

Hospice *friendly* Hospitals PROGRAMME

Design & Dignity Guidelines for Physical Environments of Hospitals Supporting End-of-Life Care

The Irish Hospice Foundation

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Putting Hospice Principles into Hospital Practice

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Foreword

Hospitals are viewed primarily as places where people are treated for illness, with the primary function of provision of curative healthcare and treatment. However, many people are not in hospitals for curative care. They are there for care at the end of their life. They will not die at home as most people said they would like to do in a survey undertaken by The Irish Hospice Foundation. (1) Instead they will die in hospital and the design of the building and the physical and sensory environment will affect their experience of dying and their relatives' memories of the death.

People have frequently approached the Irish Hospice Foundation or staff involved in the Hospice Friendly Hospitals (HfH) Programme with their stories about death in a hospital. Many remark on the efforts of kind, caring staff who do their best for patients and their relatives at this sensitive time, but the circumstances surrounding some deaths leave relatives with difficult memories and a sense that things could and should have been better. The regrettable issues are frequently connected to a general absence of dignity, related to the physical environment, for the person and their family at the time of dying and death. These Guidelines address the environmental issues impacting on the dignity of patients and relatives.

Well designed healthcare environments support best practice and enable the needs of patients and relatives

to be met. However, quality patient-focused care can only be delivered when facilities have robust operational management which incorporates rigorous procedures and comprehensive training for all staff. These Guidelines will be followed by standards to support areas of practice associated with end-of-life care.

The HfH Programme is an initiative of the Irish Hospice Foundation developed in partnership with the Health Service Executive, the Health Services National Partnership Forum, the Atlantic Philanthropies and the Dormant Accounts Board. It is concerned with improving end-of-life care for people in hospitals.

Introduction

Dying, death and bereavement, of their very nature, raise profound and practical issues for hospitals. These HfH Design and Dignity Guidelines provide direction on design of hospitals and environmental matters as they impact on end-of-life care for patients, relatives* and staff. While staff in hospitals make every effort to deliver best care, hospital environments do not always facilitate them in delivering dignified care for the patient or support for their relatives.

The HfH Design and Dignity Guidelines are general and applicable for all departments and wards within hospitals where all types of death can occur. These generic guidelines should be customised and adapted for the requirements of specific departments and wards, e.g. Out-Patients, Emergency Departments, Intensive Care Units.

All patients, but particularly patients who are dying, should be cared for in environments designed to meet their full needs. Two recent publications in Ireland, *Design guidelines for specialist palliative care settings* (Department of Health and Children, 2004) and *International expert advisory group report on palliative care* (Marymount Hospice, 2005), provide design guidance for specialist palliative care units, and *The national quality standards for residential care settings for older people in Ireland* (HIQA, 2008) provide standards for residential care settings for older people, but there are no comprehensive patient-centred guidelines to support dignified care and more specifically end-of-life care in

acute hospital settings. This is despite the fact that 40% of people who die in Ireland do so in an acute hospital setting.

These HfH Design and Dignity Guidelines provide the necessary guidance for the design and planning of acute hospitals so that the buildings can support quality end-of-life care. The Guidelines are also appropriate for community hospitals, enhancing the National Quality Standards for Residential Care Settings for Older People in Ireland.

It is anticipated that the Guidelines will primarily be used in the development of project briefs for new hospital buildings. They are also relevant for refurbishment projects, and should be used to assess existing facilities and guide improvements.

The Guidelines were developed by a working group and draft Guidelines were subject to public consultation. (See Appendix 1 for membership of the working group.)

Section One discusses the origins and background to the development of the Guidelines.

Section Two presents the HfH Design and Dignity Guidelines for Physical Environments of Hospitals Supporting End-of-Life Care.

* *The term relative is used to refer to those people who matter to the patient.*

Section 1: Rationale Supporting the Guidelines

1.1 Planning for End-of-Life Care

Information is available on the number of deaths taking place each year in Ireland, the major causes and trajectories of deaths, places where deaths most frequently occur, important principles underpinning dying, death and bereavement and the impact of the physical environment on patient care. This information means we can plan for end-of-life care.

1.2 Places of Death

Approximately 28,000 deaths occur in Ireland each year, and two thirds of these (18,000) occur in acute and general hospitals. (2) Approximately half of these (9,000) are people 65 years and over. A further 9,000 people over 65 years of age die annually in community hospitals and nursing homes for the elderly. (3) Currently there are no national figures for location of deaths within hospitals, however information about deaths is often available within existing hospitals and could assist detailed planning for end-of-life within specific areas of a hospital.

1.3 Causes of Death

Knowledge of the main causes of death can aid planners in considering the needs of patients and their families around the time of death.

The causes of deaths in Ireland fall within the following five main categories: (4)

<i>Circulatory Disease</i>	(34%)
<i>Cancer</i>	(29%)
<i>Respiratory Disease</i>	(14%)
<i>External Causes (accident and injury)</i>	(6%)
<i>Other Causes (disease of digestive system, diabetes mellitus etc)</i>	(17%)

1.4 Trajectories of Death

There are recognised likely courses of illnesses leading to death (trajectories) and an awareness of these will also assist those responsible for design of hospitals to understand the circumstances and nature of deaths.

Patients with chronic organ failure have periods of serious illness, can respond to acute intervention and regain a certain degree of health, perhaps a number of times, but could die during any one of the episodes of deteriorating illness.

Frailty is characterised by a gradual deterioration over a long period of time. Death is difficult to predict and there may be numerous times when death could occur.

Those suffering from incurable cancer can, with treatment, live for a long period of time with no noticeable decline in their health, until a point when terminal decline begins and end-of-life approaches.

Sudden deaths occur unexpectedly and are often the result of a traumatic incident or accident. Some occur as a result of an undiagnosed condition. (5)



The time approaching death can be a very intimate time and therefore should not be encroached upon unnecessarily by others

1.5 Principles underpinning the Guidelines

Design, dignity and privacy in care at the end of life in hospital: a review of the literature, carried out in 2007 by the Centre for Health Policy and Management, University of Dublin, Trinity College gathered evidence on how design and configuration of facilities can be supportive to dignity and privacy around death in hospital. This document underlined that the design of the hospital should take into account the practical, spiritual, emotional and psychological needs of patients and relatives. An understanding of the patient's journey and that of their relatives, with regard to dying, death and bereavement suggests certain principles that are important to all patients receiving care in hospitals, but which assume ultimate importance for end-of-life care.

The principles underpinning the HfH Design and Dignity Guidelines are the promotion and protection of dignity, privacy, sanctuary, choice and control, safety and universal access.

Dignity: Dignity refers to the state or quality of being worthy of respect, and the healthcare environment can contribute to or detract from a person's sense of self respect and the respect of others. People strive for and are entitled to dignity in dying and in death. Healthcare systems should ensure that patients are cared for and die with dignity and that all care and treatment is provided in environments that safeguard and promote respect for the individual and a sense of self worth. Healthcare design should therefore actively seek to prevent indignities arising from inappropriate environments. People wishing for a dignified death fear

one where their intimate and personal needs will be exposed and they will be subjected to demeaning environments which cannot support provision of compassionate care. Good hospital design must promote the dignity of and respect for the dying patient, grieving relatives and fellow patients.

Privacy: Privacy is closely aligned to dignity, and at end-of-life, patients and relatives have a heightened need for privacy, balanced with safeguards against isolation and exclusion. The time approaching death can be a very intimate time and therefore should not be encroached upon unnecessarily by others. People need private space where they can talk together, and where, if they wish, they can comfort each other naturally and follow their instincts, beliefs or religions, out of sight and hearing of others. Complex issues arise near end-of-life and sensitive information associated with these matters needs to be shared with patients, without inappropriate disclosure to others. Confidentiality is promoted by availability of private areas where discussions take place.

Sanctuary: Sanctuary implies both a place of safety and a sacred space. It suggests being shielded from the business of everyday hospital life and in a space which respects the process of dying, the emotions, and the existential and spiritual issues that are associated with it. At the time of dying, death and bereavement, people need spaces where they can have peace, and connectedness to, and support from those close to them.

