

Chapter 6 Implications



Analyses of the case studies and the mailed-out questionnaires have provided a greater understanding of the physical features that typically comprise therapeutic kitchens and the ways in which kitchens are used to support the daily program for residents with dementia. The study was exploratory in nature without intentions of drawing definitive conclusions from causal relationships. In addition, the sample size was relatively low. The identification of kitchens as residential or institutional by the respondents was a subjective, self-selected process, but contributed to the analysis by providing another layer of interpretation. Despite these limitations, the results have direct implications for design, activities programming and food service and can serve as a foundation for future research.

Design Suggestions

Several design suggestions are discussed in this section with respect to universal design principles, common physical features, residential or homelike imagery, and safety.

Universal Design

Based on the analyses, it appears that universal design features should be incorporated to a greater extent within therapeutic kitchens. When asked about specific physical features in the kitchen, standard height counters were checked by 77% of the respondents while only 8% indicated that low counters were present. In the open-ended responses, accessibility was noted as the best feature of the respondents' therapeutic kitchens. Respondents often commented that it is important to include counter areas that are wheelchair accessible and cabinets that are low enough to be reached by residents in and out of wheelchairs. Significantly, kitchen inaccessibility was also noted as an undesirable feature, and respondents often suggested a larger space to facilitate wheelchair maneuverability in the kitchen as well as accessible counters and cabinets to improve their therapeutic kitchens. (See Figure 15).

Universal design in therapeutic kitchens for residents with dementia has been addressed in the literature. Specifically, Calkins (1988) indicated that counters should be 2-3 inches below standard height, not just for wheelchair users, but also for older women who tend to be shorter and to stoop more than the able-bodied, six-foot person for whom standard height counters were set. Cohen and Weisman (1991) suggested minimizing shelving units over and under work areas such as counters to minimize bending and potential accidents that are more likely to happen if residents are reaching for items overhead. Instead, they recommended shallow shelving units between 1'-11" and 3'-8" high for residents in wheelchairs and units between 1'-11" and 4'-7" high for those out of wheelchairs.

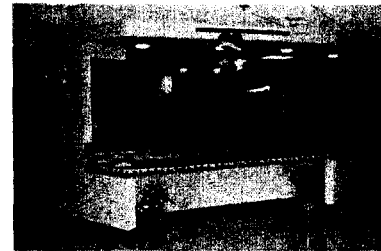


Figure 15. Based on the analyses, it appears that universal design features, such as this low counter, should be incorporated to a greater extent within therapeutic kitchens.

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Many of the other universal design features that have been documented in the housing literature (e.g. sinks and cooktops without fronts for easier wheelchair access, side-by-side refrigerator doors, counters at varying heights to accommodate workers who are standing and seated, and a five-foot turning radius to facilitate wheelchair accessibility) should be incorporated in therapeutic kitchens for residents with dementia. It is unclear why designers are not incorporating universal design principles in these spaces, despite the fact that the topic has received widespread attention in recent years with respect to the elderly and the disabled.

Common Physical Features

Based on items that were checked by the respondents, the most common appliances that are used in therapeutic kitchens include sinks, full refrigerators, ovens, cooktops, and microwaves. Other appliances such as coffeemakers and toasters were present to a lesser degree in the facilities, but were more prevalent in assisted living kitchens. Appliances that were not particularly common included mini refrigerators, dishwashers, washers, and dryers. Respondents indicated in their open-ended responses, however, that some of the less common appliances, such as dishwashers and bread machines, should be incorporated to improve kitchen designs. Standard appliances that one would normally have in a home were also noted as desirable features. This may be because these features are not only familiar and reminiscent of home, they help to facilitate activities programming. If the therapeutic kitchen is also used to prepare and cook meals for the residents (to be discussed in a later section), a full service kitchen with all of these appliances would be necessary to minimize the transportation of food and clean/dirty dishes back and forth from the commercial kitchen to the therapeutic kitchen.

Other common features included windows with views to the outdoors (particularly in the kitchens of facilities that were identified as residential), and a counter against one wall or an L-shape configuration. Respondents also indicated, in their open-ended responses, that long counters or islands which provide sufficient space to work at or sit around and socialize, as well as cabinets with adequate storage space, are desirable features.

