
Chapter 2 Literature Review



Although there is a paucity of empirical research that addresses the impact of the physical environment on older persons with dementia, a growing body of literature suggests that the environment has great therapeutic potential (Calkins 1988; Cohen and Day, 1993; Cohen and Weisman, 1991; Coons, 1991). Various recommendations ranging from overall unit layout and access to outdoor spaces to individual features such as orientation cues are provided to help make the environment an active part of a therapeutic program. More specifically, Mathew and Sloane (1991) studied several environmental factors, derived with the assistance of experts in long-term care, that are thought to impact the care of residents with dementia. They found that a kitchen that is available for resident use is a supportive environmental feature. The following chapter discusses the various ways in which therapeutic kitchens can be supportive and identifies design features and patterns of use associated with kitchens.

The Importance of Therapeutic Kitchens

A number of investigators have identified numerous reasons why therapeutic kitchens, also referred to as "country kitchens," "domestic kitchens," or "activity-based kitchens," are supportive spaces in both nursing homes and assisted living facilities. Some have stressed that a therapeutic kitchen, through its physical design, can provide a familiar setting with a homelike image and atmosphere (Calkins, 1988; Cohen and Weisman, 1991; Judd, Marshall, and Phippen, 1998). Some have also indicated that a therapeutic kitchen can function as a social area if tables and islands are available or can replace the traditional nurses' station and provide an informal surveillance point (Cohen and Day, 1993; Cohen and Weisman, 1991).

Others have addressed the benefits of activities that are associated with therapeutic kitchens. For instance, familiar household tasks such as washing dishes or setting tables can contribute to feelings of pride and instill a sense of usefulness through positive outcomes or the creation of something worthwhile (Cohen and Weisman, 1991; Zgola, 1987). This is particularly possible with household activities that consist of simple, limited, repetitive tasks and draw upon over-learned patterns that residents have retained. Familiar household tasks can also reinforce previous roles and engage residents in normal, day-to-day activities. Certain activities such as cooking can stimulate the senses through color, aroma, and touch (Berenbaum, 1994). Food-related tasks, such as chopping or stirring, can have health benefits if the tasks improve or maintain muscle strength, range of motion, gross hand coordination, concentration, and attention (Bowlby, 1993). (See Figure 1). According to Robin Orr, a kitchen that patients, staff, and family members can use in a healthcare setting can enhance desired clinical outcomes if patients are encouraged to get out of bed and ambulate to access nutritional foods. In this sense, a kitchen can be part of the healing process (cited in Ruga, 1997).

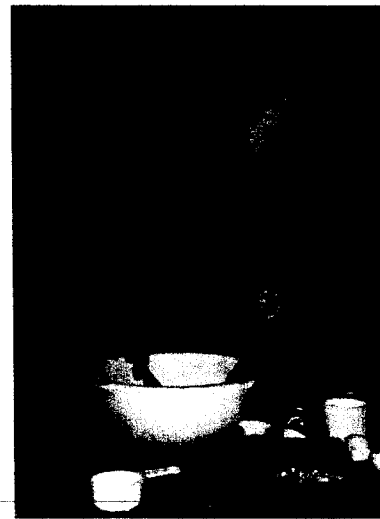


Figure 1. Familiar household tasks may help improve or maintain gross hand coordination.

Design Components of Therapeutic Kitchens

Although there is general consensus that a shared kitchen has therapeutic potential for residents with dementia, there are few references in the literature to design features that constitute a therapeutic kitchen. As a result, the kitchens that are present in nursing homes and assisted living facilities are comprised of various arrangements and equipment. For example, they may be located on or off of a unit, may be a separate room or part of a dining room or activities room, and may include appliances ranging from as little as a sink and microwave to a full residential kitchen with refrigerator, oven, and dishwasher.

A number of investigators who have addressed the design of therapeutic kitchens for residents with dementia have primarily focused on safety and universal design features (Brawley, 1997; Calkins, 1988; Cohen and Weisman, 1991). They have recommended storing dangerous equipment such as food processors and blenders, utensils, cleaning agents, and nursing station items including paperwork and medications in locked cabinets. They have suggested restricting access to appliances that are potentially hazardous through timers and inaccessible power switches so that the kitchen can remain accessible to residents when staff are not present. They have also suggested lowering wall mounted upper cabinets several inches, minimizing under-counter cabinets, providing shelving with a shallow depth, lowering counters two to three inches below standard height, providing rounded corners for counters, providing sinks without fronts for easier wheelchair access, incorporating high lighting levels, and providing non-slip flooring. They have indicated that there is a need for work space as well and that can be accomplished with small tables near the counters.

Some investigators have focused on the kitchen's relationship to other spaces in a facility. Judd, Marshall and Phippen (1998) have indicated that in Australia it is typical for the kitchen area to be separated from a dining area by a counter that is at a standard height on the kitchen side and at a low table height on the dining side. This permits residents to sit in the dining area and socialize or watch those working in the kitchen. In one of the earliest references to a shared kitchen, Valins (1988) indicated that the travel distance between resident units and the kitchen should be kept to a minimum, a kitchen size of approximately 107 square feet should be used for a group of 10 residents, and the secondary dining and sitting areas should be clustered round the kitchen. Other design features have addressed finishes to reinforce homelike imagery. Cohen and Day (1993) have asserted that tile, wood, and bright carpeting can be used instead of stainless steel and other glossy, institutional surfaces.

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Patterns of Use in Therapeutic Kitchens

In addition to the various arrangements of therapeutic

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kitchens, these spaces are used to varying degrees to support the daily program for residents with dementia in nursing homes and assisted living facilities. In some settings, for example, a therapeutic kitchen may be used for structured activity programming with staff present to supervise. Activities may include weekly cookie baking or cake decorating, daily household chores such as sweeping, dusting, and drying dishes, weekly arts and crafts, and morning coffee hour with a discussion of major headline news. Alternatively, the therapeutic kitchen may be used primarily as a marketing tool to present a homelike image to family members and may not be used for activities programming.

In other facilities, the therapeutic kitchen may be incorporated more holistically with the meal service. Residents may be encouraged to participate in meal preparation activities such as cleaning or chopping vegetables, stirring soup or grating cheese if meals are actually cooked in the therapeutic kitchen. If meals are prepared in a central, commercial kitchen, a microwave and refrigerator in the therapeutic kitchen may still be used to prepare substitute foods quickly, to reheat food, or to provide extra food (Hellen, 1992). Regardless of where the meals are prepared, residents may also help with setting tables and can assist with clean-up by clearing and wiping the tables, putting items away, and washing and drying dishes. (See Figure 2). In addition, the therapeutic kitchen can be used for beverages and snacks which residents can access when desired, saving staff the time involved in distributing these items to individual units (Cohen and Weisman, 1991). Alternatively, food may be cooked in the commercial kitchen, transported to the therapeutic kitchen, and served on multicourse trays, depriving residents of the cooking aromas and other familiar routines associated with past eating and household experiences (Bowly, 1993).



Figure 2. Residents may help staff with meal clean-up by washing and drying dishes.