Choice/Control: Design of hospital environments should ensure patient choice and control in

environmental matters. Lack of choice in these matters can be a stressor for patients and relatives. Providing patients with options in regard to where they spend time, and whether they choose to be sociable or private is essential. Providing patients with a degree of control over their immediate environment, such as temperature, ventilation and sound, sometimes in collaboration with staff, is also important.

In addition to providing options for the individual patient, buildings also need to have the flexibility and adaptability to equally facilitate the rituals and practices of different cultures at the time of death, and thus accommodate diversity within society.

Safety: All care should be delivered within a safe environment and the Guidelines are presented in a context of mandatory safe environments with systems to best protect and reduce health and safety risks for all.

Universal Access: Universal access is achieved by designing environments in such a way that they cater for the diverse needs and abilities of all people who wish or need to access and use them, allowing people to interact with their environment to the best of their ability. Because of the high percentage of deaths of older people with chronic and multiple conditions and the high levels of disability of patients nearing end-of-life within hospitals, design must take into account the need for universal access to all areas of the hospital. The Guidelines make no reference to specific needs of people with disabilities on the understanding and expectation that all new and refurbished buildings are designed to cater for them.



Patients and their relatives arriving at hospitals for end-of-life care will benefit from hospital design that incorporates these proven wayfinding features

1.6 Evidence-Based Design

The relationship between the physical and sensory environment and healthcare outcomes has been recognised for some time and the role of the visual arts, music and entertainment in enhancing hospital environments is increasingly appreciated. (6) Evidence-based design (EBD) is a process-based approach to design that uses current best evidence from research and practice to create healthcare environments that improve patient and staff outcomes and operational performance. EBD is being used increasingly throughout the world within healthcare design. (7)

Several EBD issues have been developed for application to physical environments for dying, death and bereavement.

1.6.1 Wayfinding

Visible and easy to understand wayfinding signs reduce stress and anxiety for patients and visitors who may be disoriented in unfamiliar surroundings. Aids to wayfinding include, clear unambiguous signage, information desks, “you-are-here” maps, use of colours and symbols, and views and glimpses of the local area. Gardens, environmental and artistic features within the hospital complex also help navigation for patients and visitors, as they act as landmarks that people use to orientate themselves. (8)

Patients and their relatives arriving at hospitals for end-of-life care or in stressful circumstances will benefit from hospital design that incorporates such wayfinding features.

1.6.2 Single Rooms

Single rooms provide increased privacy for patient-relative interactions, as walls and closed doors provide better protection against breaches of privacy and confidentiality than curtains. (9) Staff can examine patients more effectively and collect higher quality information from them if they occupy a single room, as patients are less likely to withhold information due to lack of privacy. (10)

Hospital-acquired infection rates are known to be reduced in single rooms because of lack of exposure to airborne pathogens from other persons. (11)

A study at two hospices in Leeds, England, (12) concluded that patients preferred single rooms, especially if they were suffering from distressing symptoms.

The Department of Health and Children’s *Design guidelines for specialist palliative care settings* (2004) (13) recommended 25m² for a single room, including an ensuite, in a hospice to allow sufficient space for the patient and their visitors.

A recent document, *Ward layouts with single rooms and space for flexibility* (NHS, 2005) (14) set out evidence for provision of sufficient space (proposing 3.6m x 3.7m) around each bed to support increased patient acuity and clinical activity, including the essential equipment required for these patients and the numbers of staff needed to provide their care. The studies for this

1.6 EVIDENCE-BASED DESIGN

document found that single rooms assist in controlling infection, reduce risk of adverse clinical errors, hence increasing safety, while also promoting privacy, flexibility and potential increase of occupancy rates. The document encourages the provision of more single rooms within hospitals and shows how the proposals put forward can be achieved within comparable floor area allowances.

Safety, privacy and confidentiality and adequate space for activities of living and caring are crucial for patients with end-of-life care needs, so provision should be made for adequately sized single room accommodation.

1.6.3 Sensory Environment

Evidence from research proposes that gardens and views of nature have a positive effect on health and well-being and offer opportunities for reducing stress and improving moods. (15)

Access to gardens and views of a garden or landscaped area improves patient satisfaction and well-being. (16) Patients confined to bed appreciate and benefit from a view of nature. (17) Research has also indicated that length of stay for patients can decrease if they are accommodated in sunny rooms with a view of nature. (18) Connections have also been made between north facing rooms and increased rates of depression and pain. (19)

Art can contribute to the creation of a physical and psychological environment that leads to an improved

sense of well-being for patients. (20) The development of an environment that reflects nature and the elements is beneficial for those accommodated or visiting. (21) Art can also contribute to staff's well-being and to a sense of pride in their work and in their hospital.

Extrapolating these findings it is proposed that a view of nature or an activity scene, accommodation with a sunny, preferably southerly aspect, the provision of art and access to gardens and spaces such as courtyards, patios and balconies will improve the well-being of patients nearing end-of-life.

1.6.4 Staff Issues

The general benefits of access to views, gardens and art similarly impact positively on staff. Studies have

shown that views help lessen the impact of stress related to work, staff benefit from spaces with well positioned windows, and there is a high correlation between levels of sunlight in the workplace and job satisfaction. (22)

Decentralising workstations and storage areas has been shown to reduce staff fatigue associated with walking, increase time available for direct care intervention and improve communication. (23) The use of sound-absorbing materials for floors, walls and ceilings creates quieter work areas, although there can be associated difficulties with infection control procedures. (24) The use of advanced technology for telephones, alarms and beepers that alert staff without noise results in calmer less stressful environments. (25) Studies have shown that staff associate quieter workplaces with reduced work demands. (26)



Access to gardens and views of a garden or landscaped area improves patient satisfaction and well-being

Workspace design that incorporates these design principles will support staff and improve their feelings of well-being as they provide end-of-life care and support for patients and their relatives.

1.6.5 Costs and Benefits

EBD is a whole systems approach which strives for significantly improved buildings that facilitate high quality care for patients. Whole life costs of the building are reduced because of decreased need to upgrade the building. Construction costs associated with this approach ought to be evaluated against resulting improvements in healthcare practice and outcomes, how these better meet the needs of patients and relatives, and the reduced projected costs of later refurbishment to meet improved quality standards. Research carried out by the Centre for Health Design estimated that the increased costs (approx 6%) of providing EBD features could be recouped in as little as one year through operational savings and increased revenue. (27)

1.7 Need for Guidelines

The Design and Dignity Baseline Review, commissioned by the HfH Programme and undertaken in 2007 assessed the physical environments of twenty hospitals participating in the HfH Programme. This study revealed that the physical infrastructure of many of these hospitals is unable to support best practice in end-of-life care. The Health Service Executive recognises the current infrastructural deficit, and has

begun a drive for improvement to healthcare environments.

The HfH Design and Dignity Guidelines are based on the knowledge and information described above, and are offered to advance design of hospital environments that can support dignified end-of-life care.

Guidelines

dignity privacy sanctuary choice/control safety universal access

Section 2

2.1 Arrival, Wayfinding and Waiting

2.1.1 Arrival Areas and External Routes

The hospital should be on a public transport route. The routes from public transport arrival points, car parks and drop off points should lead directly and intuitively to the main entrances for the principal areas of the hospital. Those used most frequently by patients nearing the end-of-life and their relatives, or bereaved relatives are the:

- Main hospital entrance
- Main reception, waiting and dining areas
- Emergency Department
- Out Patients Department
- Intensive Care Unit
- Mortuary
- Bereavement Services.

Within the main hospital grounds there should be signs to direct those arriving to the specific area they need. If arriving by car they need to be directed to the appropriate car parks or set down points. The provision of special parking arrangements, and associated systems to manage these, for those arriving for end-of-life care or because of an imminent or recent death shows understanding and support for people in these difficult situations. At these areas, and at all arrival points for all modes of transport, clear directions should be provided to the principal areas and services, and these should be visible at all times of the day or night.



