Home Again

Small Houses for Individuals with Cognitive Impairment

Jude Rabig, PhD, RN

ABSTRACT

The small house model of elder care emphasizes deinstitutionalization as a strategy to reduce the negative outcomes associated with nursing home care. The small house changes the philosophy, architecture, and organizational design of the institution and has been associated with higher quality of life and good quality of care. The intended benefits to individuals with cognitive impairment include better staff understanding of dementia care, improved physical environment, and safe, familiar patterns of everyday living. Initial research has been conducted, and additional research is underway to determine whether the outcomes match the intentions.

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In the United States, only two groups of individuals are institutionalized for the remainder of their lives: convicted murderers and frail older adults. Deinstitutionalization movements have liberated those who traditionally require care and services. Orphanages, psychiatric hospitals, state schools, and institutions for individuals who are developmentally disabled have all been replaced by more humane, community-based treatment options. However, ageism, ignorance, and the lack of an adequately resourced activist group have left intact a failed nursing home system that spends $99 billion annually to care for 1.6 million residents (American Health Care Association, 2002).

BACKGROUND

The modern nursing home has its roots in the poor houses and government hospitals of the 18th and 19th centuries. While much about the nursing home has changed, at its core, it remains an institution, closely resembling the total institution described by Goffman (1961) in structure, operation, and outcomes.

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These characteristics include the large, imposing physical plant, a factory-like focus on efficient process, and steep bureaucracy merging to produce abysmal levels of satisfaction and poor quality life.

Individuals who seek long-term care have three distinct needs: housing, assistance with activities of daily living (ADLs), and chronic disease management. The nursing home often does not meet these needs. Its architecture does not provide housing that supports frail individuals. The nurses' station, central dining room, kitchen, laundry, bathing rooms, and supply areas are configured to serve large numbers of individuals in assembly-line style. Double-loaded (rooms on both sides) long corridors designed to maximize efficiency practically mandate wheelchair dependence and encourage incontinence. Double-occupancy rooms and shared bathrooms provide dismal levels of privacy.

In its report to Congress, the Centers for Medicare & Medicaid Services (CMS) (2001) identified that in 2000, more than 91% of nursing homes had nurse aide staffing levels below those identified as minimally needed to provide adequate assistance with ADLs. At least one third of nursing home residents experience malnutrition or dehydration (Burger, Kayser-Jones, & Prince, 2000), and the national averages reported on the CMS (2009) Nursing Home Compare include pressure ulcers (12%), depression (14%), incontinence (50%), and urinary tract infections (9%).

Several theorists have clarified the psychosocial outcomes exhibited in individuals who live in the institutional nursing home. Havinghurst (1972), a social scientist who outlined developmental tasks across the life span, indicated that establishing a satisfactory living arrangement is a major environmental task in old age. If this is not successfully achieved, it produces unhappiness and frustration. Carboni's (1990) work on homelessness identified that nursing home residents expressed feelings of dependence, lack of choice, loss of identity, lack of privacy, insecurity, and helplessness—all characteristics of the homeless. Lawton (1982) theorized that a good fit between a person's needs and competencies and the environmental amenities is crucial as individuals age. He believed poor person-environment fit results in decreased individual competence and increased stress.

SMALL HOUSES

The term *small house* serves as a generic term for the deinstitutionalized model of long-term care. Early expressions of the small house can be found in the Green House® model (Rabig, Thomas, Kane, Cutler, & McAlilly, 2006), Hearthstone, Meadowlark Hills, and others. The small house is a place where individuals who require long-term care can receive services that support and maintain their highest level of holistic wellness in a small, humanistic, intentional community. The goal of the small house is to provide satisfactory housing, support with ADLs, and good chronic disease management.

