Paul: (Music). All right. Thank you for joining me today. We have Dr. Diana Anderson, she's a physician and healthcare architect with Jacobs, Thomas Gray, a research fellow at Trinity House Research Center in Trinity College, Dublin, Ireland, and Dr. Des O'Neil, Center for Aging [00:00:30] Neuroscience in the Humanities, Trinity College, Dublin, Ireland. So thank you all for joining me today. Our topic we're going to really kind of dive into is the future of elder care and elder care facilities with a special emphasis on what we have learned from our current pandemic and the considerations to take into account for elder care. So to start, and Diana, I'm going to start with you. Can you explain the importance [00:01:00] of built environments for nursing home and it's impact on residents and particularly in light of pandemics and such medical considerations?

Diana: Sure. Thanks, Paul. It's great to be here and to talk about this. We as a group have worked together in the past, Tom and Des and myself and Sean, who's one of our team members who couldn't be here today, but we've coauthored an article and thought we would center the discussion around [00:01:30] some of what we researched and wrote about for this article, thinking about resilience, nursing home design, and COVID specifically. I'd like all of us to comment on this question. I think it's an important one, Paul, but I think the importance of the built environment for nursing homes is extremely great and perhaps not well understood, but COVID has certainly brought to light the impact of the architecture on health outcomes.

We have fairly good evidence and research from the acute care environment, [00:02:00] from hospitals to show that the built environment can impact health outcomes with respect to whether you fall while you're in the hospital, especially if you're older, whether you sustain a medication error, whether you might become acutely confused or delirious, all of these issues impact older adults and we know that the environment in hospitals have an impact. We have, I'd say less research in the context of long term care and congregate living settings to, to show those same at outcomes, but for instance, with COVID, we sort of [00:02:30] are knowing now our data is showing us that older facilities with older models of design with shared rooms and larger congregate spaces for dining and socializing have not led to good outcomes in COVID.

And have probably contributed to infection spread and morbidity and mortality. I think it's important from my perspective to think about the built environment as a parameter of care and it'll be interesting to hear from Des, who's a physician as well whether we think about this in long term care in nursing home, but [00:03:00] the built environment can almost be considered a medical intervention in my mind and is very important, specifically where people live. We're not staying in a nursing home for just a few days like we are in the hospital. People are living there, it's a home.

Paul: Yeah, it's interesting, and I'm sure we'll kind of maybe touch on this or even dive into it, but it seems to me as somebody outside looking in that perhaps medical, or elder care long term care facilities weren't necessarily, and maybe they were, [00:03:30] but weren't necessarily designed to handle pandemics or maybe that was maybe not at the forefront, and I wonder if now, because of COVID 19 shedding some light on some of the challenges, that we might see some changes in how that's approached, but turning

to you, Dr. Des, same question. Can you explain the importance of built environments from nursing homes and what you see as the impact for residents?

Des: [00:04:00] Yeah, I mean, this is, I actually think this is, I believe, firmly believe and certainly, there's a circumstantial and other evidence just that this is hugely important, but we got to bear in mind that to a certain sense, society has averted its gaze from the area of nursing homes. So there really has been a little bit of everybody, but nobody directing in terms of leadership, in terms of how we merge together the [00:04:30] idea of a domestic type environment that, in many ways, liberates, facilitates independence living empowerment within the challenges of providing relatively sophisticated care, and I suppose we are beginning to see a little bit of a turn. I think one of the silver linings of the COVID cloud is we're seeing an emphasis and attention towards what's happening in the nursing home sector.

It's really clear. [00:05:00] I mean, for example, when we went looking in this area here, we can take something really, really simple and it's about putting the focus on the resident rather than the service. One of the early papers on infection control showed that in a nursing home that had say four blocks, three of the blocks had offices that were nothing necessarily to do with direct resident support. They had worse outcomes than the block that only had what the residents needed. [00:05:30] So I do think there's incredible synergy between our psychological wellbeing, our physical wellbeing. We know, for example, in gerontology that how you subjectively feel actually tells more about how you're going to survive than supposedly objective markers.