2.1.2 Main Entrance

The first impression of the hospital environment needs to be one of welcome reassurance and an expectation of a well organised, quality healthcare facility. The main entrance of the hospital should be on a scale that people can relate to.

2.1.3 Reception Areas

It is important that the reception areas convey a calm, supportive, organised ambience where patients and

visitors know where to go to obtain assistance. Many people find water features or indoor gardens create a sense of calm and closeness to nature. Design techniques, technology and materials that facilitate easy interaction for people, including children and people with physical disabilities should be used, such as information desks at suitable heights and loop systems.



2.1.4 Internal Wayfinding

There should be a prominent information desk located in the intuitive route of people entering the hospital or department and clear unambiguous signage to direct people.

Easy to use measures should be employed, such as the use of different colours or symbols for different routes; “you-are-here” maps; the creation of landmarks; the provision for views and glimpses of the surrounding area and the use of glass in lifts for the public.

2.1.5 Seating Areas

Various easily identifiable, distinctive seating areas are needed, both internally and externally, within and close to entrances and reception areas. These may include alcoves that offer more private space and shield those using them from immediate view of others. The design of some of these areas should evoke a natural sense of sanctuary for peaceful reflection and emotional or spiritual recovery.

Seating areas, set back from the main flow should be interspersed throughout patient circulation routes.

Some seating areas need to be child-friendly, with play equipment provided, since the child may be the patient, or they may be visiting adult patients. (Appropriate professional advice should be sought for all seating for patients.)

Seating arrangements in waiting and meeting areas should be comfortable and configured flexibly, to give people choice in whether they sit in groups or separately. They should take advantage of any opportunities for outlook. Some aspects of privacy may be enhanced by selection of high-backed furniture.

External areas as proposed within these Guidelines (see section on Gardens and External Environment) should be separated from any designated smoking areas.



2.1 ARRIVAL, WAYFINDING AND WAITING



2.2 Wards and Departments

2.2.1 Admissions Office

The admissions office should be located within the hospital and designed so that patient confidentiality and privacy are protected. The area where individual particulars are taken should be away from the public area, to ensure that personal and confidential information is not overheard during the admission process.

2.2.2 Doorways

All doorways in patient areas are required to be sufficiently wide to allow a bed with attached equipment and one person on either side to pass through. Entrances and doors into wards or accommodation units can be recessed to provide a sense of threshold and allow less abrupt entry into them. In such cases it is important to consider the visibility of any call alert.

2.2.3 Reception Points in Wards

There should be a defined, easily identifiable reception point near the entrance to each ward, perhaps located to the front of a workstation, where relatives can discreetly obtain information about a patient.





2.2.4 Patient Accommodation

*Because the vast majority of hospital accommodation in Ireland is currently in multi-occupancy wards rather than single rooms, it has become customary to speak of hospital accommodation in terms of “beds”. However, the changing activity patterns of patients, relatives and staff, including the practical issues of everyday care and clinical consultation, the space needed for furniture, equipment and numbers of staff attending to a patient, the ability/disability profile of patients nearing end-of-life, plus the needs of relatives visiting require significantly more space than is currently provided between beds. These Guidelines refer to the part of a multi-occupancy ward required for each patient as a **single unit of accommodation**.*

The design of each unit of accommodation should allow for adequate bed space and a personal sitting area. A minimum space of at least 19m² with clear space of 3.6m x 3.7m around each bed is recommended. Where refurbishment work is being undertaken within a ward, there should be a maximum of four single units of accommodation in any one room within the ward.

Design should ensure the patient accommodated has a view from the bed and the sitting area, preferably of nature, or a local scene which involves people in activities. Views should have a bright aspect, without glare or overheating, and preferably a non-northerly aspect.

There should be facilities for the display of some personal effects, storage of personal belongings and access to:

- A secure resource for storing valuables
- A communal fridge to store cold drinks and/or an individual small fridge (that meets HACCP requirements)
- Ice
- A telephone, preferably one that lights up and/or rings, so that it can be set to lessen disturbance for the patient or others nearby.

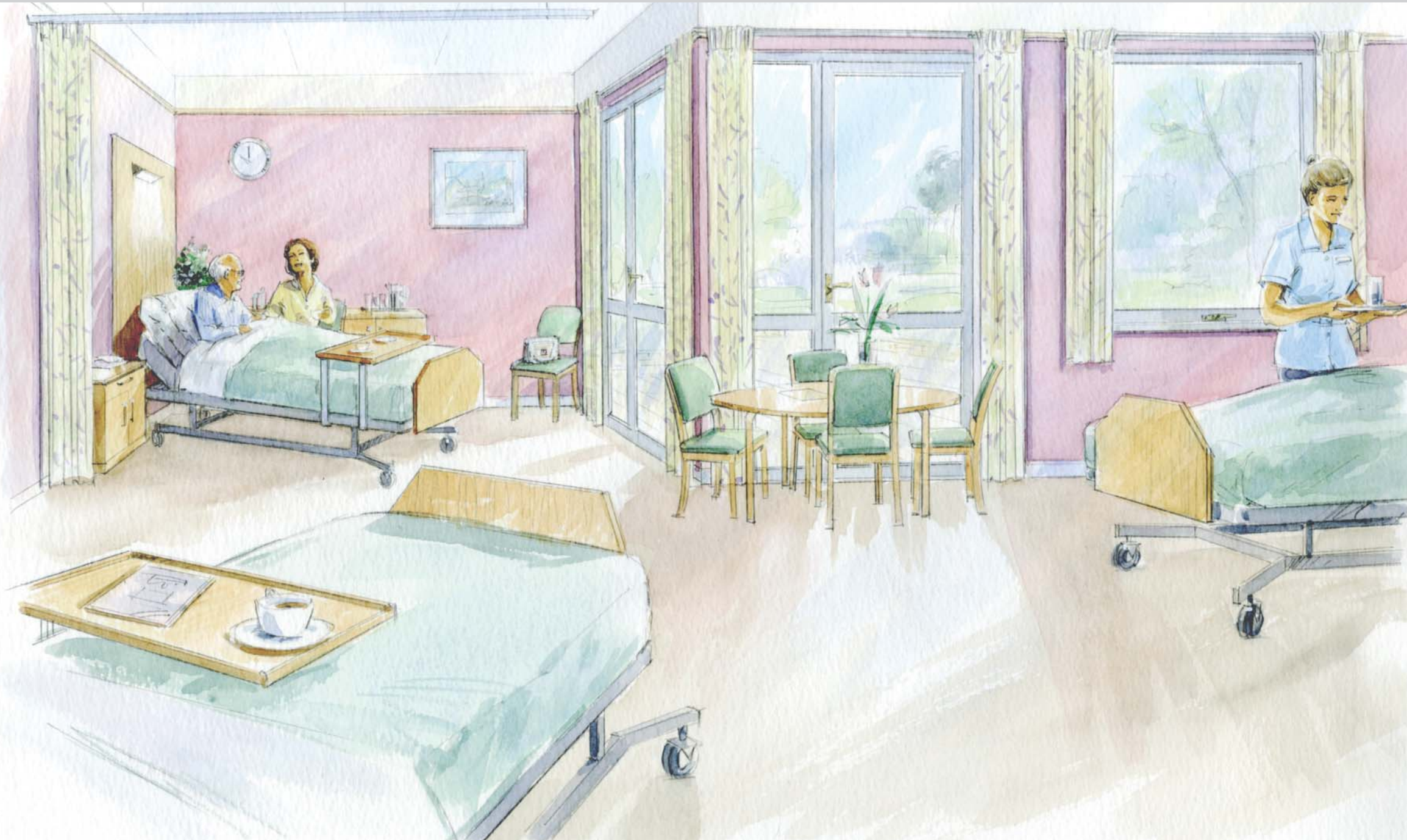
The provision of integrated television, radio and music systems is important. In addition access to wireless internet facilities should be provided. All appliances should have provision for earphones. Construction materials that minimise noise levels should be used where possible.

