can involve any or all of the senses but the most common type experienced by people with dementia are visual hallucinations (seeing things that are not really there). These hallucinations can range from seeing spots or flashing lights to seeing living things (animals and/or people).

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Question 4: How would you support a person with dementia who is convinced that there are ants crawling over everything in the lounge?

Touch

Some people with dementia may find that they have an altered experience of the sensations of hot and cold. It is important to safeguard the person's environment, and to consider doing things like colour coding taps for hot and cold water and putting warning stickers on the oven and range top.

For other people with dementia, different sensations of touch can be altered. A gentle touch can be painful, or a running shower passed over the body can feel like needles cutting into the skin. Although visual hallucinations are one of the most common symptoms that present in people with Lewy body disease, some can also experience tactile hallucinations. The 'objects' experienced through visual hallucinations can sometimes exhibit characteristic hardness and temperature when the person with Lewy body disease reaches out to touch them. These 'objects' are thought to be influenced by the person's mood, which in turn can lead to them experiencing further hallucinations[17].

Question 5: How would you support a person with dementia who begins to scream as you support them to have a shower?

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Worksheet 6: Immersive sensory activity

In pairs, take it in turns to select one of the five trays the trainer has prepared. Once you and your partner have completed a tray activity, please re-cover the tray and return to the table and select another. Please complete all five tray activities.

N.B. Please do not carry out any of these interactive activities if you have an allergy to anything used.

Please record your thoughts on the Sight Tray:

Please record your thoughts on the Hearing Tray:

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Please record your thoughts on the Touch Tray:

Please record your thoughts on the Taste Tray:

Please record your thoughts on the Smell Tray:

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Worksheet 7: Environments that promote daily living activity

The built environment should:

- Promote a feeling of 'home'. This is more easily achieved in the person's own home or a care home, and more challenging to achieve in a hospital environment as it may be difficult to apply some of these recommendations – due to infection control, risks associated with having personal possessions in the setting, physical limitations of a hospital environment, a lack of outside space and so on. In addition, hospital environments can be made more challenging for some people with dementia if they are transferred from one part of a hospital to another – bringing changes in environment and staff, which can lead to disorientation and confusion. The experience can be enhanced by good communication between staff and wards, and by familiar objects and images being transferred with the person with dementia and used around the bed-space area. Such items may reduce 'relocation confusion' and may help the person with dementia to have a greater sense of comfort, self-esteem and 'family'.

> *"Patients and their accompanying persons (APs) revealed a familiar aspect in relation to hospitals: They are busy and chaotic spaces that are especially difficult for an older person, including a person with dementia. Furthermore, sensory overload such as sound, lack of familiarity, disorientation, and difficulties in wayfinding due to the large-scale, complex, and often visually monotonous nature of the hospital contribute to the challenging nature of these environments, particularly for people with dementia"*[1].

- Reflect the life history of the person with dementia. It can be designed to help provide activities which reinforce the person's work roles. For example: a teacher may be able to access a 'study area' with a desk, pens, papers and exercise books to mark; a secretary or PA may be able to access an 'office area' with a desk, a typewriter or computer and notebook to engage with; or a mechanic may be able to access a 'workshop area' with a workbench, parts of an engine and some tools.
- Provide opportunities for people with dementia to spontaneously engage in activities. There should be a variety of recognisable items, images and objects in all communal areas (lounges, dining rooms and bathrooms) that are familiar, age-appropriate and person specific. In some care home settings, there are 'pubs', 'cafes', 'hairdressers' or 'shops' provided. These areas too can provide opportunities for appropriate spontaneous (and organised) activity.
- Provide a range of interesting spaces – for example, a care home or hospital setting might try to create a reading corner, a sewing room, a music library, a nursery, a boudoir or a potting shed. These areas might already exist in the person's own home, and they can help some people with dementia to orientate and take part in familiar activity. In care homes and hospitals, corridor junctions could be made into areas of interest (e.g. places of local interest, perhaps taking on recognisable

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themes such as a 'Village square', 'Town centre' or 'Countryside' style meeting point, with images and objects associated with each of these). Often in hospitals and care homes there is a functioning shop, and perhaps the area where this is located could be expanded to include working post boxes or way-finding signposts to other areas of the built environment (that may be of interest to people with dementia. To aid with recognition of these areas there could be a range of plants, a lamp post, maps of the local area, distinctive seating (possibly benches), stands with leaflets and postcards and local newspapers on tables. These spaces could encourage people to sit, socialise and 'people watch'.

- Have items and objects that meet the 'nurturing' needs of some people with dementia. Dolls, prams, soft toys and comfort objects should all be available and visible. Everyone should understand the therapeutic value of these objects, and support people with dementia to engage with them in a person-centred manner. Both planned and spontaneous approaches to their use should be facilitated. Everyone should be sensitive to the emotional and biographical experiences of people with dementia, should adopt their language/communication style when engaging with these 'nurturing' objects, and should not be 'precious' about these objects being moved around the built environment by a person with dementia.
- Apply a person-centred approach to the provision of tactile sensory fabrics. Items such as throws, blankets, cushions, bedspreads, towels, scarves and gloves should be available in both communal and private areas of the built environment (or in the person's own home). These sensory materials can provide opportunities for some people with dementia to engage and connect with their environment, and their location may help a person with dementia orientate to their immediate environment (for example, a distinctive and strong-coloured blanket on a hospital bed in a hospital ward may help a person with dementia to orientate to their bed).
- Reflect the music/sound preferences of the person with dementia. Music choice should be explored and provided at significant times, for example when getting up or going to bed, when bathing, when dining, when alone or when with others. We should explore opportunities to use music to help relax or energise the person with dementia. A range of music players and equipment (for example radios, record and CD players, karaoke machines, jukeboxes, headphones and personal MP3 players) could be provided, or the person could be supported to provide their own if and where appropriate. Access to natural sounds should be available to help support the person with dementia to connect with and orientate to their environment.

(1) Xidous D, Grey T, Kennelly SP, McHale C, O'Neill D. (2020) *'Dementia Friendly Hospital Design: Key Issues for Patients and Accompanying Persons in an Irish Acute Care Public Hospital'.* HERD. 2020 Jan;13(1):48-67. doi: 10.1177/1937586719845120. Epub 2019 May 13. PMID: 31084297.

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Worksheet 8: Adapting environments to support people with dementia

Working in pairs, write down your thoughts on the questions below.

Question 1: Does the environment that you work in help you support and enable people with dementia to engage with daily living activities such as meal preparation, tidying, dusting, polishing, baking, vacuuming, sweeping, washing, pegging laundry, ironing, gardening or home maintenance? If not, how can you adapt the environment to facilitate this?

Please record your thoughts here:

Question 2: Does the environment that you work in help you support and enable people with dementia to engage with aspects of their work-life role? If not, how can you adapt the environment to facilitate this?

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Question 3: Does the environment that you work in help you support and enable people with dementia to engage with a range of recognisable items, images and objects that can be found in all communal areas that are familiar, age-appropriate and person specific? If not, how can you adapt the environment to facilitate this?

Please record your thoughts here:

Question 4: Does the environment that you work in help you support and enable people with dementia to engage with a range of interesting spaces that contain items, objects and images to help them orientate and take part in familiar activities and also offer opportunities for them to sit, socialise and 'people watch'? If not, how can you adapt the environment to facilitate this?

Please record your thoughts here:

Question 5: Does the environment that you work in help you support and enable people with dementia to engage with items, objects and images that meet their 'nurturing' needs? If not, how can you adapt the environment to facilitate this?

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Question 6: Does the environment that you work in help you support and enable people with dementia to engage with items and objects that meet their 'tactile' sensory needs? If not, how can you adapt the environment to facilitate this?

Please record your thoughts here:

Question 7: Does the environment that you work in help you support and enable people with dementia to engage with their preferred choice of music? Are there opportunities for different types of music/sounds to be played? If not, how can you adapt the environment to facilitate this?

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Worksheet 9: Lighting

Effective lighting can help people with dementia to identify spaces, rooms, equipment and signs[1].

Natural light

Exposure to natural light (especially blue wavelengths of light) helps us to track time, increases vitamin D levels and regulates biological functions such as our circadian body clock. Daylight is also important for vision as well as for health and well-being. "Adequate exposure to daylight, particularly during the morning, is important for synchronising the circadian body clock, which can affect many processes including sleep, metabolism, immune function and even our mood"[2].

It is recommended that we should maximise the benefit of daylight by keeping curtains open in the daytime, and that some seating areas should be positioned close to unobscured windows (without net curtains) so that people with dementia can benefit from natural light easily. Different people prefer different vistas; some may like rural landscapes, some well-kept gardens and others an urban view. Being able to see outside may help a person with dementia to connect with their extended environment, and may encourage them to go outdoors[3].

Artificial lighting

Artificial light is light that comes from a man-made light source, most commonly from LEDs (light-emitting diodes), fluorescents, incandescent bulbs or halogen lights.

Most LEDs and fluorescent light sources are designed to mimic daylight with a blue wavelength of light. Exposure outside normal daylight hours to this light can disrupt sleep and our body clock, and can result in negative health effects[2].

Traditional incandescent bulbs and most halogen light sources provide good full-spectrum light but can only mimic sunset (red wavelengths of light). These types of light source are therefore good for evening illumination, as they don't make us feel awake or alert[3].

Ideally the dementia care environment should have an array of artificial lighting types to meet different needs and requirements throughout the day and night. There should be effective lighting to reduce the risk of shadows, glare and reflections, as these can cause visual disturbances to some people with dementia. There should also be a range of lighting available including:

- General lighting that provides broadly uniform illuminance. This can often be achieved by using an array of light fixtures such as down lights.
- Localised lighting that provides higher light levels in specific areas. For example pendant lights above a kitchen surface, or high lighting levels over beds in hospital settings to support medical and nursing interventions.