So certainly, it's really palpable to me when I go into a unit that has been designed with some care and some attention, [00:06:00] but one of the key workers and I won't over, because we've a number of areas to cover here, but I think it is really interesting the question of leadership. One of the key pioneers in this area, Richard Fleming, when somebody in Australia, when somebody comes to him and says, we'd like to make our nursing home more dementia friendly, he says, show me your dementia care processes first. So there's a synergy, I think, between good design and good care and I think the most important [00:06:30] thing we can say here is the worry almost certainly with a large corporation would think possibly, well, if we get the design right, it will improve. I think this is about moving in tandem with leaders in care and leaders in design.

Paul: Okay. And then Tom, from your perspective, can you shed some light on your thoughts on built environment in the nursing homes and some of the impact on residents that you're seen?

Tom: Yeah. Yeah. I mean, I think both [00:07:00] Diana and Des touched on a couple of important things there. I mean, I suppose it's really important for us to remember that a nursing home is somebody's home. That's really a primary thing. It's where they live their life, so the location design and operation of a nursing home should reflect this and provide all the things probably you and I would want from a home, and that's complex. We want our home to be in our community, somewhere that we recognize as somewhere that makes life worthwhile and that kind of special. [00:07:30] It needs to be some kind of refuge or retreat, but at the same time, we want it to be a place for

social interaction, somewhere where we can invite family members in, somewhere where we can celebrate stuff.

It has to be homely and familiar, yet we shouldn't kind of think of pigeonhole older people into this kind of idea that a house is very traditional thing. These are people that may be living in quite contemporary housing. So [00:08:00] the design should reflect what's going on out there in society, but definitely a nursing home has to work harder in many ways because we are talking about people who may have age related disabilities or ill health and their movements might be restricted. So the nursing home becomes a very kind of a special place, a very concentrated place, in fact, where we really need to cater to lots of needs and make it a very important and special place.

Paul: Now, and when [00:08:30] I consider nursing care, elder care, and then also in light of the fact that we have, at least here in the United States course, we have the baby boom generation. So we have like a very large and aging population. So it seems like the system is going to be a bit taxed and maybe even more taxed, and on the one hand, you have nursing homes. They are institutions in the sense that you're trying to provide a standard of care for a number [00:09:00] of people, but then at the same time, each individual has its own, has his or her own individual needs.

So there's that balance between the standardized care, standardizing care and then providing tailored care. So I wonder in light of all of that, I'm going to ask you, Des, as we kind of look to where we're going and the challenges that have probably been exacerbated because of COVID 19, what did it reveal about [00:09:30] existing challenges in the state of nursing care now, and then are there additional issues within nursing homes and then maybe take us, point to us where we might start examining going forward.

Des: Yeah, no, it's clear that COVID was the great revealer. It's a bit like the Warren Buffett statement, that it's when tide goes out that you see who's been swimming naked, and it really showed that, for example, I think [00:10:00] particularly, and it may become clearer as statistics become clearer, but financial and other efficiencies tend not to build in resilience and resilience, I think a lack of resilience was a key issue here, a lack of sectoral organization, and certainly, in most jurisdictions, there was a separation of the ways between the public health systems, [00:10:30] statutory health systems, organized health systems and those in nursing homes and I have no doubt in my mind that this was exacerbated also by a lack of creative thinking in how such institutions were built and I suppose a failure. It's interesting. One of the things we looked at, Tom and I in our studies was look at the barriers to healthcare staff.

Now, this was hospital setting, but we hope to look at in a nursing home [00:11:00] setting as well. The barriers to their feeling empowered to make change, to set the agenda around design and indeed, for example, facilities and technical services managers, the people who look after the repainting, putting up shelves, all those sort of things, they've been very much out of the loop, often not seen as healthcare partners. So what's really exciting I think about what has emerged from the work that, for example, we've been able to do with Diana [00:11:30] around clinicians for design is

trying to build up some momentum to give people handholds in the complexity, and in the first instance, I think about reconfiguration and redesign because we're not going to be going and building a whole load of new ones.