Residential/Homelike Imagery

The majority of respondents described their kitchens as residential. In the open-ended responses, respondents also indicated that a homelike appearance is a "best" feature or one that would help to improve kitchen designs. Certain features were associated with that image type based on items that were checked by the respondents. These included a full refrigerator, sink, cooktop, oven, microwave, toaster, bread machine, kitchen table, some locked cabinets and drawers, and windows. Although these features can be

incorporated in kitchens, respondents identified specific features that contribute to a residential imagery. These included the decor (window dressings such as curtains, wall paper, bright colors) wood cabinetry and furnishings (particularly a wood table), greenery (plants and live flowers), countertops, knickknacks (dish towels, aprons, potholders, pictures, crafts), and a window with views to the outdoors. These are features that should be incorporated by designers as well, since a homelike image appears to be important in therapeutic kitchen design.

Features including curtains, wall paper, wood cabinetry, plants, live flowers, knickknacks, and windows with views to the outdoors should be incorporated in therapeutic kitchens to reinforce homelike imagery.

Safety

Some sort of protective device for a stove, oven or cooktop was mentioned by a large number of respondents as a safety feature in therapeutic kitchens. These included an inaccessible or hidden switch, circuit breaker, automatic shut-off, and knobs that could be removed from stoves. Brawley (1997) recommended induction cooktops, manufactured by General Electric, as a safety feature. These cooktops do not have an exposed coil, open flame or heated surface. According to Brawley, a high frequency induction coil beneath the cooktop heats the cookware by magnetic friction without heating the cooktop surface. When the cookware is removed, the cooktop automatically shuts off. Depending on budgetary constraints, the induction cooktop may be worth considering.

Locked cabinets or drawers for the storage of chemicals, medications, and certain utensils were also mentioned as safety features in therapeutic kitchens. Since the security of certain items is a concern when caring for residents with dementia, staff might consider locking only one or two cabinets. This way the rest of the kitchen can remain accessible to residents. Another option might be to place dangerous supplies in cabinets that are difficult for residents to reach.

Instead of locking all cabinets, potentially dangerous supplies could be stored in cabinets that are difficult for residents to reach.

Restricting access to the kitchen through gates, locked doors, or closer staff supervision was also noted by the respondents. During one of the site visits (Facility A), it was apparent that the kitchen can be closed off with a half height door when staff are cleaning the area. The door is made of the same material and color as the counter and blends in with the kitchen decor. If facilities feel that access should be restricted at times, perhaps a half height door or gate-like extension of the counter can be used at the end of the kitchen counters. (Respondents were asked to note which safety features are used in their kitchens, but they were not asked to indicate whether these features are desirable. Thus, it is uncertain whether restricted access should be recommended at all). In addition, a number of staff at two of the facilities that were visited (Facility B and Facility D) indicated that accessing the kitchen from two sides (a counter against one wall with an island separating the kitchen from a dining area and access between the two counters) is preferable. In this case, a half height door may be appropriate at both ends of the kitchen.

Activities Programming

Results suggest that different types of activities for therapeutic kitchens may be more appropriate than others for residents. In addition, confusion surrounding the definition of therapeutic kitchens and varying importance ratings suggest that staff education regarding the value of kitchens is also advisable.

Types of Activities

Common activities that occurred in the surveyed kitchens included baking, arts and crafts, socializing and sitting, meal set-up, and meal clean-up. However, a higher number of residents are involved in more recreational activities such as socializing and sitting, arts and crafts, baking, holiday dinners, and ethnic meals. A rather low number participate, on average, in household activities such as meal set-up, meal clean-up, and housekeeping. It is not surprising to find that more residents participate in "fun," group activities than mundane household chores. Although meal set-up and clean-up may be particularly beneficial for some residents with dementia (those who wish to continue to participate in domestic activities and to remain helpful or those who believe they must get dinner ready for their children or a spouse), the findings suggest that household chores may be a less successful aspect of the therapeutic program. (See Figure 16). There is also some indication that residents like to be waited on (as suggested by the results pertaining to access to snacks and beverages). Some residents may prefer a hospitality model of care in that they have aspired to be waited on while others may believe they are entitled to this service because they are paying for it. Thus, activity coordinators might consider incorporating other recreational, familiar activities besides baking and arts and crafts in the kitchen. These might include a morning coffee hour, newspaper reading and current events discussion, ice cream social, and flower arranging. It is important for staff to obtain this type of information when collecting social histories of residents in order to develop activities that are consistent with the interests and past activities of their residents.

