

Humanising the Hospital Environment

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Humanising the hospital environment

FRESH FROM the 4th World Congress on Design and Health in Europe, **Jane Carthey** discusses emerging trends and the need for healthcare facilities to be adaptable and to create a humanised environment.



A European trend: the two bed patient room at Bethanien Hospital, Frankfurt, Germany

AN INTERNATIONAL debate over how to humanise the patient care environment rages. While it is dominated by the single patient room proponents (generally, but not always the Americans), there are others who think that while single rooms may be appropriate in some situations, they do not always guarantee the best patient care environment, especially if other factors are sacrificed in order to achieve them.

While the jury is still out on this debate, what has been agreed is a need to shift the emphasis from a system empowerment perspective (where staff and clinical needs prevail), to one which emphasises empowering the patient and the family as part of the healthcare process. This second paradigm, which is explored in some detail by Verderber and Fine in their book 'Healthcare Architecture in an Era of Radical Transformation', emphasises the needs of the patient in a 'humanised' hospital environment, and suggests it may also improve staff work environments at the same time.

In terms of health facility architecture, humanising the healthcare environment tends to translate into an emphasis on achieving natural light and ventilation, outlook and views for patients, producing pleasant and non stressful 'healing' environments.

Creating a humanised environment

The requirement for these to be 'homelike' appears less important than it was in the recent past, partly because we have had such difficulty in understanding what this term actually means. So, now we are looking for rooms and spaces that are interesting and pleasantly stimulating to be

within, yet, at the same time, that address the needs of special patient groups such as bariatric (obese) patients, others requiring isolation, and those who actually prefer the company of others in multi-bed rooms.

Clearly, 'patient empowerment' must be achieved at the same time, and not at the expense of recognising and responding to the reality of a healthcare facility as the primary workplace for its staff. Understandably, staff also consider that they have a right to fresh air, sunshine and a view as respite from their often stressful working day.

Defying the single room

In Europe, in many instances, the balance tips away from the higher proportion of patient single rooms that are often regarded as non-negotiable by our American colleagues. Not always a priority in European countries, the single room is seen as having a place, but the provision of all single rooms might not be the most important factor under consideration in terms of planning a facility. Support for the single room is usually more measured and often tempered by other considerations.

Tight urban sites mean that if the whole of a building's perimeter is allocated to the windows required by single patient bedrooms, there will be very little left (if any) for staff offices and recreational areas. Longer narrow buildings,



LEFT: The importance of space, light and a view: the staff room at Bethaniel Hospital, Frankfurt

> "Patient empowerment must be achieved at the same time, and not at the expense of its staff. Staff have a right to fresh air, sunshine and a view as respite from their often stressful working day."

often a combination of double loaded single corridors and deeper internally planned linking spaces, mean that more external walls are available for a variety of purposes. However, to ensure that staff walking distances are kept to a reasonable dimension requires that something has to be conceded.

Due to differing cultural expectations, the American concern for the rights of the individual and the associated priority for patient privacy are not universally shared. In addition, the hard evidence is not there to determine the incidence and cause of differing rates of infection in one-bed versus multi bed wards.

As a result, the expectation of being accommodated in a single room is not consistently held across Europe. The wider incidence of two, three (or more) bed patient rooms positively impacts the issue of ever-lengthening corridors in healthcare buildings, reduces the initial capital cost of these facilities, and often allows the allocation of windows and outlook to staff spaces such as offices and tearooms.

The Bethaniel Hospital, Frankfurt, has a mix of single and multi bed rooms. These are often two-bed rooms that provide dedicated facilities for each patient, including a locked safe for personal belongings and a small refrigerator for patient and family use. Bariatric patient needs are addressed in a specially fitted patient suite of bedroom and bathroom.

Creating an adaptable facility

The second issue that is being addressed in an innovative way in Europe, and demonstrated by the two particular facilities visited in the Netherlands, is the need to continually adapt a health facility for its changing roles over time. The NHS Future

Healthcare Network recently issued a briefing document on this issue, setting out a desirable approach to this for the United Kingdom. It lists a number of key points which it ultimately summarises as "In essence, go for 'long-life, loose-fit' solutions and think about what won't change."

The study on European Hospitals undertaken by the WHO in the European Observatory on Healthcare Systems Series discusses the same type of approach among a wider range of relevant facility planning issues. In a 2002 essay by Healy and McKee, the comment is made that 'The continuing design challenge is how a hospital building can adapt to changes in its internal and external environment. An optimal design is one that inhibits change of function least rather than one that fits a particular function best.'

Various other studies on building in adaptability and flexibility to hospitals in order to stave off obsolescence, such as those by Datta (2001), and Jonasson et al (2001), also demonstrate an approach in similar vein. Both studies stress the need to set appropriate patterns for circulation and traffic routes for patients, staff, goods and services, the 'permanent facility' that does not interfere with the use of the changing or 'temporal space' that accommodates the healthcare service delivery and which can be adapted to new purposes over time. Inherent in these systems is recognition of the patient's experience of being treated in the facility – ie, the need to consider 'humanity through many permutations of care giving.'

Creating a virtual healthscape

One hospital we visited in the Netherlands, the Martini Hospital at Groningen, under the visionary direction of the CEO, Jack

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Thiadens, has been designed and is currently being constructed in accordance with a documented approach to future adaptability. Overseen and promoted by the Netherlands Health Building Foundation, the facility design approach is described as 'Industrial, Flexible and Demountable', or 'IFD'.

The result of research into the design characteristics of multi-storey buildings, this strategy has been developed to ensure easy reconfiguration, expansion or reuse for other purposes when buildings are beyond the first useful phase of their lifecycle. A renewed interest in site master planning has arisen, scrutinising closely future development needs in terms of emerging technology, changing demographics, and clinical service needs. Future site use has been planned for the Martini Hospital, encompassing the replacement of older buildings over time with new buildings, and either demolishing or changing the use of those remaining to suit future projected needs.

Together with the University Hospital in Groningen, which was also visited on this trip, this represents, in terms of organisation and physical presence, a further step on the path of health facility design that turns away from the all-embracing concept of the 'megahospital' of the 1960's to 1990's. Although these are still being built in Australia, in other parts of the world, this particular redefinition of the role of the health facility recasts it as part of a wider network of facilities connected by technology of various kinds, the future 'virtual healthscape' predicted by Verderber and Fine amongst others.

In many instances, this results in healthcare buildings that are a better fit with their urban settings. They are more likely to become an integral component of their town or city, rather than turning their back on their urban community, or worse still manifesting as a self-contained fortress or health factory. They are thus increasingly responsive to wider urban planning considerations, including the controls set by their local communities.



Using innovative design: the Day Surgery Unit at Groningen University Medical Center, Groningen, Netherlands



ABOVE: Humanising the healthcare environment: the internal courtyard at Groningen University Medical Center.

ABOVE RIGHT: Being part of the community: Hospital entry foyer and 'street' at Groningen University Medical Center links the main access routes to the local train station and urban centre.

These are features of both the Groningen Martini Hospital Development and the perhaps more conventionally conceived Groningen University Hospital, located in the urban centre of Groningen. In particular, the latter facility takes its role as part of the community extremely seriously, with the hospital foyer and main ground level circulation routes created as public space linking into main access routes to the local train station and urban centre. Not only does the hospital fit well into its urban



environment, it also addresses the need to humanise the hospital environment in creative, innovative and often relatively low cost ways to meet the needs of its patients, their families and the wider community. **H&h**

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Creating a homelike environment: the Cardiology Outpatients Unit at Groningen University Medical Center.