So what can we do in terms of reconfiguration redesign, and then the second thing is really is to look at potentially then feeding that into new build. So I think there is a job of work [00:12:00] to be done there, but I think there are possibilities and opportunities, and we really must seek out leaders and I think we must develop probably educational and other materials around how do I engage with making my environment more empowering, more supportive? On the numbers game, I think the numbers game are, in most of the world, relatively reassuring in one hand in that most populations. Now there's [00:12:30] a little bit of a glitch in the US in recent years, are getting fitter and healthier. So it may well be that the numbers needing residential care effectively flat lines. For example, in Ireland, it's dropped by a third in the last 10 years with an increase in our population, but they are going to be more demanding.

And I think this is a really good thing, and I hope we can see more demanding consumerism from the baby boomers as to what they're going to and I just don't want to hog the conversation. [00:13:00] What are the worrying things that happened to me? I did a fair bit of radio work and one of the things came up was how much of the general population says, well, I'd hate to end up in a nursing home, and my response always was, well, let's change the dialogue for your future later life so that you'd say the nursing home is a place I'll happily be in. So if the general population are nihilistic, that translates into the politician, it translates into other areas. So there's a job of work around saying this is worth doing to make it right.

Paul: [00:13:30] Pivoting a little bit from that, let's talk for a moment about special frameworks in the context in nursing homes, and Tom, I know that you've got some thoughts around spatial scales and Diana, around design perspective. Let me start with you Diana, if you don't mind, but can you explain a little bit about a special framework, particularly in the context of nursing home homes and what are the issues that are covered by it?

Diana: Sure. And I thought [00:14:00] maybe I'd piggyback a little bit on what Des was saying with the earlier question. I think these building types in nursing homes are not strangers to the idea of infectious outbreaks, which is interesting. Of course, the pandemic and COVID has sort of stretched that boundary, but the idea of an infection spreading, it happens a lot in these facilities and they have to be ready and be flexible and resilient to them, but I think the current pandemic has really tested the limits of that and I would say some of the existing challenges too within these buildings are the fact that there's [00:14:30] many different users.

They are homes to the residents who live there, but unlike in our own home where it's really just the nuclear family or the resident themselves, we have staff coming in and we have caregivers and friends and family coming in. So I think that's posed an additional challenge and I really liked how Des was saying, we have to work in tandem with some of the care models and the design, and I would wholeheartedly agree with that, and it's

not something you can sort of fit one into after the fact. They both have to be thought about together. The idea of spatial framework and scales [00:15:00] is important as architects to think about because I think traditionally, and Des can comment on this, but I think we've sort of viewed nursing homes as a standalone building and not always thought about what's going on around them in the community and even the urban framework.

These are homes that are integrated into society or should be potentially and how can we do that, and if we think about resiliency, it probably has to go farther than just the micro environment or just the building. These residents [00:15:30] who live there are interacting with the greater community, or we hope that they do. They have family members who are coming into these facilities and I think it would be great to see more of a focus on how to integrate that into communities and urban fabrics, and Tom can probably comment on this as well as an architect and he's done quite a bit of research in this area.

Tom: Yeah. I mean, I think that is important and I think across numerous countries, we see nursing homes and care homes as very isolated from the community [00:16:00] and they tend to be built outside towns or on the outskirts or whatever because they're not seen as something that's inherent into what's going on or maybe that's what people want. They want to be removed from life and hustle bustle of what's going on. So I think first of all, just as Diana said, they're taking an almost, a planning and urban design focus first as that kind of macro scale is important. I mean, where actually are we putting them? Des makes a good point that we have a lot of existing nursing homes to deal with, but if we [00:16:30] say we think down the line of it and say, right, when we're planning new communities or we're planning new care homes, where should they go?

I mean, they should go where people live. They should go in people's communities. I mean, as I said earlier on, a sense of home or a sense of wellbeing associated with a home, there's a lot got to do with not just your house, but it's also your community, and that's shown over and over again when people are asked describe your sense of home or sense of place. They'll often start outside the home. They'll start in their community and when we talk about [00:17:00] aging at home, it's not necessarily aging in your house, it's aging within your kind of natural or home community. So that's really important. So what we've tried to do is take a systematic approach I suppose, and first of all, started that macro scale, which is the bigger planning picture.

