



Feature "Custom Interiors"

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Many words have been written and symposia presented on the concept of healing design, but less has been written on the logistics of implementation, especially at small, rural hospitals. Recently, I was put in charge of an effort to introduce the concept at one of my hospitals in Washington State, and I am pleased to share lessons from my "school of hard knocks."

Two hospitals in one

In the area around Mount Vernon, Wash., are two public hospitals within two cities. In 1992, operations and staff were consolidated at the two hospitals to reduce expenses and a feasibility study was later completed with the aim of building a single replacement hospital.

In anticipation of this project, my supervisor asked me to start research into healing design principles. I knew that the new hospital should embody warmth, nature, light and respite for patients, visitors and staff. If a building could heal, my supervisor and I wanted that philosophy incorporated into the functional programming from the start.

Eventually, plans for a replacement hospital were abandoned. However, my supervisor recommended applying my lessons to our two existing hospitals. In spring 1999, a group of 10 colleagues and I began evaluating healing design principles as practiced in local and regional hospitals in the Pacific Northwest and northern California.

Goodbye 'Pepto-Bismol pink'

Because one of the two hospitals already enjoyed a peaceful, pastoral setting, we selected the oldest, land-locked hospital to reinvent with a healing interior design concept.

This 175,000-square-foot facility held a Level III trauma designation and housed most of the acute care services. My supervisor, an assistant administrator, gathered the support of the administrative team to fund a minor remodeling project. My colleagues and I focused our attention on two medical/surgical units with 68 patient beds. The nursing units were constructed in 1954 and 1969, with double beds in the single-loaded corridor. They had not been updated in many years and sported a "Pepto-Bismol pink" décor.

Space was very tight and the unit ran a full patient census. Consequently, nursing administration dictated that remodeling could not occur in the winter, and remodeling could only occur in two rooms at a time in the summer. My first step was to organize a team.

Organizing the team

The team's composition was very important, so I helped choose well-rounded members. There were department representatives from environmental/housekeeping services, maintenance, food services, nursing administration, administration, communications, volunteer services, facilities planning, physicians, nursing and patients. We also included specialties such as cardiac/intensive care, oncology and family birth services.

Individuals didn't necessarily need to be from the management ranks. In fact, in some cases, initiatives are more widely accepted if the rank and file are empowered by membership on the team.

Under the team rules, each member had equal voting weight and no idea was too unrealistic or expensive. Reality checks on budget and logistics would come later. Meetings were held monthly or quarterly, depending on the project's status.

Handling the learning curve

A true healing environment empowers all its users: the patient, family member, visitor, staff and physician. To handle the learning curve, our team members accessed many tools and resources. These included:

- Site visits. A small group of team members from nursing administration, administration, nursing informatics and facilities planning toured four facilities of differing sizes and visions in Washington and Oregon, while I visited another eight in northern California.
- Publications. My suggested reading list included any books or articles by Sara O. Marberry, Jain Malkin, Cynthia Leibrock, Janet Carpman, Leland Kaiser or Roger Ulrich. Periodicals included Health Facilities Management and a number of other facilities and health care publications.
- Networking. Our best opportunity to network with designers from other facilities was by attending the annual Symposium on Healthcare Design. In addition, we tried to become familiar with the Center for Health Design, the Environment Design Research Association, The Healthcare Advisory Board and The Society for Arts in Healthcare, among other groups.
- Feedback. We also gathered and evaluated comments from patient and visitor comment cards, employee suggestions and a recent patient satisfaction survey.

After we educated ourselves on healing design topics, got to know our market and found out what our internal and external customers thought, we set about trying to create a proactive, restful and holistic patient environment.

Defining the mission

Simply adding a water fountain in the lobby or selecting new patient furniture does not make a healing environment. Creating an environment that heals is about creating sustainable systemic changes to the organization.

The team members would actually be catalysts to alter culture. But, first, we had to define where we wanted to be and then figure out how to get there.

Benchmarking the team's ideas against a mission statement ensured that the design and operational initiatives had purpose and focus. The "Healing Health Care Environmental Task

Force Mission Statement" was inspired by Nancy Moore, a pioneer in patient-focused environments. It held that: "A healing environment promotes physical, psychological and spiritual comfort; meets both the need for privacy and social contact; explores the use of light, color and artwork; and integrates the presence of natural elements."