Philosophy

The small house reframes the philosophical view of the person, restores metaphysical and physical home, provides good chronic disease management, and supplies sufficient staff and equipment to support personal care. A small house can be licensed as a nursing facility or as an assisted living facility, and although each organization implements small house in a unique manner, there are sets of characteristics that define an implementation as a small house (**Table**). Small house can be conceptualized (**Figure 1**) using the components of the Roy adaptation model (Roy & Andrews, 1991) and the Lawton (1986) theory of environmental press. The person who requires long-term care, like all human beings, is on a wellness-illness continuum. The environmental stressor of institutionalization creates a press that frequently moves the individual toward the illness end of the continuum. Small house creates an environment that potentially stabilizes the individual or moves him or her toward wellness by mitigating the problems caused by institutionalization. At the core of the small house movement is the unwavering belief that the problems in nursing homes are generated by the flawed institutional focus and the mindset of paternalism that accompanies the institution. It is a movement of liberation rooted in the empowerment imperative described by Estes (1979) as involving: "A commitment to the

The small house becomes the ideal setting for nurses to engage in caring, person-centered practice.

TABLE

CHARACTERISTICS OF THE SMALL HOUSE MODEL OF CARE

Policies for people who live in the house that include:

- Participation in their own care planning meetings.
- Participation in household activities of choice.
- Resident selection of all bathing choices.
- Decisions honored regarding all aspects of care.
- Opportunities to "make home" by personalizing their space, including bringing their own furniture and belongings.
- Opportunity to access the outdoors easily, without barriers to navigate or the need to secure permission.
- The ability to have visitors at will.
- Access to the greater community at will.

Staff structure that includes:

- The house as the operating unit.
- Minimized bureaucracy.
- Shared leadership and decision making.
- Collaborative work processes.
- Self-scheduling.
- Interdisciplinary participation in quality assurance.
- Self-directed learning.

Technology that includes:

- Electronic medical records.
- Wireless call system.
- Nurse-line staff communication system.
- Lift-free environment.
- Computer access for people who live in the house.

Policies and practices that:

- Provide a structured assessment and resourcing process for individual recreation and diversion.
- Maximize the use of adaptive devices to support independence in activities of daily living.
- Reduce polypharmacy.
- Provide holistic management of depression.
- Provide holistic management of pain.
- Incorporate the use of complementary therapies.

Dining that includes:

- A pleasant social dining experience.
- Access to food and drink at will.
- Choice of mealtime, food, and quantity of food.
- Opportunities to participate in food preparation or clean-up activities.

design and evaluation of social interactions that enhance the capacity of the old and chronically ill for self esteem, personal control, individual and social involvement" (p. 139).

Design

The small house redesigns the nursing facility into a decentralized model that views each house as a self-contained, functioning unit. The goal of small house design is to create a space that is "home like" (**Figure 2**). The communal heart of the small house is the hearth, the core of the household. The house includes an open kitchen, a dining room with a large table where meals are served family style, and a living room with a fireplace. The residential scale of the design precludes the necessity of long hallways for residents to maneuver, with individual resident rooms arranged in close proximity to the hearth. The rooms are private and equipped with a ceiling lift and a private bath with a shower and a separate spa-like room for bathing. For the clinical support team members, a small office serves as a space for private meetings and as a work area. A short hall creates a transition from outdoors and a space to welcome guests. Outdoor space, which is gated and fenced, is available and easily accessible by the residents.

Workforce

The small house workforce is reconfigured with attention to staff satisfaction and turnover (Harris-Kojetin, Lipson, Fielding, Kiefer, & Stone, 2004). Certified nursing assistant (CNA) staffing is at least 4 hours per resident per day, and licensed nurse staffing is 1.3 hours per resident per day, for a total of more than 4 hours per resident per day. Each house is staffed with an empowered team of universal workers who are CNAs with advanced training in cardiopulmonary resuscitation, first aid, and culinary skills. An interdisciplinary clinical support team serves each house. Nursing support uses a primary care model for care planning and chronic disease management. Staff works collaboratively with the support team to plan and provide care and services for the house residents. All leadership staff receives training in servant leadership, coaching, and communication to help them assume their roles as collaborators and guides.