Where would you locate a care home within a bigger community in terms of proximity to a person's home community, family, friends, access to public transport, all of these kinds of things, [00:17:30] and then almost working down to what we call the meso scale at a geographical scale, that would probably be the local community or the neighborhood and how does the care home actually interface with the community? It tends to be quite insular. They tend to be closed away like a lot of institutional buildings. How do they have a far more interactive, and I'd say almost relational approach with the community? These should be an important piece of local and social infrastructure. [00:18:00] So that's at that kind of community scale and at the neighborhood scale.

And then of course, drilling down into the building itself and designing the layout and components and all of that kind of stuff. That's kind of at the micro scale, but I think you need to think up and down through them all the time. I think as architects, urban planners, designers, you do that. You have a sliding scale almost that you work with and you tend to move up and down that scale quite comfortably, but I think we need to bring that to bear [00:18:30] on these kinds of designs and probably the word we could use here is a continuum. Are we creating a continuum of care or a continuum of living? Are people connected in a way that we want to be when we're living at home and not living in a care home? Can we move out and about in the community?

Is there a seamless transition? Now these are challenges of course, for a pandemic. In a way, what we're talking about here is this real integration, [00:19:00] but then a pandemic comes along and says, actually no, we want to close the gates and close the doors and protect people, but in the long run, that can be quite damaging for people's resilience. We know that resilience is underpinned and strengthened by your sense of who you are, your strength you draw from your family and so on. So careful that we don't throw the baby out with the bath water for want of a better expression.

Paul: Yeah. It's very interesting, that concept of continuum and the [00:19:30] sense of home that you're touching on because you think about the average person who's entering into a facility like this. I mean, typically I would say, and I don't know if there's any typical case, but it's a person who is going from some sort of situation where they were independently living or maybe living in their own home. Maybe they had some help, but they were living in their own home and then suddenly, they're being put into [00:20:00] communal living. It can be quite a radical shift, and in going back to what Des was saying earlier about that so much of your health is really around subjectively how you feel and not maybe even sometimes more so than objectively.

So you're putting these patients in a situation or the current system is putting them in a situation where it is disruptive and there is maybe that, [00:20:30] it undercuts that sense of home and there's some anxiety. So it's interesting to think about this, that as you're designing both in the community, and then like you're saying, Tom, at the micro level, the home that they're going to, the place they're going to call home, how important that is to establish that sense of wellbeing. And now Des, in that vein, what do you, [00:21:00] from a clinical perspective, what do you see as an ideal environment for nursing home residents and what's going to help them thrive and be resilient?

Des: Yeah. I think the key here is taking a leaf out of the book, The Greenhouse and need an alternative, which is largely around emphasizing and prioritizing empowerment of domesticity and modesty of scale within an individual unit while still allowing for the complex healthcare needs that are involved. So particularly [00:21:30] around also making communal spaces or where breakout or where you're going to meet family and friends, smaller, more intimate, breaking up the spaces. So you don't have a sense of living in your bedroom or just having a large room. My imagination as an architect would be something like the petals of a daisy where each petal would be a 10 bedded unit with its own front door, and which people would then know their co-residents and perhaps part of unit would be private.

[00:22:00] And also to bear in mind issues around biophilic design, particularly whether it's hanging gardens or gardens outside. Hugely important, natural light and air to the greatest extent possible, and to bear in mind things like smoking and ability to, if you have a strict smoking ban within the building is to bear in mind that these are disabled people towards the end of their life and if that's their pleasure, that's their pleasure. So that this is, it takes a lot of convincing in many ways that this is something that will empower and make people better, [00:22:30] feel better, and make life better for staff. I think we often don't think about quality of life for the staff. I think for both residents and staff and the system, this is the way forward.

Paul: Diana, let me bring you in on this. So you are what we refer to as a doc-chitect. You are both a doctor and an architect, which to me just blows my mind, so can you kind of weigh into on this idea [00:23:00] of what an ideal environment for nursing home residents might look like and what's going to help them thrive and be resilient?