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- Task lighting that provides higher light levels in small areas. This is typically used to supplement general or localised lighting, for example bedside lamps or reading lights.
- Directional lighting to help people with dementia navigate around the environment. For example, a brighter localised light outside the toilet door or task lighting illuminating a picture outside the lounge. Equally, the doors to potentially hazardous areas could be made less 'visible' than other doorways by lowering the lighting levels or having adjustable lighting outside them. This can help to reduce the potential for heightened anxiety which could be caused by a person with dementia attempting to access a room/space through a well-lit doorway and finding the door locked. This lighting should still be safely within the necessary lighting levels of the care setting, and should not create a potential stumbling or tripping hazard.

Lighting also plays a role in the atmosphere of any location. For example, in a hospital setting, it serves to create a comforting ambience while also fulfilling the more important function of providing visibility for staff. When it comes to hospital hallway lighting in particular, there is a fine balance between the two elements of function and atmosphere.

Throughout most care settings there should be a range of different styles/types of light fittings to reflect the different lighting needs. Depending on room and care setting type, light fittings could be used to help with orientation. For example, table lamps, standard lamps and reading lamps could be switched on in the evening to help capture the 'feel' of a lounge. Hospital day lounges, a person's own lounge or a care home lounge can be made more 'welcoming' simply by the right lighting. Ideally, light fittings should be of a domestic appearance, and age and culturally appropriate. Such lighting can help create different 'moods', and promote place recognition for a person with dementia.

(1) Social Care Institute for Excellence. *Dementia-friendly environments: Lighting* www.scie.org.uk/dementia/supporting-people-with-dementia/dementia-friendly-environments/lighting.asp.

(2) Royal Society of New Zealand Te Apārangi (2018) *Blue Light. Aotearoa. Impacts of artificial blue light on health and the environment.* www.royalsociety.org.nz/assets/Uploads/Blue-light-Aotearoa-evidence-summary.pdf

(3) McNair D, Cunningham C, Pollock R and McGuire B. (2011) *Light and Lighting Design for People with Dementia*. Australia: Hammond Press.

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Question 1: What is the orientation of the main rooms (lounge, day lounge, dining room, bedroom, bed spaces) in relation to natural light in the setting where you work?

Please record your thoughts here:

Question 2: How does light enter these rooms in the setting where you work?

Please record your thoughts here:

Question 3: What are the window treatments like in the setting where you work?

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Question 4: What types of lighting do you have in the setting where you work?

Please record your thoughts here:

Question 5: What are the benefits of having a range of lighting types around the setting where you work?

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Worksheet 10: Colour and pattern

"Colour is an important component in inclusive design for dementia, especially in regard to wayfinding and engagement with the built environment"[1].

The use of colour and appropriate low/no patterns are important elements of dementia enabling design. An inappropriate choice of colour or pattern may result in the environment becoming more confusing for a person with dementia. Pattern and colour can be present on all surface including flooring, soft furnishings and walls.

Ideally the environment should not have bold or prominent patterns with large images or striking colour contrasts. Bold patterns such as strong motifs, stripes or zig-zags can be perceived by some people with dementia as 3D images and/or moving objects. It is recommended that no pattern or low, more subtle patterns with low contrast may be more supportive for people with dementia who may experience visual difficulties.

To help support wayfinding and navigation, some hospital settings now use different colours to define bay doorways. This is specifically "to help patients navigate the Ward"[22].

It is recommended that all flooring should be relatively plain. Flooring to other areas (especially open-plan kitchenette/lounge/dining room areas, hospital wards, etc.) should be a similar colour and tone to the adjacent flooring.

The threshold between two types of flooring may cause difficulties for some people with dementia. For example, bedrooms should not have a noticeably different colour flooring to the corridor, nor should there be a noticeable carpet join. Invisible joins of different flooring are recommended.

Furniture placed in rooms should not be so well colour matched that it almost disappears in the carpet and/or walls. There should be a clear difference in the colour of the furniture and the colour of walls and flooring. It is also recommended that seat cushions should be in a contrasting colour to the main body of a chair, as this may enable some people with dementia to visually identify where to sit in the chair.

Navigation around the built environment and/or awareness of significant doorways and specific areas can be improved by employing the use of strong and distinctive colours. For example, if toilet doors are painted orange, then some people with dementia may recall that the orange door is the toilet. "Painting the bedroom door in a contrasting colour to the surrounding wall is crucial for finding the door"[21]. Colour could be used to further define spaces – for example, a purple feature wall around the lift door may enable some people to navigate to and around the lift doors by recognising/recalling the colour[23].

Some people with dementia may become agitated and/or frustrated if they can't open or get through 'obvious' doors, which for security or safety reasons are kept locked. It is recommended that doors leading to these areas should be made less visible. Such doorways should have flat unpanelled doors, and be given the same treatment as the walls around them. Door furniture should be discreet, and if possible of the same colour as the door. In effect, the suggestion is to attempt to make these doors 'invisible' and less of a focus for some people living within the environment.

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(1) Bowes A, Dawson A (2019) *Designing environments for people with dementia. A Systematic Literature Review*. Emerald Publishing.

(2) Department of Health (2015) *Health Building Note 00-01 General design guidance for healthcare buildings Health Building Note 08-02 Dementia-friendly Health and Social Care Environments*. https://oacp.org.uk/wp-content/uploads/2016/01/HBN_08-02-Dementia-Friendly-Environments_reduced2-2.pdf

(3) Social Care Institute for Excellence *'Dementia-friendly environments: Bedrooms. Help locating a bedroom door'*. https://www.scie.org.uk/dementia/supporting-people-with-dementia/dementia-friendly-environments/bedrooms.asp.

Please work in pairs and write down some of your thoughts on the questions below.

Question 1: Is there use of no pattern or low, more subtle patterns in the setting where you work?

Please record your thoughts here:

Question 2: Is the flooring around the setting where you work of a similar colour/tone to the adjacent flooring? Are there 'invisible joins' connecting different flooring types?

Please record your thoughts here:

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Question 3: What is the furniture in lounge areas like? Does the furniture 'stand out' from the walls and flooring? Are seat cushions in a contrasting colour to the main body of the chairs?

Please record your thoughts here:

Question 4: Are there strong and distinctive colours used around the setting where you work?

Please record your thoughts here:

Question 5: Do the doors to locked areas look the same as the walls around them?

Please record your thoughts here:

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Worksheet 11: Noise levels

People with dementia can often have difficulties with understanding the spoken word, and may respond to communication on a sensory level. For example, people may observe the body language or tone of voice of those around them rather than focusing on the words being used[1]. This receptiveness can fluctuate and change as time passes.

Some people with dementia have a reduced ability to understand their sensory environment, and can react to their environment rather than being supported or enabled by it. It is quite possible for other or all sense to be engaged at the same time as hearing, and if there is a sensory 'overload' of this kind, the person with dementia may respond in a noticeable way. They may show a significant change in their behavioural responses, perhaps becoming agitated or wanting to remove themselves from the area.

Noise around the environment can be specific to where the person with dementia may be. Certain rooms may have the potential for specific issues, especially in open-plan areas. This may not be such an issue in the person's own home; however noise coming from televisions, music players, other people who live with the person and so on can cause the person with dementia potential difficulties, as outlined below.

Open-plan spaces increase the possibility of some sounds echoing around the area and possibly appearing louder. To add to the confusion, the original source (and location) of the sounds can be lost or misinterpreted. Hospital environments can be particularly distressing to some people with dementia, as beeping sounds from medical equipment in and around the immediate bed space area – along with ringing and other noises from phones, smart watches, pagers, alarms and so on – can cause increased levels of irritation, annoyance and fatigue among both patients and staff. It can have a negative impact on the patients' ability to rest, heal and recover, can have a detrimental impact on their quality of sleep, and can result in sleep deprivation (and related disorders)[2].

In a care home setting, the sound of a radio, a television or conversations and laughing can come from one area of an open-plan seating area across the space, and at the same time people may be moving through the area with all the sounds associated with their purpose. Discussions, organised leisure activities, sounds of work-related activity (for example the clatter of a medication trolley or the squeak of the wheels on a laundry trolley), staff pagers, call bells, alarms, doorbells and telephones can all be disconcerting and confusing for some people with dementia. Where possible, it is recommended that quieter equipment be used, or that devices be set to vibrate rather than ring.

It is recommended that sound absorbing materials be introduced in large communal open-plan areas (such as sound absorbing soft furnishings, wall and floor coverings) to help reduce the risk of sound reverberating or 'bouncing' around the area. Ideally, smaller seating areas, dining rooms and lounges should be available to help reduce the risk of this happening. Although appropriate stimulation is required, professionals should endeavour to undertake 'noisy' work-related activities away from areas where larger groups of people with dementia may be sitting, especially if they are aware that this may cause anxiety or distress to some residents. However, some people with dementia do fully engage with these types of activities, and it is therefore recommended that full awareness of people with dementia and their needs is taken into

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account when planning any activities to be carried out.

In communal areas, attention must be paid to the needs of *all* people with dementia when group leisure activities are being carried out with small groups or individuals. If the leisure activity is causing others (who are not engaging in the activity) to become agitated or distressed, then alternative approaches should be explored (location, time, nature of activity, engagement in alternative activity for others, etc.). Offering appropriate levels of stimulation and activity for people with dementia will almost always bring with it an increase in noise. Therefore, there should also be an increased awareness of how to appropriately reduce noise levels within all settings where people with dementia may be, whether this is a care environment, a day-care setting or the person's own home.

Within dining areas, the noise of other people talking and the clatter of dishes and cutlery can all contribute to a sense of disorientation for some people with dementia. Sometimes radios or televisions may be on, which can increase confusion and disorientation still further, even if they are playing programmes or music that the person with dementia would choose. However, for others this may truly help with orientation and engagement in the dining experience. It is essential to observe and talk with the person with dementia and their friends and family to ensure that they are comfortable with a TV or radio playing whilst they dine.

Again, it is recommended that sound absorbing materials be used in large communal dining areas. This helps to reduce the noise from other diners and other related sounds echoing around the space. It is always recommended that professionals should limit or remove (where and when possible) any unnecessary noise, as this may help to reduce the person becoming distressed or anxious in the dining environment. Limiting sounds from the kitchen during dining and food preparation should also be explored.