On a more practical level, most of the team members did not know what a healing environment could be, so I created one to level our backgrounds and bases of knowledge.

The stage was set in one of our nicer conference rooms. Soft music played as members gathered around a semicircular table. Brightly colored folders and a variety of writing materials were available for their personal selection. Flowers, artwork and a miniature waterfall adorned the head table.

No explanation was given before the meeting convened. Having team members "live" a healthy environment experience was ultimately easier than trying to explain it. Once all the members had expressed their feelings about the environment, we proceeded to write the mission statement and create a list of ideas.

It was critical to define what kind of support the team could expect from administration. All projects take human, financial and leadership support to be successful. If any team members were most important, it was the administrative representatives because they were closest to the purse strings.

Creating an idea list was the most fun part. My team brainstormed without qualifications as to cost or difficulty. Each submission was benchmarked against the goals of the mission statement. The following ideas were eventually developed by the team:

- Ideas for promoting physical comfort: Making massage therapy available, offering therapeutic touch classes for staff, developing a customer service binder, exploring "room service" food delivery, upgrading patient seating and exploring sleeper chairs for family.
- Ideas that meet the need for privacy: Providing earphones for television and music, and implementing nurse pagers to reduce noise.
- Ideas that explore the use of light: Implementing full-spectrum light bulbs, investigating the use of indirect lighting and upgrading the acute care corridor lighting.
- Ideas that explore the use of artwork: Setting up a healing fine arts committee, creating a patient activity cart, inventorying all existing art at the hospital and implementing an art acquisition program.
- Ideas that promote psychological and spiritual comfort: Installing cable televisions and exploring the availability of VCRs, implementing guided imagery tapes, updating signage and wayfinding, exploring aromatherapy, and exploring a closed-circuit TV Care Channel.
- Ideas that meet the need for social contact: Encouraging customer service at information desks, hanging whiteboard/corkboard for patients, installing nurse chart stations close to patients, reducing clutter on corridor walls and adding a community health care bulletin board.
- Ideas that explore the use of color: Introducing new patient wall colors, installing nicer panel fabric in one of the waiting rooms, customizing paint details in patient rooms and replacing poorly functioning vanity sinks in patient rooms.
- Ideas that integrate the presence of nature: Devoting some art to nature scenes in rooms, exploring the use of waterfalls in waiting rooms, testing wood flooring in patient rooms and investigating rooftop gardens.

Moving forward

The team members researched the ideas for all possible implications, logistics and associated costs. Once the data were gathered, the team decided which ideas to implement.

Some research involved locating facilities that had implemented similar ideas, and that is where networking with other facilities proved most valuable. Once we identified the costs and implications, the team prioritized the ideas. Easily implemented ideas were selected to maintain positive momentum.

Many of the cosmetic project ideas were merged into a remodel of two medical/surgical units. The remodel spanned five months around a full patient census and ended in success.

To garner full support and funding from administration, I fashioned a foam-core scale model of a patient room, a materials board and a draft budget. I later implemented the original ideas from the model into an actual full-scale patient room where I gathered comments from patients, visitors and staff.

Three-dimensional tools such as scale models or demonstration rooms were essential in conveying the feeling and ramifications of real changes in a hospital. Often, two-dimensional blueprints or sketches do not adequately represent the possibilities or solutions.

Additionally, the team strived to maintain communication with the hospital staff, the community and administration throughout the project. Corporate newsletters, Web sites and staff meetings created awareness and educated users about project goals and logistics.

Another beneficial tool was the staff in-service meeting. The vendors and I demonstrated new furniture and window coverings, empowering staff and enhancing their satisfaction level. It was hoped their ownership would contribute to making patients happier and positively affect market share.

Completing the project

Our team implemented over 85 percent of the ideas on our list. For example, the remodeled patient rooms and toilets donned new simulated wood flooring, and creamy biscuit colored walls with a buttercup accent wall. On the footwall hangs a framed landscape poster, containing the full-spectrum of colors.

Nature was represented by the earth-tone leaf pattern on the cubicle curtains and window drapery. Natural light is always present with the installation of plastic web-style shades. The nature of the shade's construction maximizes patient privacy, while allowing full views of outside surroundings.