Diana: I'll try to wear both hats when I answer that or talk about it. Sometimes it's hard to wear them both at the same time, but I really liked what Tom said about the continuum of care and I think when we explain the sort of spatial scales from an architectural perspective, because I'm not sure how many architects are listening versus clinicians versus engineers, I think [00:23:30] I guess analogy to medical care and healthcare is the idea of providing individual care at the level of physician and patient, but then also public health, which has really grown as a field and I think that's where we address healthcare of larger groups and bigger societies, and so we're sort of doing the same thing, I think, with our design and thinking about the individual resident in their room or in this home, but also how does the home fit into the greater context?

How do we think about the wellbeing of all the residents and their families and the staff, even that work there? So just a bit of an analogy to [00:24:00] public health, which I think might be important. Public health is very important when we think about the pandemic. The ideal environment, I think Des hit the nail on the head when he talked about the greenhouse model and sort of domestic scales. Those are very important to consider. Geriatric medicine, we talk about geriatric syndromes that people might experience. I think resiliency can diminish as we age and we become more frail in the sense that smaller stresses can send us [00:24:30] sort of over the edge of the cliff faster than if we were younger and had more resiliencies were built into our physiology, but in geriatric medicine, we talk a lot about the five M's.

So these are sort of a common way of sort of thinking about geriatric issues when we see patients, let's say in the clinic or in the nursing home, but we think about things like mobility. If they're using assisted devices, how can they get around? We think about fall prevention. We think about medications that they're on. We think about this idea of multi complexity. It's very common [00:25:00] that older adults have many different chronic illnesses going on at the same time and how do we balance that? We think of about another M, which is mind, and we think about mood, which is so important and we think about memory and problems with dementia as people age, and then we think about what matters most to people in terms of their goals of care, what they want to be doing with their time.

What's important towards the end of someone's life and I wonder, Des, when we think about design, we can think about these sort of five M's or these geriatric clinical syndromes and figure [00:25:30] out how the environment can foster and promote each one of them, and I think that it can and I think we probably even have some research in each of those areas that could help guide us in our designs, but I definitely agree that the way forward is to work clinicians and architects together and even expand it to think about those who are planning these sites and funding these sites and how can we all work together to develop these multidisciplinary solutions? I'm not sure we can work in silos anymore.

Paul: Okay. And then my last question for [00:26:00] today is the flip side on the ideal environment, and it's what are the obstacles? What do we need over a home to be able to achieve ideal built environments for nursing homes, and so let me do this. Let me start with Des and then to get the clinical perspective, and then Diana, I'm going to ask you to weigh in on that, and then Tom, give us the architectural follow up as well, but so Des, starting with you, what obstacles [00:26:30] do we need to overcome?

Des: Yeah, I think the first obstacle is probably an attitudinal educational one. I was quite shocked in the mid to 2010's on the sites where we were working, a nursing home was designed without asking specialist dermatological nurses or the specialist geriatricians what their inputs would be. The rooms are fine, but it's very institutional and so I think [00:27:00] there needs to be developing an awareness that this actually makes a difference. It makes a difference to the residents. It makes a difference very likely to healthcare costs. It very likely improves resilience. Good design almost certainly will equate with better infection control. So I do think that it's around education and awareness. I think there's quite a significant amount of private chains involved so I think around [00:27:30] trying to reach in to commissioners, both state commissioners and also effectively, those who are commissioning from the private sector.

Teasing out exemplars, I think is very useful. For example, one of the things we did with the hospitals is we created a digital book of exemplars. So if people saw, I think there's a lot to be said for a templates models and I think Diana's, there's a bit of work back [00:28:00] to us still and I think Diana's point is very nice about the five M's. We need to provide hooks. Those of us who are embedded in this, we almost take for granted what we're saying, but I think there needs to be a sense of a realism, a pragmatism, this will meet this end. This will meet this end to a certain extent. So education, awareness, and teasing out who are the key stakeholders who are going to make [00:28:30] a difference.

Paul: Okay. And then Diana, same question for you. What obstacles do you see that we need to achieve, or what are the obstacles that need to be overcome to achieve an ideal built environment for nursing homes?

