Case Studies in Creating Privacy in Shared Nursing Room Renovations

Today's long term care providers think in terms of "service to customers" rather than "patient care" and in terms of "households" rather than "wings" within the buildings they manage. The concepts of residential character, privacy and dignity are far easier to provide while planning a new building. But what happens when your building is 20 or 30 years old and you're saddled with the basic footprint of a medical model facility with predominately double occupancy rooms? Is there a way to afford some privacy to these hospital-like rooms?

This article will demonstrate through two case studies that a genuine commitment for change combined and with careful planning strategies can achieve privacy within a shared room without razing an existing structure. With budget in mind, the goal is set to improve the daily lives of the residents by providing environmental improvements within the confines of the existing footprint.

Case One

The Jewish Home of Rochester provides care to 362 residents in a six story mid-rise building and opened in 1985. With 230 of those beds in a shared, medical model arrangement, the Owner had considered more aggressive solutions by means of additions and heavy renovations, but the financial impact of the plan could not be solved.

The existing semi-private rooms had a unique angled wall layout that forced a more or less toe to toe configuration and were rather small by contemporary standards, ranging from 230 to 246 SF. The goal to add a privacy screen between the beds had to be approached carefully due to the small size of the rooms, the required clearances to the mechanicals and the fact that the two opposing sides of the room were dramatically different in size and shape. At the very least, the illusion equity had to be maintained.

The solution includes a multi-functional partial height fixed partition. The partition cap provides some evenly distributed supplemental lighting to both sides of the room and is low enough to allow the existing sprinkler heads to remain in place. The partition is angled to allow access to both mechanical units on the exterior wall and straddles the need to allow daylight into both resident quarters. To make the best use of the modest space, the Owner decided to provide every resident with a personal flat panel television, and the partition provides a natural location to mount it and conceal all the cables. Additionally, picture rails and tack surfaces allow for personalization of the room as well as provide acoustically absorptive materials. The entry to

each room is recessed in order to provide some visual relief from the otherwise relentless corridor. Each entry recess is fitted with a curio cabinet for each resident to embellish.

Bathrooms, corridors, bathing facilities as well as neighborhood kitchen and dining spaces were also renovated at the same time as the rooms. In order to renovate without compromising census, new resident rooms were retro-fitted into one wing of the building that contained offices. These offices were relocated elsewhere permanently and these new rooms provided the "swing space" necessary to temporarily house one neighborhood at a time while their spaces were improved. Once the 30 months of phased renovations were complete, the "swing space" became the facility's short term stay rehabilitation beds.

Case Two

The Mennonite Home in Lancaster, PA housed skilled care residents in a menagerie of buildings that spanned the 1950's, 60's, 70's and 80's. Inspired by the Culture Change Movement, the Owner's challenge to the design team was to convert the existing and varied footprints into households of 18 to 22 residents across 5 floors. The facility was totally built out to the limits of their allowed impervious coverage so the impossibility of additions to reduce the number of shared rooms was a foregone conclusion. Each floor was to be divided into two separate neighborhoods, and while some amenities could be shared by both, many of the resident service and support areas had to be duplicated on each level for each household to operate autonomously.

The Owner's wanted to move away from the institutional Provider-driven model to a Consumer-driven model that embraces resident self-determination. The Owner's challenge was to reinvent the delivery system of care. The design team's challenge was to reinvent the environment based on this new service program and design decisions were based on the ability to reinforce the new program in the most effective way.

Creating new, contemporary private rooms in the existing footprint was could not be achieved without additions or a significant drop in census. Due to the diverse floor plan arrangements, several variations of resident rooms evolved. Believing that privacy does not exclude shared rooms, but does include acoustic and visual privacy, existing side by side shared rooms were provided with a fixed partition between the beds in lieu of the traditional cubical curtain. Because there is only one window in the room, the new divider has a window opening in it to

allow the resident by the door to still have a line of site to the exterior, without having to see their neighbor.

Several of the existing private rooms had adjoining bathrooms that were so confined that they were virtually unusable by the residents. In this instance two private rooms were combined into a shared room and both bathrooms were demolished in order to provide one functional bathroom complete with a fully accessible "European" style shower. It seems counterproductive to the challenge to create a shared room from two former private rooms, but privacy and dignity are not sacrificed. First, the ability for the resident to bathe without leaving their room provides an alternative choice to the trip down the corridor to the community spa. Second, full height partitions between the beds provides each resident a defined private space while a foyer at the entry allows for visitation to one room without disrupting the other. And last, since each room was formerly a private room, each resident has retained individual control over their own thermostat and their own window.

Since each floor is now divided into two households where there was once one "unit", the design team carefully considered visitor and staff circulation to each neighborhood. A new, common elevator empties into a public zone and visitors are able to enter either household through its own front door so cross circulation through neighborhoods is eliminated. Additionally, service traffic is reduced by using a dedicated staff elevator.

A carefully orchestrated phasing plan allowed full census to be maintained throughout the entire 24 month renovation project. In order to do so, one floor of the Owner's under capacity Assisted Living on campus was converted to Skilled care to allow for the redistribution of the 195 nursing beds. As with the Jewish Home of Rochester case study, the design team had partnered with an experienced Construction Manager to map out the steps to complete the project on schedule with limited disruption to the residents during construction.

Conclusion

"What can we do with what we've got?" It is a question that is relates as well to a family budget as it does to a large corporation. Sometimes trying to reuse aging building stock doesn't make any sense. Sometimes what once served well as residential housing is better converted to another use all together, such as administrative offices. But sometimes, the existing bones are strong enough and, with some creative thinking, can be reorganized to serve the same residents in a completely different way. By using the existing infrastructure in two very different

nursing facilities, each Owner was able to find an affordable solution to improve the everyday lives of their residents.