The acoustics in a bathroom can cause the running of a shower, the sound of water flowing from taps or the flush of a toilet to be very disturbing for some people with dementia. These noises can cause the person to become agitated or confused as they try to process what the sounds might mean. If the sounds of running taps or showers raises anxiety levels or causes distress for a person with dementia, then professionals should consider using approaches to limit the distress experienced. Perhaps run the bath before the person enters the bathroom, reduce the need for using the shower, or use a jug of water or flannel instead. Flush the toilet once the person has left the toilet or bathroom, rather than when they are still in it.

Professionals can also try other sounds in the bathroom. Relaxing, familiar music that a person with dementia enjoys may help them to engage in bathroom-related activities. A simple intervention of learning a person's favourite songs, and humming or singing them while supporting the person in the bathroom, can help to reduce potential agitation significantly. "For many… their sense of self shattered by illness or injury – songs provide a surrogate feeling of structure or personal continuity"[3].

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It is recommended that everyone should observe the following:

- Don't talk over someone.
- Don't communicate with others in a language that is not understood by the person with dementia.
- Ask if you can turn off or turn down the television or radio before you start to speak to the person with dementia (explaining to them that you will turn it back on or up before you leave).
- Speak calmly and clearly, and be aware of your body language and tone of voice.
- Be aware of any noises that may be misinterpreted by the person with dementia and may result in them becoming anxious or distressed.
- Make sure that the person's hearing aids (and glasses) are clean and working.

Talk to other colleagues, the person's family and friends about all of the above points, as they may find them helpful too.

(1) Van Hoof J, Kort HSM, Duijnstee MSH, Rutten PGS, Hensen JLM (2010) *'The indoor environment and the integrated design of homes for older people with dementia'*, Building and Environment, vol 45, no 5.

(2) British Medical Journal (2018) *'Noise pollution in hospitals'*; 363:k4808 BMJ

(3) Sacks O (2011) *'Musicophilia: Tales of Music and the Brain'* Vintage Books.

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Worksheet 12: Noise awareness quiz

Working in pairs, please complete the following noise awareness quiz.

Q1: When speaking with a person with dementia, what should you do?

1. Really focus on your words
2. Be aware of your body language and tone of voice
3. Only use gestures
4. Get others to speak for you

Q2: Because some people with dementia can have a reduced ability to understand their sensory environment, what should you do to help them?

1. Turn off all the radios
2. Be aware of how the person is responding to their environment
3. Ask professionals not to speak, unless essential
4. Only do one sensory activity at a time

Q3: Which of the following might not help reduce anxiety levels among people with dementia in open-plan areas?

1. Make sure the area has carpets, curtains and lots of cushions
2. Don't do 'noisy' activities in this area
3. Be aware of everyone's needs when running group leisure activities
4. Get everyone to sing along to a song

Q4: When running a group leisure activity, which two of the following approaches would be advisable to reduce agitation and distress in those who aren't taking part?

1. Take them to their bed for a nap
2. Make them take part in the activity
3. Run the activity in a different lounge
4. Ask a colleague to help engage them in another activity that they might enjoy while you do the group activity

Q5: Where is the most suitable place to provide appropriate levels of stimulation and activity for people with dementia? (There may be more than one correct answer.)

1. A hospital
2. A residential or nursing home
3. A specialist day care centre
4. In the person's own home

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Q6: How can we help reduce unnecessary noise in dining area?

1. Don't ever play music
2. Only use paper plates and have finger foods
3. Ask the kitchen staff not to play their radio while people are dining
4. Encourage everyone not to talk at mealtimes

Q7: What type of dining experience would be likely to be the most supportive for people living with dementia? (There may be more than one correct answer.)

1. A busy canteen-style space
2. A large open-plan restaurant-style space
3. A small intimate café-style space
4. Single tables strategically placed around the care environment

Q8: How can professionals reduce anxiety levels for a person with dementia while supporting them to bathe?

1. Keep the door open so the person can see their exit
2. Only have showers
3. Have one professional run the bath as another helps the person undress
4. Prepare the bath before the person comes into the bathroom.

Q9: Acoustically, which answer would not make the bathroom a more welcoming space for people with dementia?

1. Have lots of soft furnishings (lots of fluffy towels on shelves, a dressing gown on a hook, a fabric shower-curtain, etc.)
2. Install sound absorbing wall panels
3. Hang canvas pictures and paintings
4. Open the windows

Q10: How can you help the person with dementia to feel more 'at home' and less anxious whilst offering personal care?

1. Sing a familiar song that the person with dementia knows
2. Play some classical music
3. Support the person in silence
4. Sing one of your favourite songs

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Worksheet 13: Lounges, living rooms and communal seating areas

Domestic lounges are usually rooms where people sit and relax. They often provide facilities for people to engage in relaxing pastimes. The arrangement of furniture is typically designed both to enable social exchange and for activity engagement. The larger, the lounge, the greater the possibility for engagement in a broader range of relevant activities. For example, there is usually a television, an opportunity to engage with music, a shelf with books and photos, a window, a fireplace with ornaments and other objects on the mantlepiece, a coffee table with newspapers and magazines, and a cupboard with games).

Day lounges, living rooms and/or communal seating areas in a hospital, day centre or care home should replicate, where possible, the key features of a domestic lounge.

Some communal lounges are oversized to accommodate a larger number of people. These lounges can lose the intimacy of a domestic lounge, but they can still capture some of the key elements that would enable someone with dementia to connect with the space. They do provide an opportunity for people with dementia to observe activities without actually participating, thereby promoting social and sensory stimulation[1]. Ideally there should be a range of smaller more 'domestic-sized' lounges that can meet the variety of needs that people with dementia using the service may have. Each smaller lounge area could have distinct focuses and functions.

Some services may have only larger lounges. These spaces should be adapted to meet the variety of needs that people with dementia using the service may have. This can be achieved by creating 'activity-zones' to support people to connect with specific activities associated with the space. There could be a fireplace zone, a music zone, a TV zone, an intimate dining zone, a garden view zone and so on. Each zone should be arranged to create the maximum opportunity for people to connect with it – for example, a couple of comfortable chairs with cushions and blankets, and coffee tables with physically accessible objects such as books, newspapers and a basket of wool, can reinforce the experience of sitting by the fire.

(1) Goodman C and Watson L. (2010). *'Design guidance for people with dementia and for people with sight loss'*, Thomas Pocklington Trust Research Findings Number 35.

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Your trainer will guide you through a practical activity where you will have the opportunity to arrange items that may typically be found in a lounge.

Please record your thoughts here:

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Worksheet 14: Dining and dining rooms

A good dining experience should provide an opportunity for a person with dementia to have food that is nutritious and delicious, supported by trained professionals who have a clear understanding of what level of support each individual may need in a setting that reinforces their understanding of where they are. All these elements should support the person with dementia's connection with this activity, and enable them to dine with confidence. The dining experience can be enhanced by supporting people with dementia to be involved in preparing food and/or drinks (in accordance with their level of ability and food safety regulations) and in pre- and post-dining activities.

People with dementia may often have difficulty recalling menu choices or what they requested for their meal. In addition, some people with dementia may not fully understand the choices being offered to them and/or may not be able to clearly indicate what their choice of meal might be. A variety of ways can be adopted to reinforce a person's meal choice at the time of the meal – for example a menu board in the dining room, individual written menus, photographs of the meal (in 'menu' format or displayed on a tablet computer), and staff verbalising and describing the choice that the person has made. Arguably, the most effective way to offer choice would be to show a choice of actual plated meals to the person at the time of eating. Menu options which reflect the cultural diversity of the people with dementia should be available.

Ideally, members of the professional team, relatives and friends should be encouraged and enabled to eat and drink with people with dementia, and space should be available around the table to enable this to happen.

The atmosphere throughout the dining experience should be calm. People with dementia should be supported to walk or move if they wish to. When and where appropriate, music and suitable objects and photos should be used to enhance the atmosphere. However, team members should have an awareness of how some people with dementia can become agitated and over-stimulated by too many sensory experiences and, in these cases, it may be more beneficial to delay playing music and sharing objects until the dining experience has come to an end.

Food and drink should be clearly placed within the visual field of the person with dementia, and located toward their dominant hand. People with dementia should be allowed to dine at their own preferred pace, without any attempt to speed them along. Individuals should be supported by team members to engage in conversation with those around them, pour drinks for each other and so on. All verbal communication adopted by staff should be supportive and encouraging, and use an appropriate volume and tone.

People with dementia who require assistance to eat and/or drink should be supported to do so in a dignified manner. Members of the professional team should ensure that the person with dementia is the entire focus of their attention throughout the process, that the environment is supportive of the resident, and that the person's dignity and privacy is maintained. They should sit at the correct position to assist with dining, maintain appropriate eye contact and support the person with dementia at their own pace.

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Clothes protection should be non-invasive and age and culturally appropriate. Unnecessary or inappropriate provision of aprons or other clothes protectors can be infantilising and undignified, and they should only be used when following a clear plan of care (or when specifically requested by the person). Staff should be adept enough at assisting the person with dementia that they do not regularly spill food, and that a napkin across the lap is sufficient protection.

If the dining room is located away from the kitchen, any opportunity for meal preparation smells will be lost. Cooking smells help to prepare us for the dining experience. "Food odours increase appetite for products with a similar taste and/or energy density. Odours thus steer us towards intake of congruent food products, and perhaps help to prepare the body for digestion of this product"[1]. Approximately 30 to 45 minutes prior to a meal, staff should begin to alert people with dementia to the smells from cooking. For example, a coffee machine or bread maker can be switched on near to where the person with dementia is sitting.

Members of the professional team could take time to talk with the person with dementia about their favourite foods, and possibly show cue cards, cookery books or magazines to generate and orientate discussions with the aim of encouraging an increase in appetite. Team members could also provide pre-meal apéritifs (in accordance with the person with dementia's specific care and cultural needs). There have been many clinical trials to ascertain the effectiveness of alcohol as an appetite stimulant. The outcomes are varied; however, most suggest that energy uptake in food consumed after an apéritif is greater than when one is not taken[2,3]. One research study concluded that: "intake at lunch (excluding energy from alcohol) was significantly higher following alcohol"[4].