A stock of furniture should be available so that furniture appropriate to a patient’s medical condition and physical needs can be provided within each unit of accommodation. Seating should be adjustable to meet the comfort and needs of the patient safely and appropriate professional advice should be sought in this regard. Seating will also be used by relatives and should be adaptable for both sitting and resting, as some relatives may stay with the patient for long periods. A parent or partner may wish to lie beside the patient and where the patient’s bed cannot accommodate this, the layout of furniture within the unit of accommodation should allow for a temporary arrangement beside the bed.

Patients should be able to adjust the immediate environment within their unit of accommodation, in consultation with staff if necessary, including their bed position, lighting, temperature and ventilation.

The lighting arrangements for each unit of accommodation should be bright enough to allow necessary therapeutic procedures to be carried out by staff at the bedside. They should also allow bedside and reading lamps to be dimmed, so that they can be used by relatives without disturbing any patient.

Technical and clinical equipment at the bed head should be inconspicuous but accessible.



2.2.5 Separate single units of accommodation

Every hospital should be able to offer patients approaching end-of-life a **choice** of a separate single unit of accommodation (single room) with individual en-suite facilities. For patients who wish for privacy at end-of-life, that option is very important.

There are a number of benefits for patients and their relatives associated with single separate units of accommodation. These include:

- Facilitating some treatment and delivery of intimate personal care at the bedside without impacting on the dignity of the patient or other patients
- Providing less stressful conditions for patients, as disturbance from other people is minimised
- Offering more control over the immediate environment
- Providing people with more choice in activities of daily life
- Providing optimum conditions for protecting patient confidentiality
- Facilitating good communication with healthcare staff
- Supporting minimal contact with other patients' illness or death
- Allowing some therapies to be provided
- Reducing the need for transfer
- Facilitating the short term repose of the patient immediately after death and prior to removal to the mortuary, with minimum impact on other patients.

Each separate single unit of accommodation should have ensuite facilities.

A minimum space (including en-suite facilities) of 25m² with clear space of 3.6m x 3.7m around each bed is recommended for each separate single unit of accommodation.

The current provision of separate single units of accommodation in acute hospitals in Ireland is low by international standards and below today's desired level of provision. The majority of this accommodation is used for infection control purposes, leaving little, if any, for patients nearing end-of-life. There needs to be an absolute minimum risk of patients nearing end-of-life acquiring an infection while in hospital that would contribute to cause of death or increase difficulties with dying.

A working group for the Strategy for Control of Antimicrobial Resistance in Ireland (SARI) National Committee is suggesting the future provision of at least 50% single unit accommodation in the acute hospital sector to manage the risk of hospital acquired infection. However, the ratio of separate single units of accommodation to multi-occupancy wards must be higher than 50% if risk of infection is to be managed **and** the needs of patients at end-of-life are also to be met.

Newly built residential care settings providing long term care for older people must have a minimum of 80% of residents accommodated in single rooms. (28)

In order to meet the ambition of these Guidelines, which is to ensure an option of a single unit of accommodation for patients nearing end-of-life, all future new hospital developments must provide 100% separate single units of accommodation (single rooms). This will, over time, increase the overall level of single rooms in any one hospital, thus better meeting competing demands and ensuring the necessary quality environment for patients at end-of-life.



2.2.6 Workstations within Wards

There can be several workstations positioned throughout departments or wards, with attached decentralised stores for supplies. One of the workstations can be larger and function as a main workstation. A recessed area within the main workstation should be soundproofed in order to ensure confidentiality.

Within the workstations the orientation of both computer screens and staff notice-boards should be such that information displayed cannot be viewed by patients and relatives thereby helping to protect patient confidentiality.

2.2.7 Sitting Rooms

Each ward should provide patients with a choice of two sitting rooms, one of which is a quiet room that does not double up for other uses and the other a child-friendly TV lounge. Seating within these rooms needs to be supportive for persons in pain or discomfort.

2.2.8 Meeting Rooms

At least one meeting room should be provided on each ward or in each department for sensitive private discussions such as those between healthcare staff and patients and/or relatives. Where wards do not have single separate units of accommodation, meeting rooms should be accessible to people confined to bed. There

should be an indicator on the door to signal when the room is in use.

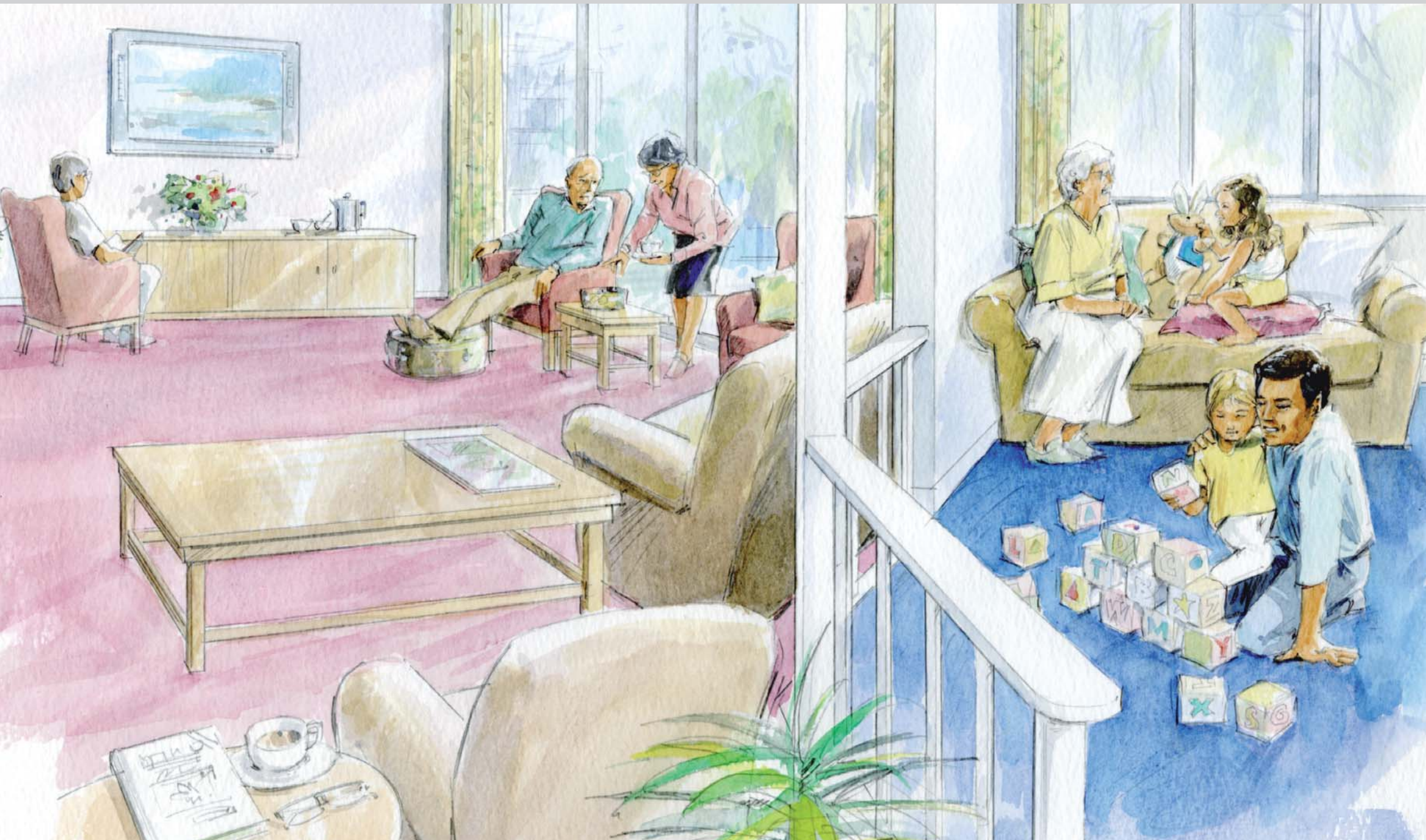
Consideration should be given to the need for a design that permits people to leave the meeting room without having to re-enter the ward or department. This is of particular significance in Out-Patients departments where bad news regarding diagnosis is often broken.