Meeting the Needs of Those with Cognitive Impairment

According to Kahn's (1999) qualitative research on nursing home adaptation, older adults identified the nursing home as a place that met their needs and allowed them to "hold on a little longer" (p. 130) but also as a place that provided a regimented and restricted life. The informants engaged in active processes in an attempt to cognitively and emotionally reframe and recon-

struct the social environment. The informants referred to this adaptive process as *making the best of it.* This adaptive *making the best of it* was described as an active, creative process that requires a variety of skills, critical thinking, analysis, problem solving, and decision making.

However, 50% of nursing home residents have some form of cognitive loss (Morriss, Rovner, Folstein, & German, 1990). These individuals with cognitive impairment lack the skills needed to engage in this adaptive process. The rigid schedule, insufficient number of ever-changing staff, and the nature of the physical plant challenge and mystify those who are cognitively impaired. These challenges, coupled with the inability of those with cognitive impairment to verbally communicate their needs, provoke a response to the institutional nursing home that is often maladaptive, evidenced by disturbing behavior (Donaldson, Tarrier, & Burns, 1997; Souder & O'Sullivan, 2003).

The small house supports those with cognitive impairment by consciously implementing changes in philosophy, environment, daily life, and staff understanding of care. Architectural, social, emotional, and psychological cues are built into the environment to make the space home-like. Individuals with dementia are provided with a familiar environment that is more easily identified as home. The small house is rooted in home—the warm, private, familiar, comforting, safe, and predictable living spaces people have created for themselves all their lives (Molony, McDonald, & Palmisano-Mills, 2007). The living room, dining room, and kitchen are carefully designed to residential scale and furnished with residential furniture and fixtures. Residents and families are encouraged to bring meaningful art, furniture, and accessories for the resident's room and the common spaces to increase familiarity. The open kitchen adds the smells and sounds of cooking characteristic of a home. The front door and doorbell, the usable outdoor garden, and the absence of medication carts and medical supplies contribute to environmental familiarity.

The small house philosophy rejects the medical model's "paternalistic-maternalistic" relationship that casts the older adult as broken, malfunctioning, and in need of monitoring, supervision, and protection. It embraces the individual as someone who has strengths and weaknesses, a unique and rich life history, a future, wisdom and knowledge—a person who seeks independence, roles, productivity, autonomy, dignity, and choice. Small houses envision staff and residents as equals in an "I-thou" relationship. Staff contributes to the residents' success by providing the support required and requested by each individual on the basis of the staff's skills and the person's needs.

The end result is a living situation that fluidly responds to the needs of the residents and creates an environment of intimate care. This is possible with residents who are cognitively impaired because the

TABLE (CONTINUED)

CHARACTERISTICS OF THE SMALL HOUSE MODEL OF CARE

Architecture that includes:

- Conscious elimination of the signposts of the medical model.
- Small, self-contained homes or communal apartments for 10 to 14 people.
- A private room for each resident.
- Private bathrooms for each person, with showers, sinks, grooming space, tilting mirror, and storage.
- Home-like configuration (e.g., a front hall, living room, dining room, kitchen, and den).
- Short walking distances from bedrooms to living areas.
- Access to all areas of the house for those who live there.
- Residential finishes and hardware.
- Access to outdoor space and connections with nature.
- Accessible details (e.g., windows, faucets, light switches, doors, floor transitions, power outlets, thermostats).
- Driveways, sidewalks, and exterior lighting that are residential in size and configuration.
- Interiors that echo the neighborhood.
- Lighting that meets guidelines for the aging eye.

Staff training that includes:

- Change, and its effect on people and organizations.
- Safe restoration of choice.
- Holistic view of all people who live in the house.
- Maslow's (1943) hierarchy of needs.
- Habilitation in activities of daily living.
- Communication and collaboration.
- Caregiving effectively for individuals with cognitive impairment.
- Alternate bathing practices.
- Leading and being led.
- Convivium, food practices, and safe food handling.

Clinical care that includes:

- Advanced training in geriatric nursing for all nursing staff.
- Evidence-based clinical protocols.
- Management of polypharmacy.
- Early identification of problems related to chronic disease.
- A robust program of advanced directives discussion.
- Therapies that are integrated into the household.