Twenty-four-hour visible finger foods or 'grazing stations' should be made available in public areas – closely monitored, replenished and changed frequently to reduce the risk of cross-contamination and to meet Food Hygiene regulations. These 'grazing stations' should be at key points throughout the environment, with the aim of encouraging people with dementia to eat when they feel like it.

Ideally, dining should be an opportunity for people to socialise[5]. However, some communal living environments adopt either a 'canteen-style' or a 'restaurant-style' dining experience. Although these models can meet the dining needs of many people with dementia, others may struggle. These large spaces would benefit from the inclusion of soft furnishings such as curtains and acoustic panels to absorb noise which might otherwise distract and possibly cause distress to some people with dementia[6]. The large open-plan nature of these dining rooms could also be made more 'personal' by using low level dividers or partitions to create spaces, giving people greater choice over where they sit and dine. Research has shown that providing choice can improve quality of life[7].

There should be opportunities for people with dementia to choose to dine in a variety of different spaces. The built environment should provide for this need – for example, there could be a 'pub-style' area, a 'café-style' area, lounge-style dining rooms enabling small groups to dine together, conservatories, patios and so on. The arrangement of dining tables should allow for people with dementia to eat alone or to move to another table or area if they so wish. Place settings should be arranged to meet the variety of needs of residents, and if necessary additional place settings should quickly be made available in a flexible and spontaneous manner.

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The décor, furniture, pictures and object placement should all replicate a 'homely' dining environment with staff reinforcing the sense of welcome and 'family' atmosphere by being approachable, friendly, appropriately humorous, interested in others, receptive and spontaneous in their response to questions and challenges. To this end, dining rooms should ideally have a maximum capacity of 10 people with dementia eating at any one time. If there are more than 10 people, it is likely that noise levels will be greatly increased, and there will be more distractions for people with dementia, which in turn can increase the possibility of over stimulation and compromise people's ability to concentrate during the dining experience.

There should be enough appropriate crockery and cutlery for everyone. Adaptive cutlery (easy grip handles, plate guards, spill-proof cups etc.) should be made available, if required. However, "for people with dementia, crockery, cutlery and glasses should be chosen with care to look familiar (beakers and specially shaped plates may not be recognised)"[5]. Crockery, cutlery and all tableware should be of a traditional and culturally appropriate design, with reference to the age and culture of each person with dementia. The colour, shape and size of the cutlery and crockery should enable people with dementia to recognise and engage successfully with them. The objects should be easy to handle, not too heavy and visually pleasing.

Both the meal and the dinner table should look inviting. Dining rooms should have tables laid ready for mealtimes with tablecloths, cutlery and napkins. Additional features such as edible plants and flower displays, menu cards, salt and pepper may help orientate people with dementia to what the activity is. It may also turn the functional act of eating into a more social experience of dining.

Table coverings and place mats should be of a notably contrasting colour to plates. There should be a clear visual contrast between foods on each plate. Foods of different colours should be placed adjacent to each other so that it is obvious that they are different foods. Pureed food should be presented following the same guidance. Some people with dementia "may not be able to distinguish white food presented on a white plate, so crockery needs to offer a colour contrast to food"[5].

The smell, taste and texture of the food and drink should be appropriate and pleasing to the person with dementia. Members of the professional team should have an awareness of the possible impact of neurological impairment on sensory modalities, and understand how to support some people with dementia to prepare for and maintain their enjoyment of food and/or drink when required[8].

(1) Zoon HF, de Graaf C, Boesveldt S (2016) *'Food Odours Direct Specific Appetite'*. Foods. 2016 Feb 22;5(1):12. doi: 10.3390/foods5010012. PMID: 28231107; PMCID: PMC5224573.

(2) Eiler WJ 2nd, Džemidžić M, Case KR, Soeurt CM, Armstrong CL, Mattes RD, O'Connor SJ, Harezlak J, Acton AJ, Considine RV, Kareken DA (2015) *'The apéritif effect: Alcohol's effects on the brain's response to food aromas in women'*. Obesity (Silver Spring). 2015 Jul;23(7):1386-93. doi: 10.1002/oby.21109. PMID: 26110891; PMCID: PMC4493764)

(3) Westerterp-Plantenga MS, Verwegen CR (1999) *'The appetizing effect of an apéritif in overweight and normal-weight humans'*. Am J Clin Nutr. 1999 Feb;69(2):205-12. doi: 10.1093/ajcn/69.2.205. PMID: 9989681.

(4) Hetherington MM, Cameron F, Wallis DJ, Pirie LM (2001) *'Stimulation of appetite by alcohol'.* Physiol Behav. 2001 Oct;74(3):283-9. doi: 10.1016/s0031-9384(01)00598-4. PMID: 11714490.

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(5) The King's Fund and University of Worcester, UK. Third Edition (2020) *'Is your care home dementia friendly? EHE Environmental Assessment Tool'* https://ext-webapp-01.worc.ac.uk/kings_fund/files/Is%20your%20care%20home%20dementia%20friendly.pdf.

(6) Calkins MP, Brush JA (2002). *'Designing for dining: the secret of happier mealtimes'.* Journal of Dementia Care, 10(2), 24-26).

(7) Edgerton EA, Richie L (2010). *'Improving physical environments for dementia care: making minimal changes for maximum effect'.* Annals of Long Term Care, 18(5), 43-45).

(8) Houston A et al (2017) 'Dementia & Sensory Challenges. Dementia can be more than memory' Life Changes Trust. https://www.lifechangestrust.org.uk/sites/default/files/project/peer-to-peer-resources/Dementia%20and%20Sensory%20Challenges%20Booklet%20April%202017_0.pdf

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Worksheet 15: Wish list for dining and dining room improvements

- Be prepared to discuss the dining experience in your place of work. Are many/any of the points highlighted on **Worksheet 14** present?
- In pairs, write a list of issues that need tackling and a wish list of actions you can take to effect change in your workplace, with the most easily achievable at number 1. Use an additional sheet of paper if necessary.
- Once completed, please share your list with the whole group.

Dining and dining room improvements wish list (most easily achievable first)

Number 1: Issue that needs tackling:
What I can do to effect change:

Number 2: Issue that needs tackling:
What I can do to effect change:

Number 3: Issue that needs tackling:
What I can do to effect change:

Number 4: Issue that needs tackling:
What I can do to effect change:

After listening to others, are there any common themes? Do other learners have similar things on their wish list? Have they shared any ingenious approaches that you could try?

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Worksheet 16: Bedrooms and bed spaces

"Photos, a hair brush, a favourite blanket or a bottle of perfume – can provide reassurance and remind the person with dementia what room they are in"[1].

Even before entering a person's bedroom, there can be an indication of who they are on or around the bedroom doorway. This might reflect what their passions and preferences are; perhaps it might give an indication of what their significant roles in life have been, or some information as to where they might be from.

In a care home setting no two bedroom doors should be the same, as each should reflect the uniqueness of the person whose door it is. Ideally, bedroom doors should be painted in different colours (with resident involvement on choice of colour). This may assist as an orientation cue for some: "I've got the blue door". "Painting the bedroom door in a contrasting colour to the surrounding wall is crucial for finding the door"[1].

There should be a variety of 'sign-posting' pictures of familiar images and objects around the outside of the doorway. There should be memory boxes placed outside of each room, containing items that have specific meaning to the person whose room it is. Door furniture should be varied to enable choice – for example with a doorbell on one door, a knocker on another, and different door number styles. All of this may also help with orientation. Some sources recommend that images should be placed on the door itself[2]; however, caution needs to be taken with doing this as the person with dementia may see the images on the door and register it as a continuation of the wall. If this is the case, the doorway needs to be made as obvious as possible. Different approaches for different people with dementia should be explored.

Once in the bedroom, the person's identity should be very evident. There should be visible personal belongings, possessions and furniture. Bedrooms should be personalised with objects and pictures that can act as frames of reference for the person with dementia. The person's own belongings should be welcomed into the care setting to help create a home-like environment. All these personal items should be used appropriately by team members in order to reinforce the person's identity.

There should be recognisable, accessible and familiar styles of bedroom furniture. The bedrooms should resemble domestic bedrooms, with age-appropriate and culturally-specific furnishings that reflect the identity of the person with dementia whose room it is. People should be encouraged to furnish their bedrooms with items of their own furniture, when and where appropriate, although fire safety risk assessments need to be carried out on all furniture and soft furnishings that are brought into the care home setting to help ascertain what might present a significant risk[3].

A person with dementia may have difficulty locating their bed. To help support them with this, it is recommended that the bed should be visible from as many locations as possible. Ideally, the bed should be accessible from both sides, in order for the person to independently increase their opportunity of entry and exit. Distinctive, plain-coloured bed linen and sheets should be used, and these should be in a noticeably contrasting colour to the walls and flooring to help clearly define the bed.

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Ideally all care home bedrooms will have en-suite bathroom facilities. When this is the case, the layout of the bedrooms and the positioning of furniture in these rooms should allow for the person with dementia to have a direct view of the toilet from the bed. With the toilet in a direct visual line of sight, there is a greater possibility of more people with dementia accessing the toilet independently. There should be a bedside table lamp and directional lighting over the toilet to aid orientation, location, independent use of the toilet at night and a successful return journey. This would help avoid some people with dementia needing assistance when using the toilet, or possibly not getting there in time.

'Smart' lighting can assist with wayfinding for people with dementia. There are many uses for the provision of appropriate Assistive Technology, which can offer benefits of increased security, independence and quality of life, as well as reduced risk for people with dementia. If the directional lighting over the toilet light is switched on when a motion detector registers significant movement in the person with dementia, and the bedside table lamp is then switched on by another motion detector registering significant movement in the bathroom, the person may be supported unobtrusively and effectively[4].

There are many examples of bedroom furniture that has been specifically designed to support people with dementia. Wardrobes and cabinets have been adapted which have recognisable doors fronts with exposed areas to allow the viewer to see what is inside without having to open them. Some wardrobes have narrow openings which can display one day's clothing, while the rest of the clothes are still hanging within the wardrobe.

Bedroom chairs should also be easily recognisable. They need to be comfortable, with padded upholstery in a strongly contrasting colour to the walls and flooring. As already mentioned, strong patterns on wall or soft furnishings can be confusing and disorientating, and their use should be avoided.