2.2.9 Therapy Rooms

The design should consider the need for wards to have access to a room suitable for the delivery of a variety of therapies, such as art, music or reflexology for adults or play therapy for a children's ward.

2.2.10 Storage Facilities for Patient Belongings

Each ward requires adequate storage facilities where belongings of deceased patients can be stored until they are returned to the patients' relatives.



2.3 Communal Spaces and Services

2.3.1 Patient and Public Circulation Spaces

Patient and public circulation spaces should have natural light, access to fresh air and well directed views to the outside. They should be separate from service routes which are used for hospital operational processes.

The design of the building should also ensure that patients accessing treatment areas and facilities for therapies have minimal, if any, passage through public circulation spaces. Equally, patient lifts should be located and orientated to protect the privacy of patients waiting for them.

2.3.2 Relatives' Rooms

Toilets for relatives are required on or near each ward.

A relatives' room, with a shower and toilet, should be provided close to each ward or department. Furniture within these rooms should be adaptable for sitting or resting.

Design can allow offices to be multi-functional and adapted to a relatives' room outside office hours.

2.3.3 Relatives' Accommodation Areas

Overnight accommodation for relatives close to the hospital needs to be considered. This can be provided

in a variety of ways, such as hotel accommodation contracted with the hospital, or accommodation blocks provided by the hospital authority, possibly in collaboration with a voluntary organisation.

2.3.4 Catering Facilities for Relatives

Relatives' need for food and refreshment has to be taken into account, and they should have access to dining areas with a range of spaces that offer the choice of privacy or sociability.

In addition to dining areas there should be a range of refreshment facilities located throughout the patient areas that provide access to drinking water, hot and cold drinks and healthy snacks.

Provision should also be made for the relatives who spend long periods of time with patients, and small kitchenettes should be provided to facilitate preparation and consumption of hot drinks, snacks and light meals. This is a matter which requires associated systems within operational management to ensure compliance with Health and Safety legislation.

2.3.5 Multi-Faith Area

Every hospital should have at least one suitably sized multi-faith space, accessible to patients, relatives, staff and the local community that can be used by everyone regardless of personal faith or religion. The location should take into account the appropriateness of adjacent areas and facilities.

2.3.6 Business Centre

It would be beneficial for some relatives if the hospital had a business centre where those staying with patients can maintain contact with their work places. This resource should have internet access and furniture suitable for a short period of work.

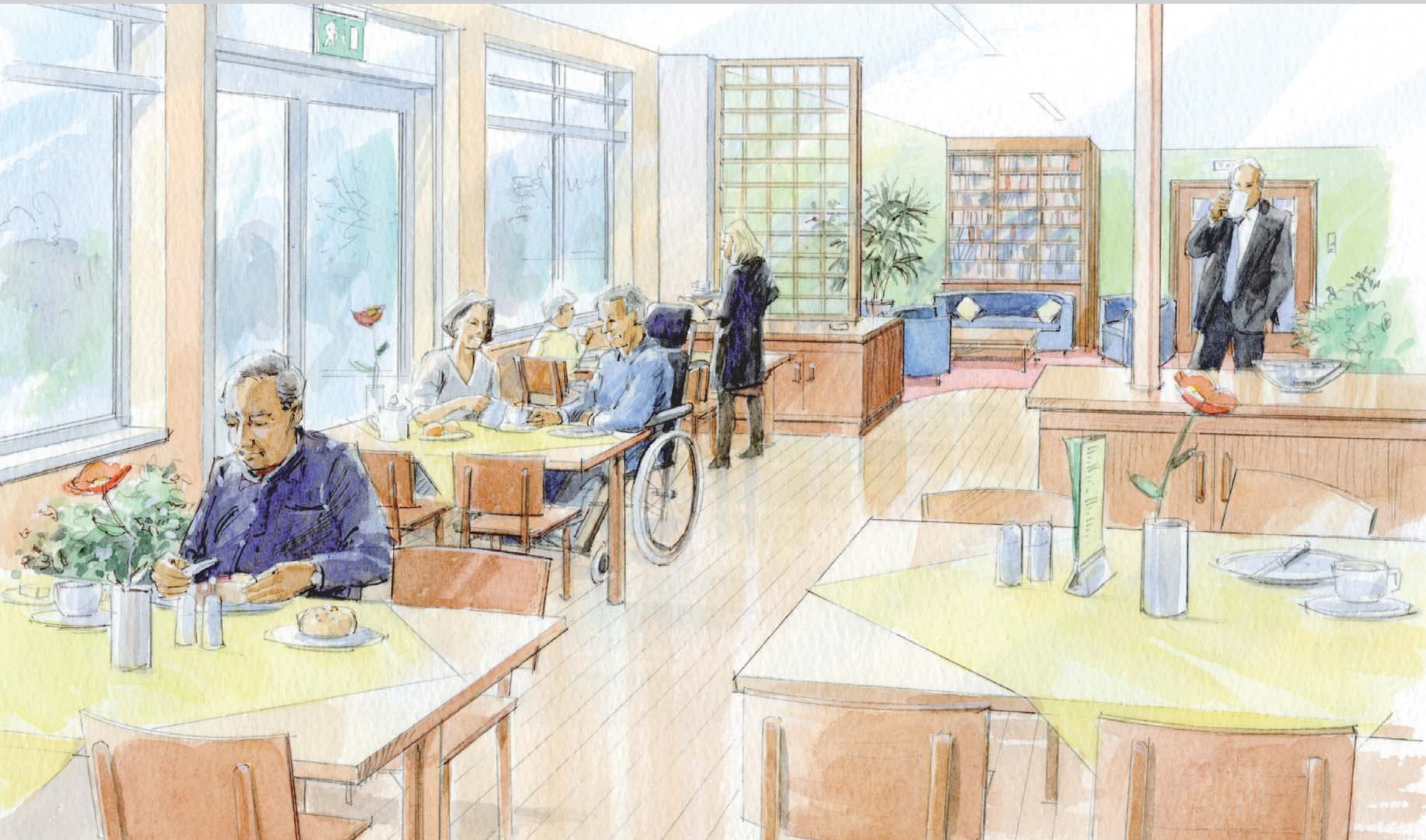
2.3.7 Information and Resource Centre

A citizens information and resource centre providing information on health and social services, general and specific health matters should be provided.

2.3.8 Art and Music

It is important that appropriate pieces of art and installations, provided through an integrated arts strategy and reflecting the sensory elements of nature and human activities, tranquil and comforting, distracting and contrasting, are displayed throughout the building. There should be diversity in the scale of the artwork, with a range of appropriately located large scale pieces that can be viewed at a distance, and small pieces which demand close up attention. Art that draws the viewer to progressive layers of visual engagement elicits ongoing interest, and tactile work is also appealing.

Having areas that can be used for various sizes of assembly provides opportunities to develop a programme of performance arts and music. Having facilities for playing music in certain areas