Diana: Yeah, I think there's a few, Paul. I certainly think a culture change is needed and probably a culture change with respect to ageism and how we view the importance of older adults and their contribution to our societies and how we integrate them into our urban fabric with respect to the buildings. That's a [00:29:00] big change and it differs

country to country, but I do think that's probably needed here in North America. I think I'm a big supporter of evidence based design and thinking about how can we quantify the impacts of the built environment and once you do that, you could even put it in the context of financial incentives or returns on investment because there are financial concerns, I think that have been brought up with changing the way we build some of these centers.

But I do think the research is showing us that if we [00:29:30] do it right at the beginning and if we use good evidence based design principles, we can not only achieve better health outcomes, better quality of life, but also potentially even cost benefits, which I think is important to some groups in thinking about this problem. So I would like to see more research in this area and that has to come from, I think, a collaboration from both medicine and architecture and the financial community and the leadership. It can't just be one of those, but it'll be important because we know the environment can influence behavior [00:30:00] in many ways and outcomes, but just like in medicine, we base our treatment decisions and our medication decisions on good research. I think we're tending to do that more and more in architecture and design and we're going to need more research going forward.

Paul: Okay. And then Tom, your perspective on the obstacles that need to be overcome.

Tom: Yeah. I think the guys hit on a lot of them there. It's funny, the first thing that springs to mind for me and both of my colleagues mentioned it is actually [00:30:30] ageism in the design profession. I think it's hard to generate a real interest among a lot of architects in this area. I mean, designing nursing homes isn't seen as a sexy thing to do, and we know when you're an architect and you want to win awards and stuff, it's the kind of glossy magazines and the big architecture awards and stuff that are important, and that's like museums and cool stuff. So it's not actually seen as that and that's a bit of a problem and because it's an [00:31:00] incredibly fascinating and challenging area to work with.

So I think there's a big bit around education and professional training and so on that we need to start dealing with, and as we've all talked about here, bringing together these professions to learn from each other. There's an incredible low bar, I think. The culture, the accepted norms around care home and long term care design is incredible, the poor standards that are accepted. We see the innovation around housing. We see the innovation around hotels and restaurants [00:31:30] and offices now, but there's very little of that in long term care. It's these very stayed and stilted models. So there's an intransigence almost of existing models. They're really hard to break cope and move along. So I think that's a major thing. Then from the point of view of planning and building control and building standards and so on.

I mean, that's really important. We've looked at over the last couple of decades, the distance that [00:32:00] accessibility and design for disability, how far that's moved. I mean, that was a niche thing just a couple of years ago, whereas now, nearly all planning systems and building standards and building control and so on have it built in, and they have a good understanding, even a planner that's looking at any kind of a development now understands about wheelchair access and so on. What we find, and

certainly is the case in Ireland and I argue it's probably the same all over the world, you have planning [00:32:30] applications being made to local authorities without, and they have really no filter. They have really no training to understand what's good or what's bad.

And then so it gets planning permission, and that, from a developer's point of view or a client's point of view, that is locked down. You're really not going to change that design and what happens then is people get brought in, geriatricians like Des get asked what would you advise us, and it's the horse is running down the field at that stage. [00:33:00] So it's way too late. So we need a proper level of awareness and understanding and training at a planning level that when they receive these applications and they look at the designs, they go, well, no, this isn't right. This isn't working. So that's a major thing. So look, there's a lot of things, but there's certainly some major obstacles in terms of good, helpful nursing home design.

Paul: So it sounds like some of it is changing the incentive model for like say architects so that it's, like you were saying with the awards and things [00:33:30] like that, so it becomes a little more attractive to really put their thought into what makes for good design, and also maybe perhaps at the municipal level or the planning stage level, having a physician on staff or somebody who can actually consult, so when these applications come in, then it's like, well, let's have Dr. Smith take a look at it before we approve this and that sort of thing. Des, [00:34:00] I think you might have had a comment that you wanted to-

Des: Yeah, I suppose it's interesting. I'm fully with Diana on going evidence based as much as possible, but we also have, I suppose, a key issue now and I think the other element of this is actually curation and I think if you take a thought leader or very influential group like Jacobs, there's an issue of putting something out into a spotlight of bringing people into a new culture. Hans Ulrich Obrist [00:34:30] has written this wonderful thing, ways of curating. So I think there is a really interesting opportunity to look at how we can curate this artfully.