Many people with dementia enjoy having mirrors around their environment. They enjoy self-grooming whilst looking in the mirror, admiring themselves or simply checking how they look. There is a comforting familiarity with the face that looks back at them. However, carers need to be aware that some people with dementia may begin to have difficulty fully recognising who the person in the mirror is, and can become anxious and frightened when they see their reflection. This may be because they do not recognise that it is a mirror that they are looking into; instead they may perceive it as a window or doorway, and see a stranger looking at them or blocking their way. It may even be that they truly don't recognise the person who is looking back at them. If this appears to be a problem for a person with dementia, then members of the professional team should explore ways of limiting that person's access to mirrors. If the mirrors come with shutters, close them; if not, cover or remove them[2].

Some people with dementia can experience significant perceptual difficulties which can be exacerbated by distinctive and unnecessary changes in flooring. The flooring in bedrooms, ensuite bathrooms and corridors should all be of a similar colour/tone. There should be a uniform colour flooring throughout the environment. Flooring in adjoining areas/rooms should be of a similar colour (or ideally, of the same colour). Doorway thresholds should not have noticeable carpet strips or grips joining different flooring treatments. Instead 'invisible' joins or same colour carpet grips should be used.

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As already highlighted, some people with dementia may have perceptual difficulties that cause them to interpret shadows or changes in flooring as steps or holes in the floor and try to step over them. The action of stepping over an area of flooring can increase a person's anxiety levels and risk of falling. Patterned or shiny flooring should be avoided, as this can be confusing and disorientating. A good level of lighting enables everyone to navigate more effectively. Ensuring that there are times during the day when there are elevated, even light levels and access to natural lighting in the environment can help promote daily living activity (including increased mobility and movement). This can also encourage healthy sleeping patterns for some people with dementia if the elevated lighting levels are reduced throughout the day to low light levels at night.

Some people with dementia can become agitated in unfamiliar surroundings. Personalising bed spaces may help people orientate to their own space. Opportunities for the person with dementia to bring in personal objects (e.g. photographs, significant items) should be promoted as these can be reassuring and encourage self-care. Perhaps the environment could have lots of visually accessible clocks and calendars, as these can help some people with dementia orientate to the passing of time.

Ideally the environment should have multiple views onto a range of urban/rural settings. It is essential that people with dementia have opportunities to see to the outdoors. The experience of staying in hospital, in particular, can be distressing for many of us. Some people with dementia may struggle to understand where they are and how they found themselves in this environment. The moment-to-moment challenge that some people with dementia may have with orientating to their location can become hugely disabling. They may become fearful, anxious or distressed and respond accordingly, and having ease of access to a safe outside space may be essential for their well-being[5].

(1) Social Care Institute for Excellence *'Dementia-friendly environments: Bedrooms'* https://www.scie.org.uk/dementia/supporting-people-with-dementia/dementia-friendly-environments/bedrooms.asp

(2) University of Worcester and The King's Fund. Third Edition (2020) *'Is your care home dementia friendly? EHE Environmental Assessment Tool'* https://ext-webapp-01.worc.ac.uk/kings_fund/files/Is%20your%20care%20home%20dementia%20friendly.pdf

(3) HM Government (2006) '*Fire safety risk assessment: residential care premises'* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/14885/fsra-residential-care.pdf.

(4) Goodman C, Watson L (2010). *'Design guidance for people with dementia and for people with sight loss'*, Thomas Pocklington Trust Research Findings Number 35).

(5) University of Worcester and The King's Fund. Third Edition (2020) *'Is your ward dementia friendly? EHE Environmental Assessment Tool'* https://ext-webapp-01.worc.ac.uk/kings_fund/files/Is%20your%20ward%20dementia%20friendly.pdf

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Please reflect on the statement from*: Dementia-friendly environments: Bedrooms* – "Having personal items in a bedroom – photos, a hairbrush, a favourite blanket or a bottle of perfume – can provide reassurance and remind the person with dementia what room they are in."

How do you think having these things around them might make a person with dementia feel?

What do you do when a person with dementia has no personal belongings in their bedroom or bed space?

Have you had any experiences of how you supported a person with dementia to engage with their personal items? If so, what?

What do you do if a person with dementia accesses the bedroom of another person?

Have any of your fellow learners shared ingenious approaches that you could try?

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Worksheet 17: Kitchens, kitchenettes and related activities

"The kitchen is the heart of every house, for the most part. It evokes memories of your family history." Debi Mazar

Throughout history and around the world, people have shared the experience of cooking and eating. As Guy Fieri, the US restauranteur, says, "Cooking is all about people. Food is maybe the only thing that really brings everyone together. No matter what culture, everywhere around the world, people eat together". Most people who enjoy cooking and those that enjoy eating will often say that the kitchen is the heart of the home. Indeed, many will say that people always gravitate towards the kitchen.

It is fascinating, therefore, that in many health and social care environments designed to support people living with dementia, the kitchen is an area that can often be 'out of bounds'. The main working kitchen of the service may be too busy, too hectic or too dangerous a place for people with dementia who may not be trained, or who may not comply with the Food Safety Act and Food Safety Regulations.

In recent years, care home environments have begun to be adapted to reflect the need that many people with dementia have to access a kitchen. Some teams have adapted existing parts of a built environment and created kitchen-like areas. Some activity rooms and dining rooms have an area that replicates a kitchenette or a 'therapeutic kitchen'. These areas usually contain a sink, a refrigerator and possibly an oven or microwave. They often have standard-height worksurfaces, although some may have split level work surfaces to enable equal access for people with different needs. There will be an array of kitchen units and cabinets (some with lockable cupboards and drawers). There will always be kitchen equipment such as a coffee maker, pots and pans, baking equipment and a toaster. It is very common that these areas also incorporate a kitchen table.

In 2001, 631 nursing homes and assisted-living facilities providing support for people with dementia in the US were involved in a research study looking at what the components of a 'therapeutic kitchen' should, and building on the empirical evidence to support the efficacy and utilisation of such spaces. The study identified that these spaces can provide a familiar setting with a homelike image and atmosphere. A therapeutic kitchen can function as a social area if tables and islands are available, or can replace the traditional nurses' station and provide an informal surveillance point.

These spaces can unlock the benefits of activities that are associated with therapeutic kitchens. Familiar household tasks such as washing dishes or setting tables can contribute to feelings of pride, and instil a sense of purpose and usefulness in some people with dementia. This is particularly possible with household activities that consist of simple, limited, repetitive tasks and draw upon learned patterns of behaviour that some people with dementia may have retained. Familiar household tasks may also reinforce previous roles, and engage people with dementia in normal, day-to-day activities. Certain activities such as cooking can stimulate the senses through colour, aroma, taste and touch. Food-related tasks, such as chopping or stirring, can also have health benefits, as the tasks may improve or maintain muscle strength, range of motion, gross hand coordination, concentration and attention[1].

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In some settings, therapeutic kitchens appear to be primarily a marketing tool for presenting a home-like image to family members, and may not be used as effectively as they could be. Before his death, Tom Kitwood said, "It is conceivable that most of the advances that have been made in recent years might be obliterated, and that the state of affairs in 2010 might be as bad as it was in 1970, except that it would be varnished by eloquent mission statements, and masked by fine buildings and glossy brochures"[2]. Fortunately, in many settings, therapeutic kitchens are used in structured ways (e.g. for baking, household chores, arts and crafts) with staff members facilitating the activities.

Food is often cooked in a main working kitchen and transported to the therapeutic kitchen in heated trolleys for distribution. Unfortunately, this can deprive some people with dementia of the cooking aromas and other familiar routines associated with pre-dining activities. Occasionally, therapeutic kitchens are incorporated more holistically with the meal service. Meals may be prepared in the therapeutic kitchen, and some people with dementia may be supported to participate both in this and in post-dining activities (collecting dishes, washing, drying, putting away)[1].

Flooring in kitchens and kitchenettes should be washable, durable and non-slip. In addition, the flooring should be non-sheen and pattern-free. This is believed to be helpful for some people with dementia who experience perceptual difficulties. As mentioned in previous Learning Activities, flooring to all areas, especially in open-plan kitchenette/lounge/dining room areas, should be similar in colour and tone to the adjacent flooring.

It should be possible to increase the lighting levels in kitchens and kitchenettes to help support visibility during food preparation and other kitchen-related activities

Individual activity plans should be developed to identify who might be most interested in engaging in kitchen-related activities. These plans should be accessible to all relevant staff members, including chefs and kitchen assistants. People with dementia should be actively supported to engage in familiar food preparation activities in dining rooms and kitchen/kitchenettes. Provision for activities that can help maintain and stimulate preserved skills should be actively encouraged. Almost everyone has been involved in food and drink preparation to a greater or lesser extent throughout most of their life. These skills might still be current, but remain unknown if a person is not offered the opportunity to engage in such activity. If the kitchen/kitchenette is visibly accessible to people with dementia, then they might gravitate towards this familiar space or the objects arranged in it. This should indicate to staff members that this person may have an interest in kitchen-related activities and/or a skill-set that should be explored further.

(1) Marsden JP, Meehan RA, Calkins M (2001) 'Therapeutic Kitchens for residents with dementia' *American Journal of Alzheimer's Disease and Other Dementias*. Volume 16, Number 5

(2) Kitwood T (1997) 'Dementia Reconsidered, the person comes first'. Open University Press:

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Worksheet 18: Case study – Roland

Roland, a retired *poissonier* (fish chef), worked in many top restaurants in Paris and London throughout his career. He ended his work on a high, gaining a Michelin star for his food at 'Les Choses de la Vie'. As head chef, Roland helped steer the restaurant to become a London institution, known for its classically rich French *haute cuisine*.

Roland retired to Brighton, the city of his birth, and quickly became a regular customer at all the restaurants throughout the town. "Always hunting for new exciting flavour combinations" as he would say.

Around 10 years ago it became apparent that Roland had begun to have what he calls "lapses in memory". He was diagnosed with mixed dementia (Alzheimer's disease and vascular disease) 7 years ago. When Roland's nephew (and only living relative) died in January due to COVID-19, Roland's neighbours, Beth and Sharon, noticed how much their lovely neighbour had been supported by his nephew and was now struggling. It became clear that, even with their help and the support of a fabulous home care staff team, Roland needed 24-hour care.