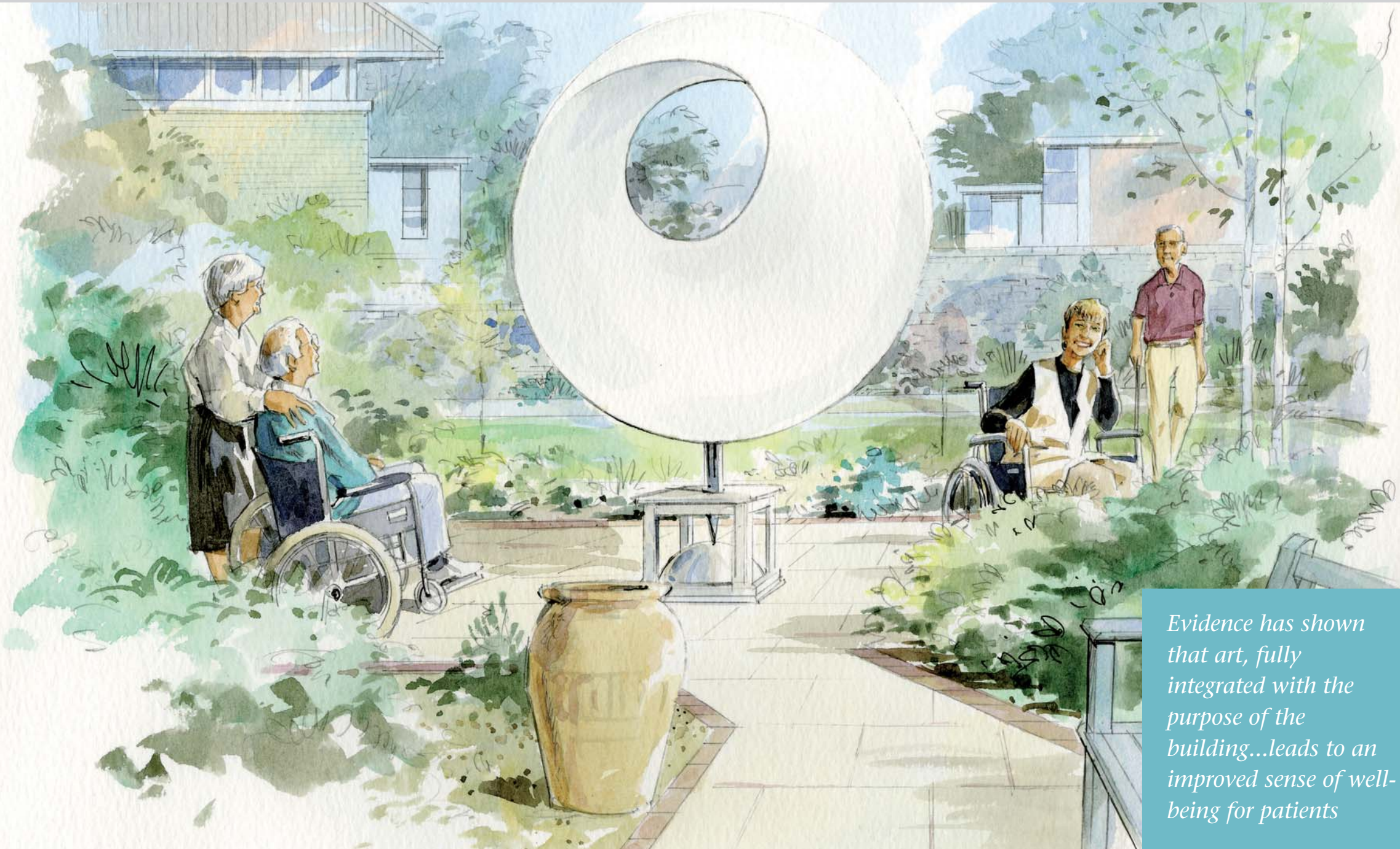
should be considered, though this needs to be well managed, with music carefully chosen for creation of appropriate ambience.

2.3.9 Gardens and External Environment

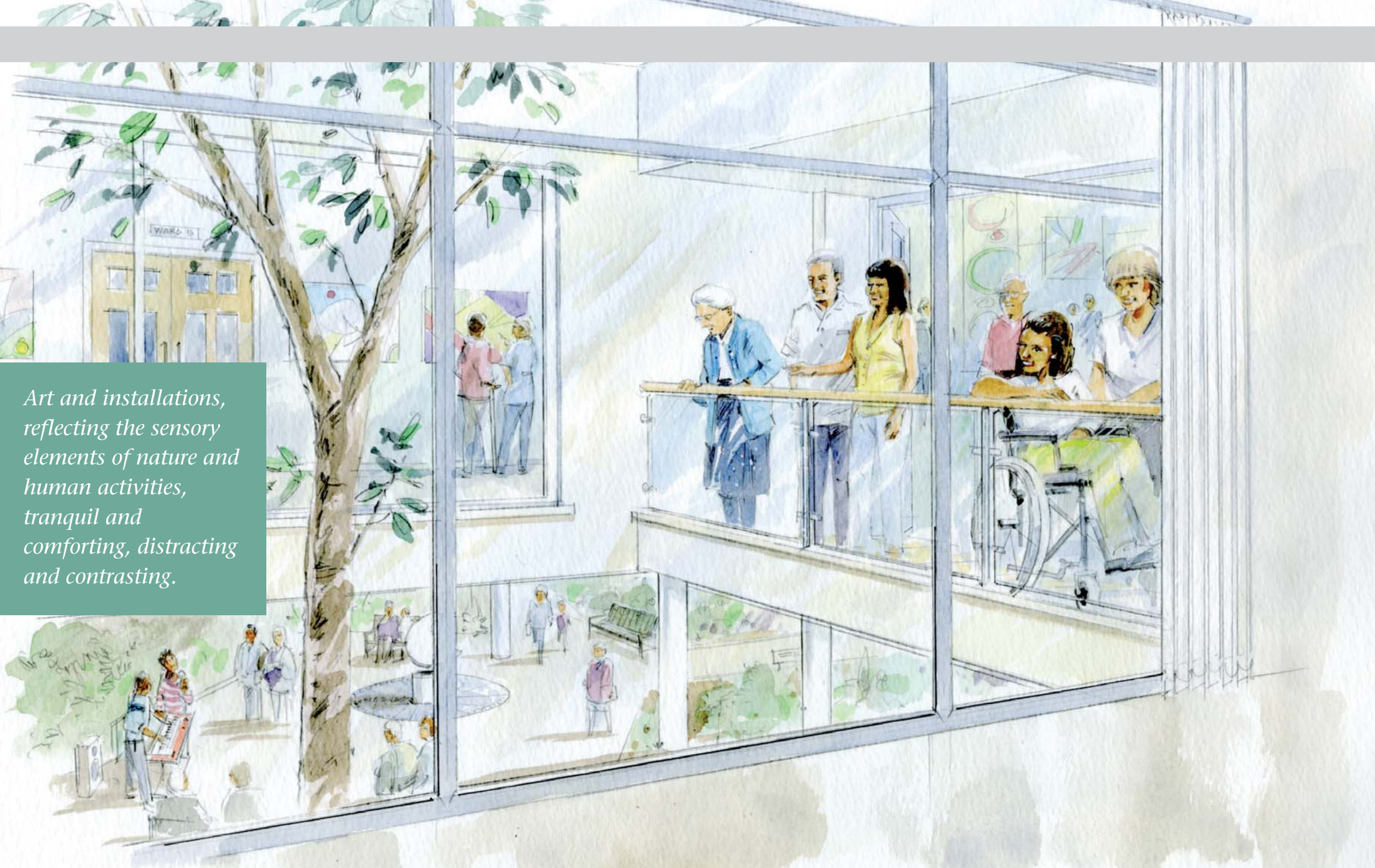
Garden spaces lend themselves to being an integral part of the arts and wayfinding strategy. Planning a range of outdoor spaces, such as gardens, patios, verandas and courtyards, is key, as they provide important opportunities for therapeutic contact with nature. These spaces should be accessible to patients, including those confined to bed, and to their relatives. They can also provide an opportunity for patients to have contact with their pets.

The garden areas should have a range of types of area, including open spaces and retreats, and seating, some with protection against the elements, and configured to give people choice in whether they sit in groups or separately, are involved in activity or reflection. Appropriate planting will carry year round interest and consider scent and touch as well as appearance.