Staff Education

Of the 45 surveys returned from facilities that were contacted by telephone ahead of time in order to determine whether therapeutic kitchens were present, 12 respondents indicated that they did not have kitchens when filling out the questionnaires. Although the terminology that was used over the telephone with the receptionists (or whomever answered the telephone) was also used in the cover letters accompanying the mailed-out questionnaires, it appears that there was some confusion over the definition of the kitchen. This clearly suggests that there is a need for staff education regarding what a therapeutic kitchen is and how it can be



Figure 16. More residents appear to participate in "fun" group activities than household chores.

used.

In addition, importance ratings for the kitchen for residents, staff, and families, as reported by the respondents, were highest for facilities with residents in the early stages of the disease and lowest for facilities with late stage dementia residents. This suggests that as residents become less functional, it becomes more difficult to make the kitchen an active part of the therapeutic program and to realize its value. Thus, it is important to keep staff educated about the value of therapeutic kitchens and to encourage their commitment to the program through education. The fact that importance levels decreased less for families in facilities with later stage dementia residents suggests that the kitchen remains important as a marketing tool and a familiar feature, even if the space can not be actively used by residents. In this sense, staff may need to be educated not only about ways to use the kitchen effectively depending on the cognitive status of residents, but also about how to present the kitchen to families.

Food Service Suggestions

As reported in the results, there is some indication that the level of importance of kitchens for residents, staff, and families is higher in facilities that prepare and cook one or more meals in the therapeutic kitchen. A low number of cases (five respondents indicated that at least one meal is cooked in the therapeutic kitchen) makes it difficult to draw definitive conclusions. However, during a site visit (Facility C), it appeared that cooking a meal in the therapeutic kitchen helped to make the kitchen a more integral part of the program. For example, aromas filled the space, some residents helped to season the food, food was plated in the kitchen, and staff were able to monitor residents at the same time. In general, it appeared that the kitchen was the center of activity, creating a truly homelike feeling. Cooking meals in a therapeutic kitchen may be a foreign concept to many, but it may be worth considering. If the therapeutic kitchen is integral to the food service, there will be less of a need for institutional carts and trays that were used to a great extent in the facilities surveyed. In addition, it may also make more sense to provide a large, eat-in kitchen or to have the kitchen adjacent to a dining area.

Cooking meals in a therapeutic kitchen may help to make the kitchen more integral to the meal service and the facility's program.

Future Research Directions

The study identified physical features that are typically included in therapeutic kitchen design and explored how those features support daily use for residents and staff in relation to food service systems and activities programming. The descriptive results serve as a foundation for additional research. In the future, it would be advantageous to examine correlations between physical features identified in this research and quality of life outcomes. For example, how do therapeutic kitchen activities impact the health and attitude of residents? What is the effect on staff? Is there a

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benefit when families are more involved in kitchen activities?

It would also be beneficial to study satisfaction more directly. In this work, satisfaction was indirectly examined by asking respondents to document the best and worst features of their kitchen design and to provide suggestions for improving the design. A set of features were compiled based on responses. Effects of the recommended features on satisfaction and quality of life measures could be examined. In addition, it may be worth including the perspective of family members, as opposed to asking staff to report what they believe family members value.

Despite the exploratory nature of the research, the results have provided an enriched understanding of a constellation of features that support levels of use in therapeutic kitchens and contribute to the perceived importance of the space. The design suggestions and recommendations for activities programming and food service will ideally help to educate staff and designers about ways in which therapeutic kitchens can be supportive spaces for residents with dementia.