Although Roland now has limited verbal communication skills, he is still very able to express his own wishes, choices and desires. After a robust assessment process, Roland moved into the Beaches Care Home six months ago, and he has settled in quite quickly. Unfortunately, the home has not received much life history information but Fakhirah, his key worker, has spent a lot of time with Roland and together they have begun to complete a life history profile. Fakhira, who Roland lovingly calls "*ma petite elégante*", has identified some key pieces of life history information, and as recently recorded in the care plan that Roland was formerly a chef.

Roland spends most of his time in the dining room and repeatedly tries to gain entry to the kitchen. The kitchen assistants have complained to the chef manager that "Roland keeps getting into the kitchen, touching everything and moving things around". The chef manager complains to the registered manager that he can't keep him out, and they agree to immediately install a Yale lock with a hook for the key at the top of the door frame. This is ineffective, though, because while some of the kitchen assistants complain that they struggle to reach the key, Roland has no problem. He observes the kitchen staff reaching up and taking the key, unlocking the door and putting the key back on the hook before entering. Moments after a kitchen assistant enters the kitchen, Roland follows their lead – he unlocks the door, pops the key in his pocket and goes into the kitchen.

The chef manager immediately goes to the registered manager and demands that Roland be removed from his kitchen. Fakhirah hears staff shouting at Roland and goes into the kitchen. She is surprised to see Roland holding a piece of raw fish in one hand and a boning knife in the other. As Roland sees her, he smiles and immediately tosses the knife into the air – it spins and he catches it without looking. Fakhirah is astonished and quickly picks up a plate on her way over to him. She calmly asks him to put the fish on the plate and to come into the dining room to show her how to remove the skin. He hands her the knife and they both leave the kitchen before the chef manager returns.

Within an hour, a key-pad lock is put on the kitchen door. Over the next few days, Roland repeatedly tries to enter the kitchen. He pulls and pushes against the door as he

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tries the door handle. After three days, becoming frustrated, he begins to shout out. The team call for Fakhirah, who is supporting another resident in the lounge. She is very surprised when she hears how Roland is behaving, as she has never heard him raise his voice. She manages to calm him and they both walk away from the kitchen door. Roland keeps repeating the same sentence as they walk: "The stuff of life, the stuff of life…".

The following morning, after a very restless night, Roland is having breakfast. As he sits and drinks his black coffee, he watches the care staff go to and from the serving hatch. He watches them make small talk with the kitchen staff as they wait for plates to be piled high with food. Holding his coffee, he stands and walks over to the serving hatch. No-one notices as he manages to haul himself up onto the counter and slide through into the kitchen. As Roland hits the kitchen floor, he calls out in pain. One of the relief chefs sees his predicament and calls for assistance. An ambulance is called and Roland is taken to hospital. Both the ambulance crew and the senior A&E nurse raise a safeguarding concern.

The home is visited by a member of the safeguarding team who asks for an explanation as to what happened and for a chronology. The Quality and Safeguarding Team Lead (Q&STL) asks if a risk assessment has been carried out, and the staff take out their risk assessment folder. They go to their catering section and show her their risk assessment identifying that the kitchen is an 'out of bounds' area for residents due to the multiple high-risk factors: "*Cuts, burns, lacerations and injuries may be very serious due to the nature of kitchen equipment. 1). Residents are not permitted to enter kitchen. 2). Knives and other dangerous implements are only to be used to prepare food in the kitchen*".

The Q&STL then asks for clarification on Roland's previous life experiences, as she has been told that he was head chef at a Michelin starred restaurant in London. The staff confirm that they have recently been told this by a couple of old neighbours of Roland. The Q&STL explains that they should have individualised risk assessments, especially when a resident has clear desires linked to past experiences. She agrees to help the team complete a risk assessment for Roland. The outcome is that Roland is to be allowed access to the kitchen, but must be supervised by an allocated kitchen assistant.

The chef manager is not happy that one of his team has to be taken off their duties to supervise a resident. However, after two weeks he tells Fakhirah that having Roland in his kitchen has been more fascinating than he would ever have expected. He goes on to explain that Roland is supervising the kitchen assistant – not the other way around! "He's always reminding her to wash her hands and not to prepare certain foods in the wrong areas of the kitchen!" He then admits that Roland has begun to teach him how to prepare certain types of fish adding, "Do you know he was the head chef that got 'Les Choses de la Vie' their first Michelin star – it's amazing! He came up with the name… do you know what it means? 'The stuff of life' – what a great name, eh?"

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In pairs, read the case study and answer the following questions.

What do you think this experience must have meant to Roland, Fahkirah and the chef manager?

What might you encourage members of the care team to do if they were supporting Roland?

What specific goals or purpose would you encourage them to consider drawing up?

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Do you have generic or person-specific risk assessments?

Does life history work get read by the whole professional team?

Do any of the people with dementia you support have culinary skills? If so, how and where do you support them to exercise this skill? How often does this happen? Daily? Weekly? When staff have the opportunity?

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Worksheet 19: Bathrooms and toilets

Bathrooms are usually places of pampering, where someone might indulge or look at their body. Many people engage in self-grooming, trim their nails, fix their make-up, comb their hair, brush their teeth or have a shave. It's a place to get clean and to enjoy a long soak in the bath, using favourite scents, oils and soaps. For many of us, a bathroom is a place of relaxation or meditation, somewhere we might read a book, magazine or newspaper – a place to find solitude and listen to our internal voice.

Maybe the bathroom is a place to put the world to rights – to capture, clarify or create thoughts and ideas. It's often said that we all have at least one great idea in the shower. Not only might the warm water elevate our mood, it can also help focus our attention inward. "You have some mild sensory deprivation. You can't see very much. There's the white noise of the water. The water is warm so you can't feel the difference between your skin and the air. This sensory restriction is like an extended brain blink. You cut out the outside world and ideas bubble up into awareness"[1].

A bathroom can also be a place to lower our defences and be ourselves – to have fun, sing, enjoy our own music, be creative, rest, recharge, exercise, pour our hearts out, cry, let go the pain and be free. The interior design of the bathroom is almost secondary to the myriad of things we use it for. However, over time it will reflect who we are and what do in there. In an environment designed to support people with dementia, the bathroom must reflect all these diverse uses and needs.

Because of the complexities of perception that many people with dementia have, there should be recognisable and easy-to-access bathroom facilities and visible bathroom accessories. All fixtures and fittings in bathrooms should be easily recognisable, using a contrasting colour from the walls and flooring[2]. Toilets should include familiar cisterns, toilet seats, flush handles and rails in a colour that contrasts with the sanitary ware, walls and flooring. Taps and toilet roll holders should be of a domestic style and should be easily accessible. Hand washing facilities should be recognisable, appropriate and safe for the people with dementia who might be using them.

Bathrooms and toilets should have familiar objects and accessories in them that are age- and culture- appropriate, and that aid place recognition and help with all the room's uses. Warmer colours should be used on the walls, and consideration should be given to the contrast between this and the sanitary ware and furniture placed in the room. There should be a recognisable 'bathroom-style', and a noticeably contrasting plain-coloured shower curtain. A range of toiletries should be provided; however these should be for orientation only and not for use in communal bathrooms, as they could possibly cause harm if ingested. These 'decorative' toiletries should be emptied and cleaned, or filled with drinking water that is replaced regularly. Fluffy towels also aid with orientation, but again they should not be for actual use in communal bathrooms as this could increase the risk of cross infection. It is therefore recommended that they be placed on high shelves, out of easy reach. Other items that should be provided include sensory objects (e.g. radio, safe candle lights), pictures, non-toxic plants, other age and room-specific ornaments. There should not be any items that would not usually be found in a

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bathroom – for example hoists, stored wheelchairs, items of non-bathroom furniture, or boxes of personal protective equipment (PPE).

All bathrooms should have a mirror. However, the mirrors should ideally have shutters, covers or doors, or they should be easily removed and remounted. Many people with dementia would enjoy having mirrors in key areas throughout their environment, and having a mirror in a bathroom would aid with a wide range of self-grooming activities. However, some people with dementia may begin to have difficulty fully recognising who the person in the mirror is. Members of the professional team need to have an awareness of who might become anxious and frightened if they see their reflection, and should explore ways of limiting the person's distress by reducing or removing visual access to the mirror. Perhaps the mirror could be framed by a shower curtain (of a similar colour to the walls), which could be drawn over it if required[3].

The view from all baths should be 'domestic' and not clinical. Pictures or objects should be in the direct line of sight from the bath, rather than clinical or hygiene-focused items such as paper towel dispensers, sterile wipes, shelves with protective clothing or visible equipment instructions intended for staff. At a general level, bathrooms should have a non-clinical, warm and welcoming atmosphere. Some people with dementia may become anxious or distressed if they're accompanied to a room that is unfamiliar, unwelcoming and stark or has a 'cold' atmosphere. If they are then expected to undress in front of a member of the professional team, their emotional state may be heightened further

(1) Kounios J, Beeman M (2015) *'The Eureka Factor: Aha Moments, Creative Insight, and the Brain'* Random House.

(2) Kelly F, Innes A, Dincarslan O (2011). *'Improving care home design for people with dementia'* Journal of Care Services Management, 5(3), 147- 155 (1).

(3) University of Worcester and The King's Fund. Third Edition (2020) 'Is your care home dementia friendly? EHE Environmental Assessment Tool' https://ext-webapp-01.worc.ac.uk/kings_fund/files/Is%20your%20care%20home%20dementia%20friendly.pdf

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Worksheet 20: Bathrooms and toilets quiz

In pairs, please complete the bathrooms and toilets quiz.

Q1. Name three things that you do in the bathroom (apart from getting clean).

1.

2.

3.

Q2. Should people with dementia listen to music whilst in the bath?

Yes No

Q3. What is believed to be the best colour combination for a bathroom?

1) White walls, sage-green flooring and white sanitary ware.

2) Cornflower-blue walls, cornflower-blue flooring and white sanitary ware.