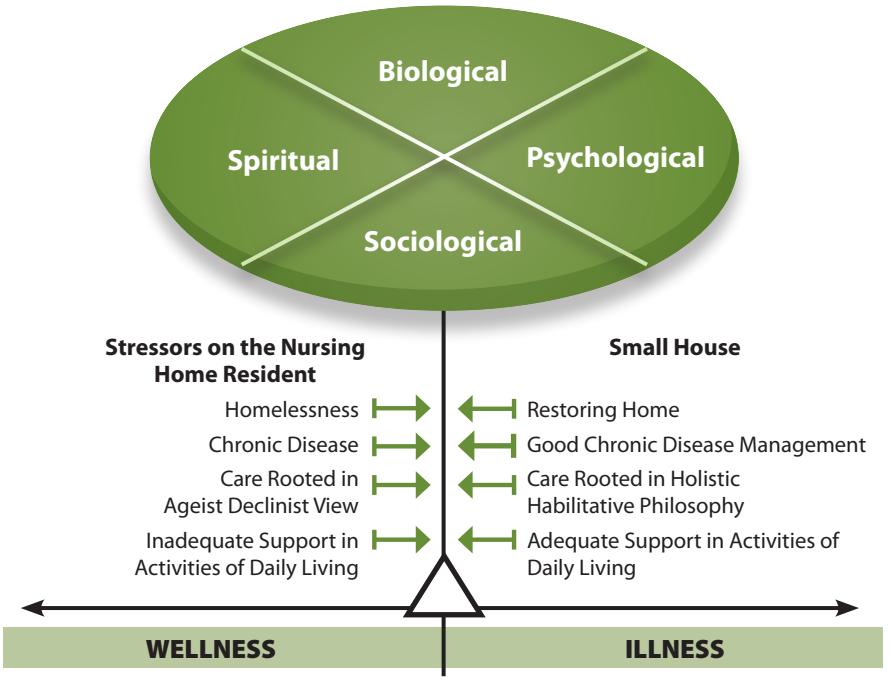

Figure 1. Intended effect of the small house on the holistic person's movement on the wellness-illness continuum.

staff are educated on the principles of the need-driven dementia-compromised behavior model (Algase et al., 1996; Kovach, Noonan, Schlidt, & Wells, 2005). This model reframes the behavioral symptoms of the person with dementia from chaotic random actions that are caused by a brain disease and framed as a problem to staff, to behavior that is indicative of an unmet need. The learners are coached to understand that resident behavior is a meaningful indicator of unmet needs and that the role of the caregiver is to be a detective and problem solver, that is, to identify the need and meet it.

Care Planning and Activities

Care planning is person centered (Kitwood, 1997), incorporating the use of dementia-friendly bathing techniques (Barrick, Rader, Hoeffer, & Sloane, 2002), personalized schedules, and an understanding of residents' personal habits, likes, and dislikes. Low staff turnover and permanent assignment to a house ensures consistent caregivers who can engage in care that is rooted in responsive knowing and individualized normalization.

Food options are personalized, and an effort is made to have each resident's favorite foods on hand. In-between meal snacks are visible and available at all times to promote increased food intake. Daily engagement opportunities include participation in familiar household tasks, such as laundry, dusting, vacuuming, and cooking. Staff are encouraged to use recreational and engagement opportunities that are consistent with the person's cognitive and physical capabilities. Simple Pleasures multilevel sensorimotor recreation items that promote resident opportunities for self-initiated activities and social interaction are provided (Buettner, 1999). These items are made by staff or volunteers and are inexpensive and engaging. Small houses also use a variety of complementary therapy interventions, such as massage, aromatherapy, music, and drumming. Some houses also use video-, audio-, and computer-based interventions to increase opportunities for engagement.