Patients now enjoy personal television sets, platform rocking chairs, and a fold-out sleeper chair for family members. Physicians and staff now enjoy new plumbing fixtures, exam lights directly over the patient bed area and whiteboard/corkboard to enhance staff-to-patient communication.

In process is the patient activity cart, appropriately called the patient healing cart. In addition, customer service binders in each room are similar to those found in hotels, and provide information about meal times, patients' rights and the services available. Volunteers are also currently inventorying color books, art supplies, seek-n-find and crossword puzzle books along with guided imagery and patient education tapes.

Finally, as an offshoot of the project, a fine arts committee of community members, artists, hospital staff and administration was established to create a framework for accepting formal art

acquisitions. Previous art acquisition was haphazard. Now, under the guidelines of the fine arts committee, the art acquisitions have a purpose and meet a specific criteria. The bylaws are made up of a vision, mission, art donation policy, membership guidelines and art collection maintenance policy.

Among the 15 percent of the ideas that didn't come to fruition, individual VCRs and closed-circuit television were mooted because costs were prohibitive.

The project was estimated at approximately \$200,000 but closed out at about \$400,000 because of additional abatement costs and change orders often associated with remodels. In 2003, the team will forge ahead with the nursing unit corridors by repainting, adding a local poster art collection and installing full-spectrum lighting.

Measuring the results

To evaluate the results of a physical or operational change, it must be measured. As with evidence-based medicine, a health care setting can use chart review, surveys, observation and other data collection methods to track the effects of a design or operational improvement on the patient, visitor and staff environment. This is called "evidence-based design."

Patients, physicians and nursing staff were surveyed before and after the project. The same questions were used for both surveys. The patient and physician questionnaire attempted to measure the perception the patient and physician had on how the built environment affected the patient's recovery. The staff survey focused on how the nursing staff perceived the environment affected their ability to provide patient care. The surveys had five questions rated on a five-point scale of "strongly agree," "agree," "no opinion," "disagree" and "strongly disagree."

The patient survey included 50 patients who had three-day lengths of stay or longer. Patients were asked if they felt their access to a warm, non-institutional environment, exposure to nature, and ability to control light positively affected their recovery. They were also asked if the patient environment supported their need for physical, psychological and spiritual comfort, and about their overall satisfaction with the patient room décor.

Ninety-five percent of the patients felt that their room environment could positively affect their recovery, and there was a 6 percent increase in patient room satisfaction. Although the patients by the windows expressed more satisfaction, the patients by the corridor still reported the same increase in satisfaction as those by the windows.

The physician survey included more than 25 respondents focusing on how they felt the room environment contributed to their patients' recoveries. While 96 percent of physicians believed that the patient environment can positively affect their patients' recovery, only 50 percent believed that our facilities actually did.

The biggest complaint among patients and physicians were the semiprivate rooms. While 71 percent of the patients felt the room positively affected their recovery, only 49 percent of the physicians concurred.

When comparing before and after results, the physicians showed a 5 percent increase in overall satisfaction compared to a 6 percent increase from the patients.

The staff survey inquired of 52 staff members whether the patient room environment could positively affect the quality of care the staff provided. The results were murky. While questions posted a hardly noticeable increase of 4 percent, the most interesting statistic was a 12 percent

decrease in staff members belief that a patient room could positively affect the quality of care. I would have to attribute that downturn to tense contract negotiations and on-going disaffiliation issues.

The day shift showed no change at all, while the swing shift showed a 28 percent decrease. Surprisingly, the night shift showed a 41 percent increase. No cause can be shown for the increase, other than the change in paint and window coverings that created a softer environment in the morning light.

In short, the surveys showed an 8 percent average overall satisfaction with the newer rooms. To increase satisfaction levels further, our facility would likely have to convert to all-private rooms. However, it was encouraging to learn that even small, cosmetic changes could make a difference in the patient experience.

A collaborative effort

Each of the hospitals within a 60-mile radius of my two hospitals has made a multimillion dollar modification and is advertising heavily in our market. Our new healing design will help us keep up with these competitors.

This project was not the result of one person's work, but of everyone at the hospital. From those giving feedback to those implementing the changes, collaboration made it successful.

I sincerely hope our experience can help your hospital move healing design ideas from your idea list into your patients' experience.

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