3) Pale-gold walls, ochre flooring and white sanitary ware.

Q5. Why is this?

Q6. What colour toilet seat is believed to be most supportive to people with dementia?

1) White toilet seat and white sanitary ware.

2) Black toilet seat and white sanitary ware.

3) Red toilet seat and white sanitary ware.

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Q7. Why is this?

Q8. List five objects and/or accessories that could be placed in the bathroom to aid place recognition.

1.

2.

3.

4.

5.

Q9. Should bathrooms have mirrors?

Yes No

Q10. When sitting in the bath, which three items from this list might people with dementia prefer to look at?

1) A picture of ducks

2) A wall mounted towel rack with different coloured fluffy towels

3) A shelf with some nautical items

4) A paper towel dispenser

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Worksheet 21: Corridors

The corridors around our homes are often full of furniture, objects, items, images and photographs. It is not unusual to have 'themes' running along corridor walls – perhaps prints or paintings of favourite scenes, or a wall of photographs of children and extended family. Near the front door there may be a mirror, a narrow table and hooks with coats, scarves and hats. Near bedrooms there might be more narrow tables with lamps, ornaments or items that have spilled out of the rooms.

The corridors around a built environment that supports people with dementia should take elements of what may be found in domestic settings and recreate them to help a person orientate around the environment. There should be strong, distinctive age and culturally appropriate themes in different corridors. Each corridor should have sufficient imagery, objects and items to reinforce its theme – all designed to help the person recognise that this is a different corridor to a previous one. As a person walks around the environment, the images, furniture, and objects should provide opportunities for engagement and connection. Some items may be significant enough to the individual that they repeatedly gravitate towards them. Staff should be observant of this and explore the item with the person, perhaps considering whether related objects hold the same fascination. These memorable items may become signposts for some people with dementia, and they may begin to navigate around the built environment.

To help with orientation around a hospital setting, it is recommended that strong blocks of colour be used at key areas. Framed artworks of the local area may help some people orientate to where they are geographically[1], as well as within the built environment.

All corridors should lead to meaningful places. Dead ends should be avoided or, if this is unavoidable, should be made interesting – for example 'potting shed', 'reading corner', 'sewing room', 'music library, 'boudoir', 'nursery'. Corridor junctions should also be areas of interest – for example a 'village square', 'town centre' or 'countryside' meeting point, with images and objects associated with the chosen theme. There could be shops, plants, lamp posts, maps of the local area, appropriate seating, stands with leaflets and postcards of the local area, and magazines and local newspapers on tables. These themed spaces might encourage people to sit, socialise and 'people watch'.

There should be way finding signage to other areas of the care setting – for example an arrow pointing in one direction with 'Bluebell Drive' written on it and an arrow pointing in the opposite direction to 'Honeysuckle Walk'). Signs should ideally use both images and text. All signs should have a high contrast between the colour of the lettering and the colour of the background. It is recommended that lettering should be black on a yellow background, as this is believed to be the highest visible colour contrast for ageing eyes. Traditional signage identifying key rooms should be placed directly on the doors (not around them) and at a height where it can easily be seen[2].

There should be significant 'landmark' objects at key places along the corridors to act as orientation cues. Images or paintings could be hung on the walls outside important rooms to act as signposts. For example, outside the lounge door there could be images of fireplaces to help people recognise or remember where the lounge is. Teams can "introduce noticeable landmarks that might have special meaning to users and can

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be used as reference points" or consider using "personal items to identify personal or private spaces (e.g. on doors to bedrooms)"[3].

A bright red working post-box near the reception or main entrance may be a memorable signpost for many people. However, items that may cause frustration and confusion should be avoided. For example, large photo-quality murals can be misleading and may increase frustration for some people – a large mural of a cornfield might be a beautiful image, but could also be perceived as real by a person with dementia. It might be a space that a person would want to explore, but find themselves unable to walk into. Equally, bus-stops in corridors (or anywhere inside or outside of the care setting) will set someone with dementia up to fail. There will be no buses coming to whisk them away, just a long and very disappointing wait. As previously mentioned, where possible, shelving, sideboards, plants, objects, pictures, mirrors, seats and coffee tables should be placed in corridors to act as orientation cues and to help create a welcoming, homely feel.

Good use of prominent visual information can help to support and promote wayfinding and navigation. "It is based on lessons learnt elsewhere in wards where images are used extensively to help patients locate their beds"[3]. There should be easily visible handrails in all the corridors, especially in high-risk areas such as thresholds and areas where there is a noticeable change in environment (lighting, decoration etc.). As with other areas of the built environment, all flooring in corridors should be in a contrasting colour to the walls, and both should be in a contrasting colour to the furniture to aid with clear identification and recognition of where these items are.

Members of the professional team should have multiple spontaneous connections with people with dementia who are moving around the built environment. Ideally, they should make use of the objects, items and images in the corridors (and around the rest of the environment) to facilitate these meaningful moments.

(1) University of Worcester and The King's Fund. Third Edition (2020) *'Is your ward dementia friendly? EHE Environmental Assessment Tool'* https://ext-webapp-01.worc.ac.uk/kings_fund/files/Is%20your%20ward%20dementia%20friendly.pdf).

(2) University of Worcester and The King's Fund. Third Edition (2020) *'Is your care home dementia friendly? EHE Environmental Assessment Tool'* https://ext-webapp-01.worc.ac.uk/kings_fund/files/Is%20your%20care%20home%20dementia%20friendly.pdf)

(3) Department of Health (2015) *'Health Building Note 00-01 General design guidance for healthcare buildings Health Building Note 08-02 Dementia-friendly Health and Social Care Environments'* https://oacp.org.uk/wp-content/uploads/2016/01/HBN_08-02-Dementia-Friendly-Environments_reduced2-2.pdf

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In pairs, please answer the following questions.

What are the corridors like in your place of work?

Do you have strongly themed corridors in your place of work? If so, what are the themes?

Do all your corridors lead to meaningful places? If so, what are they?

What is your signage like? Does it follow the suggestions made here?

Do you have blocks of distinctive colour to help with orientation?

Do you have significant 'landmark' objects at key places along the corridors to act as orientation cues? If so, what?

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Worksheet 22: Greenspaces and the importance of getting out

Many studies show that being outside in greenspaces builds stamina, improves core muscle strength, is relaxing and reduces our stress, cortisol levels, muscle tension and heart rates. There are also many mental health benefits associated with being outside in greenspaces. Having regular access to the outdoors has been proven to lower the risk of depression and to aid psychological recovery from stress. Studies have also shown that being in nature can restore and strengthen our mental capacities, increasing our focus and attention. Going outdoors can help us meet and get to know people, connect with our local communities and feel more at one with nature. Everyone has a different experience of being in greenspaces, and those who love it will have their own unique reasons for wanting to connect with the outdoors more[1]. "Greenspace exposure is associated with numerous health benefits in intervention and observational studies. These results are indicative of a beneficial influence of greenspace on a wide range of health outcomes"[2].

Spending time in greenspaces is not only essential for our general well-being; exposure to sunlight also triggers the body's creation of vitamin D. Vitamin D helps to regulate the amount of calcium and phosphate in the body, nutrients that are needed to keep bones, teeth and muscles healthy. Research has even shown that exposure to vitamin D can play an important role in mood regulation. "Too little vitamin D can lead to bone pain and muscle weakness in adults, which may also increase the risk of falls in older people"[3].

There is an almost universal recognition of the importance of the human right to go outdoors. Research has identified that spending at least two hours per week in greenspaces can promote better health and overall well-being. Further, it seems that the specific activity that a person engages in does not matter; whether being physically active or just relaxing, the simple act of being outside in good-quality spaces is what matters[4]. If needed, people can initially be supported to look at nature from a safe indoor space, before being outside. Once outside, there are a range of activities to engage in: going for a walk, having a picnic or simply sitting to watch a sunset are all examples of activities that can help to make us feel good in greenspaces. Most services providing support for people with dementia have an outdoor space and/or some greenspaces close by[5].

The right to greenspace access is outlined in policies for many different groups of people in institutions, from school children to prisoners. Within education, "Ofsted expect a rich and stimulating outdoor area to be present in schools and good use of the school grounds to be made on a daily basis"[6]. And according to the European Prison Rules: "Every prisoner shall be provided with the opportunity of at least one hour of exercise every day in the open air, if the weather permits"[7]. The Association for the Prevention of Torture says that: "All detainees have the right to a minimum of one-hour outdoor exercise per day. This is crucial for their mental and physical well-being."[8]

The Care Quality Commission (CQC) has clear expectations that care home services should have arrangements in place to ensure that people have access to gardens and other outdoor spaces[9]. However, there is no guidance for how often and for how long providers should support people with dementia to access greenspaces – and when

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spending time in a built environment, many people with dementia can have little access to the outdoors. Some health and social care settings have very limited outdoor environments, or even no immediate outdoor space at all, while some simply don't prioritise the need to support people with dementia to access the outdoors unless the person is a smoker.

Sometimes, staff may find that the people with dementia they support do not wish to go outside. For some people with dementia, the longer they live without going outside the more fearful of it they become. In addition, some teams may lack knowledge as to what they can do and how they might support people with dementia in terms of accessing the outdoors. It was identified in a consultation document that the most significant barriers to going into greenspaces and taking part in outdoor activities were "a lack of confidence, fears and safety concerns, not having transport, insufficient information about what places have to offer and their suitability for visitors with dementia, and lack of support to get to locations, use facilities, and participate in outdoor activities"[10].

It is clear, however, that people with dementia, including those with no verbal communication, can still enjoy greenspaces, and especially outdoor activities like listening to birdsong, gardening and growing food. There is evidence that using local greenspaces, having a water feature in the setting, watching wildlife, being involved in allotment projects and so on can appeal to some people with dementia[11]. Because of the uniqueness of personal experience, one person with dementia might gain something completely different from accessing a greenspace or taking part in an outdoor activity to another. Although people can share passions and interests, no two are the same.