And in a sense, I have some faith that nobody went out and did evidence based stuff for making hotels nice. Nobody did evidence based stuff really to make restaurants nice and attractive. So I think the evidence is fantastic if you have it, but it's a [00:35:00] complex area to... It's very difficult to see how you could do randomized control trials and there's also this challenge that if you get a well designed nursing home, back to Richard Fleming, it's very likely that arose from a well designed culture of care, so disentangling. So I think smart curation and promotion of the rewards is we need a little bit of genius around curation.

Paul: No, I think that's very well said and you're right. [00:35:30] I guess as an average citizen, I don't think about it. You think somebody makes it restaurant or a public building, they're trying to create it aesthetically pleasing, but they're also creating it typically for younger people or people who are not an elder care facility constituency, which is going to have its own special medical needs on top of trying to just make the building look nice or function or whatnot.

Tom: [00:36:00] Could I just, one thing there that strikes me, and it's one of the areas that as a team here, Diana and Des and Sean, and that we'd be looking at is the overlap or reinforcing that goes on between quality life and care homes, resilience, and infection control. These aren't mutually exclusive things and this is a really important point I think that a lot of the really good models we're looking at that Des mentioned, the Eden alternative [00:36:30] and the greenhouse model and so on, they're always rated as really high quality environments. They fit into the community.

They have all of the things we're talking about, and yet they've had really good record in terms of infection evidence. So it's not like by doing one thing, you compromise another. In fact, there's a sweet spot here that really needs to be investigated and when you reinforce one thing, you're reinforcing the other. So we know looking at the evidence, as Diana says there, that we know that when we start focusing on quality of life, [00:37:00] resilience, and pandemic preparedness, these things actually converge rather than diverge. So that's a really exciting opportunity.

Paul: Excellent. And then Diana, so just as we're closing today's discussion around elder care, I just wanted to turn it over to you, if you had some closing thoughts that you around this topic and where we can go from here.

Diana: Yeah. I think Tom just said it best just before. They're not mutually exclusive and I think part of the driver for us to get together and write about [00:37:30] this is I think at least for me, I'm very concerned with what I'm seeing around COVID and nursing homes and long term care. I see a reactionary approach, saying let's change the design, let's have negative pressure rooms, let's close all the doors. Certainly, if you lock someone in a room, they're not going to get an infection, and so there's I think a very reactionary approach going on. How do we change it going forward? I think this is a mistake and I don't think infection control can drive our care model or our design model for [00:38:00] these types of facilities going forward. That would have a huge impact in a negative sense.

So I think I agree with Tom and Des, this idea of resiliency and always keeping in mind quality of life, which you're right, probably isn't quantified in some of the evidence based design. So I think evidence alongside just what we know to be good design, quality of life in general, and listening to people who are living in these facilities. That's extremely important, living and working there because I think that the staff who [00:38:30] work there are equally as important, but they need to have a voice in this and we're all going to get... Well, many of us will get to that stage and thinking about where we would like to be is very important, but we have to be very proactive and we can't let COVID shift our thinking to just design for infection control. We have to design for resiliency in general.

Paul: No, and I think that's a great thing to keep in mind because it's not a matter of living in a bubble. It's the difference between surviving and living. I think [00:39:00] we all aspire to live long, healthy lives and when we're at the end of our lives, we want to be happy, and like Des said earlier, it's a mindset thing. So nobody's going to be happy if they're in an infection control over a room and that's their environment. They want to actually

live. We were designed, we were created to live. So Diana, Tom, Des, thank you all so much. Very fascinating conversation and be really interesting to see how [00:39:30] we shift elder care facility design and built environments as of move forward, hopefully getting this pandemic behind us. So thank you so much for your time and energy today. Appreciate it.

Des: Thank you, Paul.

Tom: Our pleasure. Thank you.