OUTCOMES

Field notes (Rabig, 2002-2009) from four separate implementations of small house projects reflect observed behavioral changes in residents with cognitive impairment, including decreased wandering, pacing, and aggression and increased engagement. In a study of the four small houses in Tupelo, Mississippi, two of which housed residents who had been transferred from a nursing home's locked dementia unit, Kane, Terry, Cutler, Degenholtz, and Yu (2007) found that residents or families of the small houses reported better quality of life on 7 of the 11 subscales (privacy, dignity, meaningful activities, relationship, autonomy, food enjoyment, and individuality) than those in the comparison traditional nursing homes. Small house residents also reported greater satisfaction, emotional well-being, functioning, and mobility. In addition, they had lower prevalence of bed rest, fewer residents with little or no activity, less depression, and a lower incidence of decline in ADLs.

SUMMARY

While there is a need for continued research on many elements of this paradigmatic redesign, these early results are promising and the benefits to individuals with cognitive impairment derived from living in a familiar, calm home while receiving nursing home care have already begun to become evident.

The changes for nursing practice in this new environment are dramatic. However, they are consistent with the core values of nurses as caring professionals. Watson's (1988) theory of caring proposes that nursing views clients as unique, holistic beings who deserve care rooted in understanding of the individual and his or her particular needs. The small house becomes the ideal setting for nurses to engage in caring, person-centered practice. Indeed, after nurses transition and adjust to the change, a common response to the small house model of care is: "This is what I went into nursing to do—care for people."

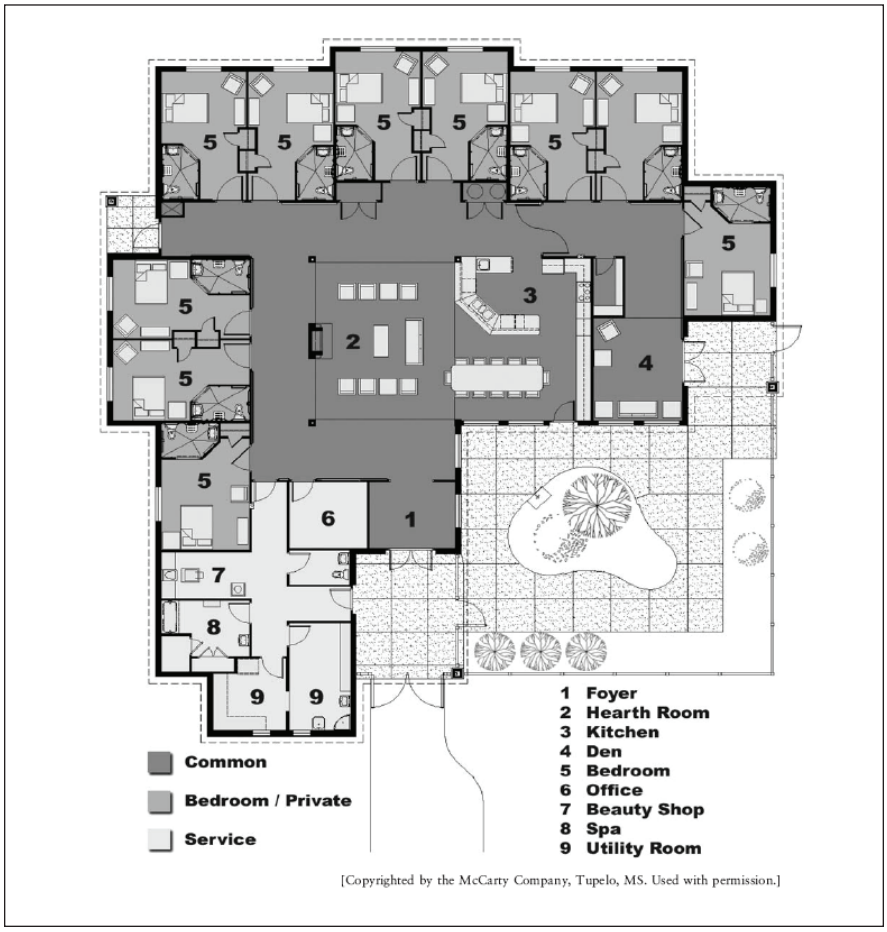

Figure 2. Small house floor plan. © The McCarty Company, Tupelo, Mississippi. Used with permission.

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