One of the key recommendations made in the consultation document 'Is It Nice Outside?' is that carers' organisations and providers of support to people with dementia have a role to play in encouraging family carers and members of the professional team to be more ambitious in their expectations of what people with dementia can do. This could be achieved by "the sharing of innovative good practice highlighting the positive outcomes, and how concerns and practical difficulties have been overcome to enable someone living with dementia to participate in outdoor activities safely"[9].

(1) MIND *'Nature and mental health: How can nature benefit my mental health?'* https://www.mind.org.uk/information-support/tips-for-everyday-living/nature-and-mental-health/how-nature-benefits-mental-health/

(2) Twohig-Bennett C, Jones A (2018) *'The health benefits of the great outdoors: A systematic review and meta-analysis of greenspace exposure and health outcomes'* Environ Res ;166:628-637. doi: 10.1016/j.envres.2018.06.030. Epub 2018 Jul 5. PMID: 29982151; PMCID: PMC6562165.

(3) Department of Health and Social Care. (2021) *'Guidance: Vitamin D and care homes guidance'* https://www.gov.uk/government/publications/vitamin-d-for-vulnerable-groups/vitamin-d-and-care-homes-guidance.

(4) White MP, Alcock I, Grellier J, Wheeler BW, Hartig T, Warber SL, Bone A, Depledge MH, Fleming LE (2019) *'Spending at least 120 minutes a week in nature is associated with good health and well-being'*. Sci Rep 9, 7730. https://doi.org/10.1038/s41598-019-44097-3.

(5) NHS Highland. *'Feeling Good Outdoors'* https://www.nhshighland.scot.nhs.uk/YourHealth/PhysicallyActive/Pages/FeelingGoodOutdoors.aspx#: ~ :text = Making%20use%20of%20our%20outdoor,our%20day%20to%20day%20lives

(6) OFSTED (2008) *'Learning outside the classroom'* https://www.ltl.org.uk/wp-content/uploads/2020/05/ofsted-learning-outside-the-classroom.pdf.

(7) Council of Europe (2006) *'European Prison Rules'* Council of Europe Publishing https://rm.coe.int/european-prison-rules-978-92-871-5982-3/16806ab9ae.

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(8) The Association for the Prevention of Torture. *'Outdoor exercise'* http://www.apt.ch/en/knowledge-hub/detention-focus-database/life-prison-regime-and-activities/outdoor-exercise.

(9) CQC. (Updated 2022) *'Accessible premises E6. How are people's individual needs met by the adaptation, design and decoration of premises? E6.3 What arrangements are there to ensure people have access to appropriate spaces'* Care Quality Commission.

(10) Mapes N, Milton S, Nicholls V, Williamson T (2016) *'Is it Nice Outside? Consulting people living with dementia and carers about engaging with the natural environment'.* Natural England Commissioned Reports, Number 211. http://publications.naturalengland.org.uk/publication/5910641209507840).

(11) NHS Humber Teaching. (2021) *'How spending time in nature can benefit your mental health'* (10 May 2021) https://www.humber.nhs.uk/news/?postid = 367439).

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Worksheet 23: Action plan for increasing access to greenspaces

The National Institute for Health and Care Excellence (NICE) has developed the guideline: *Dementia: assessment, management and support for people living with dementia and their carers* to help teams develop action plans, improve approaches and create self-reflective development opportunities.[1]

Here are some pointers to help you draft an action plan for increasing access to greenspaces (following the NICE guidelines):

1. Raise awareness through routine communication channels, such as email or newsletters, regular meetings, internal staff briefings and other communications with all relevant partner organisations. Identify things staff can include in their own practice straight away.
2. Identify a lead with an interest in the topic to champion the guideline and motivate others to support its use and make service changes, and to find out any significant issues locally.
3. Carry out a baseline assessment against the recommendations to find out whether there are gaps in current service provision.
4. Think about what data you need in order to measure improvement, and plan how you will collect it. You may want to work with other care organisations and specialist groups to compare current practice with the recommendations. This may also help identify local issues that will slow or prevent implementation.
5. Develop an action plan, with the steps needed to put the guideline into practice, and make sure it is ready as soon as possible. Big, complex changes may take longer to implement, but some may be quick and easy to do. An action plan will help in both cases.
6. For very big changes, include milestones and a business case, which will set out additional costs, savings and possible areas for disinvestment. A small project group could develop the action plan. The group might include the guideline champion, a senior organisational sponsor, staff involved in the associated services, and finance and information professionals.
7. Implement the action plan with oversight from the lead and the project group. Big projects may also need dedicated project management support.
8. Monitor and review how well the guideline is being implemented through the project group. Share progress with those involved in making improvements, as well as relevant boards and local partners.

(1) NICE guideline (2018) *'Dementia: assessment, management and support for people living with dementia and their carers'* https://www.nice.org.uk/guidance/ng97/resources/dementia-assessment-management-and-support-forpeople-living-with-dementia-and-their-carers-pdf-1837760199109

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Think about your place of work. In pairs, consider how you could improve access to greenspaces for people with dementia.

Are there any issues that need to be addressed before people with dementia can get outside?

How might you combat these issues?

Who might be able to support you with this?

How will you get everyone in the team to support you?

What would the first outdoor activity be?

How would you evaluate the 'success' of this approach?

Forester-Morgan, T. & Mould, S. (2022) *The Dementia Care Training Library*.
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Worksheet 24: Gardens, terraces and balconies

Gardens, terraces and balconies need to be accessible and safe. People with dementia should have direct access to an outdoor space without needing to be acompanied by a staff member to access the outdoors via a locked door or a lift. The journey through an outdoor space that a person with dementia may experience should be full of interest and enjoyment, and devoid of disquiet and distress. Pathways that come to an abrupt end, that lead to 'stepping stones' or that have a significant change in nature can result in some people with dementia becoming anxious because there is no clear guide for where to go. There should be areas of interest along the journey, but the pathway should ultimately lead the person with dementia back to a place of safety (i.e. back to the building).

Objects to engage with (visually and/or physically) should be present in all accessible outdoor areas. These should be familiar and relevant to an outdoor setting – for example garden tools, potting sheds, benches, parasols, bird feeders, safe water features and washing lines. Objects should not set a person with dementia up to fail – for example locked sheds, inaccessible tools, or decorative bus stops that have no buses. Staff members should actively support and encourage people living with dementia to engage with the objects that are present, either independently or when supported to do so.

There should be a range of things that help to reduce risk and promote safety without making the outdoor environment feel like a jail. A range of measures should be in place – for example garden planting should be planned so that all species are non-poisonous, and an information poster highlighting dangers of certain common garden plants should be available for all to refer to. There should be level access to all areas of the outdoors, and also to the outdoors from indoors (door thresholds should be level). There should be no visual or physical barriers to gardens, and minimal changes in the colour of flooring to gardens, terraces or balconies. All exterior pathways and patio areas should be level and non-slip to aid ease of movement from one area to the next.

As already mentioned for interior surfaces, any exterior surfaces should have non-reflective treatments. If surfaces are reflective, this may cause confusion and be open to misinterpretation by some people with dementia. Reflective surfaces may appear to be wet, or may challenge the person's perception (as with strong colour changes in surfaces, some people with dementia may percieve the visual change to be a step or hole). There should be no 'obstacles' blocking visual or physical access. Doors to safe areas should not be locked, and perimeter fences should be safe but not oppressive or prison-like.

There should be plenty of opportunities around the garden for people with dementia to stop, sit and enjoy the greenspace. Seating must be recognisable, age and culturally appropriate, stable and safe. There should be visibly accessible signage back to the building at key points around the garden or terrace/balcony (if large enough). There should also be landmark planting to aid with way finding, and sculptural or specimen plants near doorways can act as significant memory prompts or signposts.

The landscaping and design of all outdoor areas should enable people with dementia to orientate to the season and time of year, and should help to support opportunities for

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familiar, everyday outdoor activities. Thought should be put into the planting and placing of a range of seasonal plants and seasonal garden objects. For example:

- Spring: Snowdrops, crocuses and daffodils in window boxes and planters. Trees with blossom. Trays with spring flowers ready to be bedded in.
- Summer: Sunflowers, agapanthus, echinacea, geraniums, daisies, sweet peas. Tables with parasols, sun-hats, watering cans and washing lines (full of clothes in good weather, empty in inclement weather).
- Autumn: Chrysanthemums, asters, cabbages, pumpkins and apples on trees. Autumn colours, garden rakes and mounds of leaves.
- Winter: Trees without leaves and bare ground, holly bushes, fir trees, pine and spruce trees decorated with lights, bird-feeders with seed, all within visual range from indoor seating areas.

Sensory experiences can help to reinforce where a person with dementia is both in space and in time, and planting and garden ornaments should therefore facilitate opportunities for a variety of sensory experiences. Opportunities to engage each of the five senses should be present. A sensory garden to stimulate touch, smell, sight, taste and hearing (chimes, the rustling of grass or bamboo, light catching ornaments, water features, soft textured and highly scented plants, edible plants and brightly coloured flowers) should be made available.

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What outdoor sensory experiences may help a person with dementia orientate to the seasons?

Spring outdoor sensory experiences

Summer outdoor sensory experiences

Autumn outdoor sensory experiences

Winter outdoor sensory experiences

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Worksheet 25: Self-audit on outdoor spaces

Indicator	Is this achieved?			If yes, how? If no, what action needs to be taken?
	Yes	No	N/A	
There are paths with handrails, where the gradient is greater than 1:20, that lead from and return to the building.				
There are traditional and recognisable outdoor objects to enable familiar, everyday activity. People living with dementia are observed to engage with these objects, either independently or when supported to do so.				
There is a range of things that help to reduce risk and promote safety.				
The landscaping and design orientates people with dementia to the season and time of year, and enables familiar, everyday activity.				
The planting and ornamentation facilitate opportunities for a variety of sensory experiences.				

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Indicator	Is this achieved?			If yes, how? If no, what action needs to be taken?
	Yes	No	N/A	
There is landmark planting to aid with wayfinding.				
There is good access to and from buildings for people with a range of spatial awareness and mobility needs.				
There are no visual or physical barriers to outdoor spaces, and minimal changes in the colour of flooring leading to and from gardens, terraces and balconies.				
All hard surfaces are level, non-reflective and non-slip.				

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