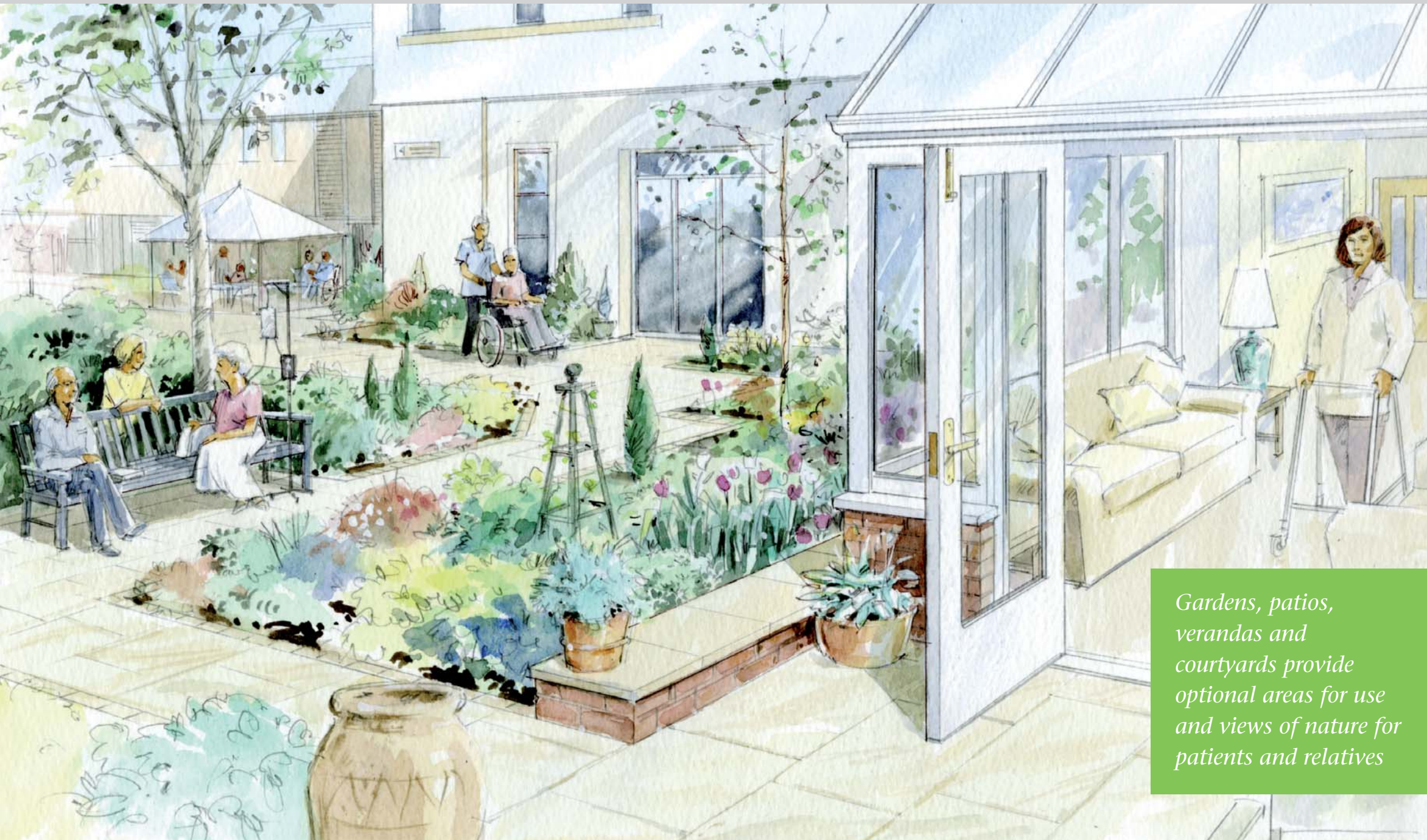




Evidence has shown that art, fully integrated with the purpose of the building...leads to an improved sense of well-being for patients



Art and installations, reflecting the sensory elements of nature and human activities, tranquil and comforting, distracting and contrasting.



Gardens, patios, verandas and courtyards provide optional areas for use and views of nature for patients and relatives

2.4 Staff Areas

2.4.1 Location of Key Services

The offices of the palliative care service should be located within the hospital so that those involved in the service can easily reach or be reached by all wards and departments.

Similarly the offices of services such as pastoral care and social work should be located within the hospital site so that they are within reasonable reach of wards and departments and easily accessible by the public or patients attending for day care.

2.4.2 Staff Only Spaces

Designated staff rooms and staff meeting rooms should be provided. The doors to these rooms must have a means of clearly indicating when they are occupied.

2.4.3 Dining Space

The design should incorporate dining spaces that are not accessible to the public so that staff can have private time on their breaks away from the demands of patients and relatives.

2.4.4 Adjustable Working Environments

The lighting within the working environment should be adjustable. Various lighting arrangements are available, such as floor lighting, and lighting that is

adaptable for different tasks and different times of day. Lighting should avoid disturbance to patients, yet be sufficiently bright to allow safe working practice.

Temperature and ventilation systems should also allow for some local modification by staff.

Communication systems, such as telephones and pagers, should have the option of soundless alerts.

2.4.5 Gardens

Staff should have easy access to gardens and views of nature or landscaped areas.





Adaptable working spaces



Design can allow offices to be multi-functional and adapted to a relatives' room outside office hours

2.5 Mortuary

2.5.1 General

The mortuary is a sanctuary and must convey a sense of reverence and respect for life, death and bereavement. The public areas within the building should evoke a serene and reassuring atmosphere.

There should be visual, auditory and olfactory segregation of:

- The mortuary from patient areas of the hospital
- The areas within the mortuary used by the public and the operational areas.

The route from all wards within the hospital to the mortuary should be covered and a respectful passage should be assured for the bodies of the deceased, as well as for their relatives.

2.5.2 Arrival and Waiting Areas

Both an outer entrance area with protection from the weather, and an inner reception area should be provided.

At least one waiting room is required. Two rooms or a room that can be subdivided will provide facilities for more than one family at any time or an extended family that does not wish to be together.

Refreshment facilities will be required in the waiting room(s) and sanitary facilities should be provided close to the waiting and viewing rooms.





2.5.3 Viewing Rooms

There needs to be at least one viewing room, but depending on the incidence of deaths occurring at the hospital, the mortuary may need more than one facility for viewing the deceased. Viewing rooms should be adaptable to meet the needs of different faiths and cultures, and if paediatric deaths are expected, facilitate viewing the body of a deceased child.

Suitable furniture should be provided so that bereaved relatives or spiritual advisors staying overnight with the body of the deceased are comfortable.

Each viewing room requires hand washing facilities and a means for people to indicate to staff when they wish to leave. The doors to the viewing rooms need to be of a height and width to allow a coffin to be carried through.

The viewing rooms should have direct access to an enclosed garden area with an exit from the mortuary area directly from the garden.

2.5.4 Multi-Faith Room

A multi-faith room is required within the mortuary building. Design should take account of the varying numbers of people that may wish to congregate within this room.

2.5.5 Meeting Rooms

A meeting room is needed where staff and other agencies, such as An Garda Síochána, can meet relatives or others.

2.5.6 Storage Area

A lockable facility, accessible from the multi-faith room and the viewing rooms, should be provided for the storage of religious symbols from different faiths, when not in use.

A storage area for items required within the public area of the mortuary, such as extra furniture, is also necessary.

2.5.7 Preparatory and Holding Rooms

It is essential that there is a facility for ritual washing of bodies and an area for relatives who wish to personally prepare the body of the deceased prior to viewing. The provision of a preparatory room between the operational area and the viewing room(s) will facilitate this.

To facilitate the view of a body where public contact is denied, normally because of forensic investigation, there should be a glass partition between the viewing room and the room where the body is held.

2.5.8 Exit Areas

The design should incorporate an inner exit area and an outer exit area with protection from the weather.

2.5.9 Garden

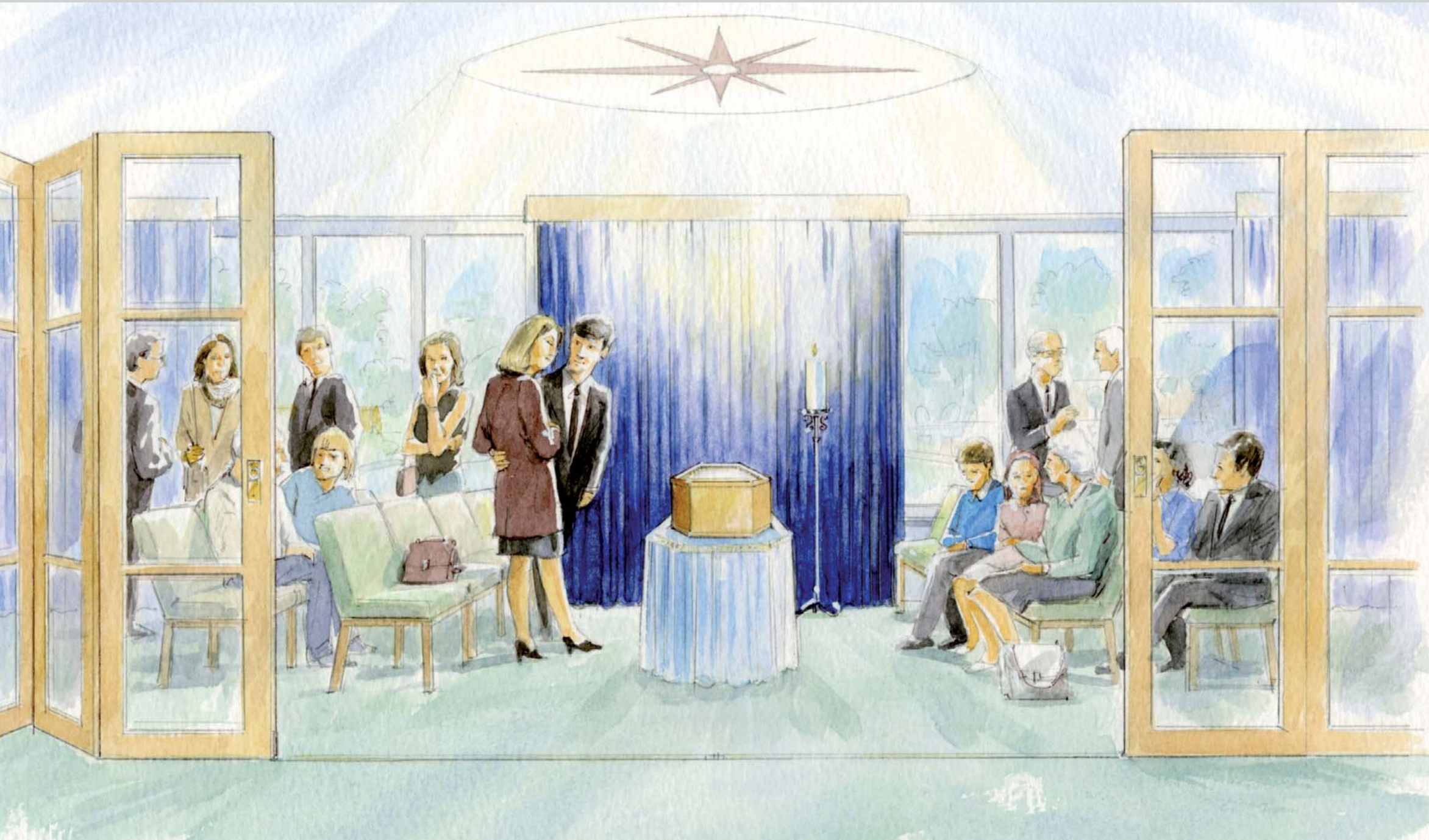
The mortuary should have an adjacent garden area with direct access from the waiting and viewing rooms, and provide a direct exit from the mortuary area. The garden area should have a range of walking and sitting areas. (See section on Gardens and External Environment).

2.5.10 Car Parking

There should be sufficient area around the mortuary to allow adequate parking for groups using the facility.

Designated parking spaces, close to the exits, are required for a hearse and the cars of the immediate family.

The layout of the vehicular access and egress routes and parking areas should be designed to prevent congestion between arriving and departing parties.



2.6 Bereavement Services

2.6.1 Location

The location of the bereavement service needs to be such that it:

- Facilitates the creation of a calm atmosphere
- Protects the confidentiality of those using the service
- Is accessible with minimal passage through busy clinical areas.

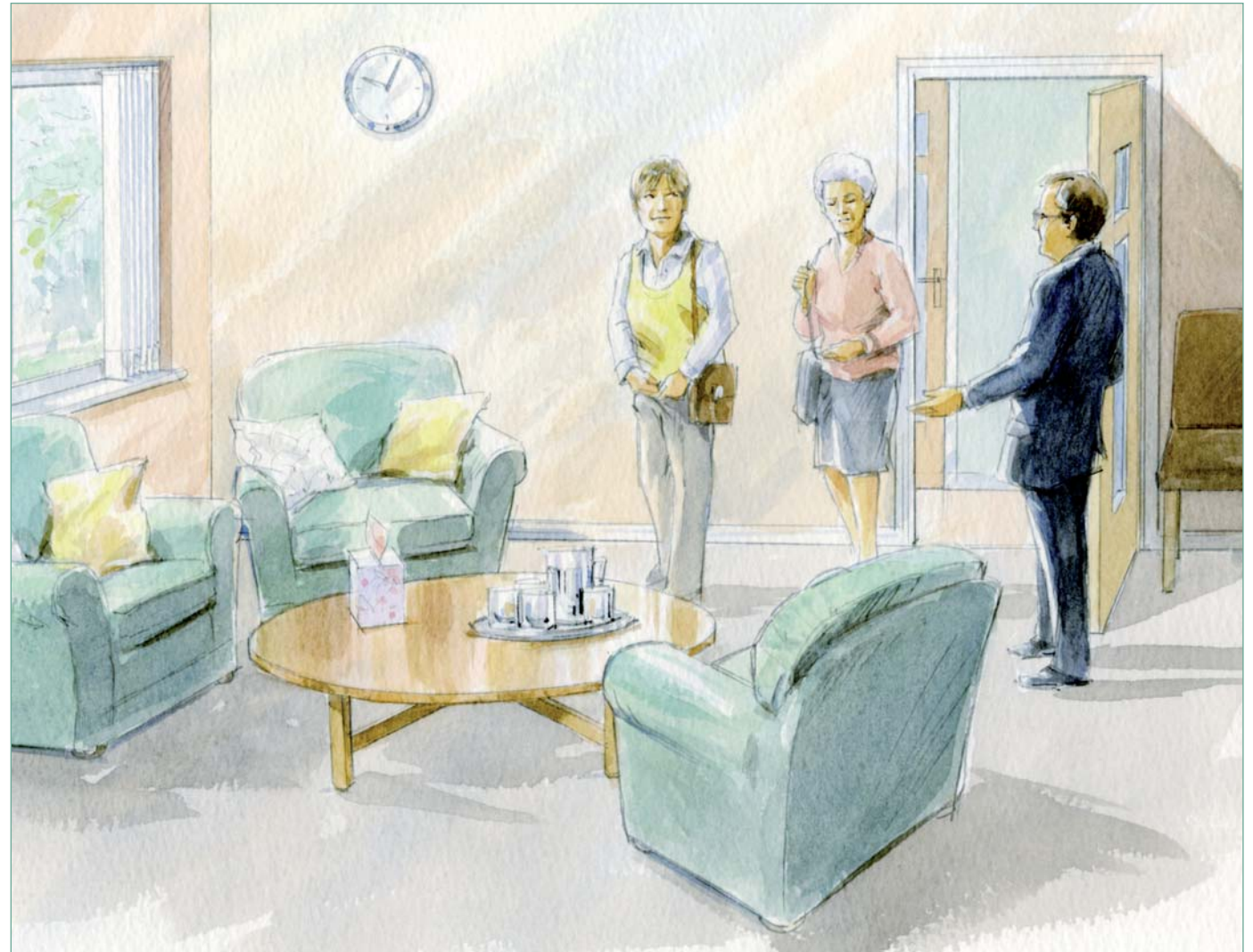
2.6.2 Counselling Rooms

The windows in the room should either be at a height that prevents persons outside seeing into the room, or of obscured glass to prevent persons seeing in, but allowing those inside to have access to natural light.

Each counselling room needs space for at least two comfortable matching chairs, with more available within the room if needed.

At least one counselling room needs to be child friendly.

Counselling rooms should be adjacent to or have easy access to a washroom and toilet.



Appendix 1 Working Group Members

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