

# Programme for the Good Hospice in Denmark

*An outline for the hospice as part of palliative care*

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*An outline for the hospice as part of palliative care*

*Prepared in 2005/2006 by SIGNAL architects for the Realdania Fund in collaboration with the steering group for the project:*

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# Preface

*Tove Videbaek, chairperson of the Hospice Forum Denmark*

Since **The Programme for the Good Hospice in Denmark** was published in February 2006, the development of the hospice situation in Denmark has advanced very rapidly.

Never before have so many hospices been built in Denmark during one year. Never before have so many hospice beds been made available in our country. Never before have so many hospice buildings been on the Danish drawing-board as there are now.

In Hospice Forum Denmark we are grateful for the new ‘hospice law’ of December 2004, and subsequently for the publication of **The programme for the Good Hospice in Denmark**. We appreciate very much the great work done by the steering group, the entire reference group, the leader of the project, the architects, and the Danish Realdania Fund, who initiated the project and made the publication possible.

Hospice Forum Denmark consider **The programme for the Good Hospice in Denmark** to be of such a high quality, so innovative and of such great value, that we have decided to translate it into English to make it available internationally. Thanks to donations from Lions Club Soeborg, Denmark (Member of The International Association of Lions Clubs), this translation and distribution has been made possible. Furthermore we owe thanks to the translator, Anne-Birgitte Mullins, and to the proof-reader, Dr. Jonathan Rout, Reading (UK), for their work.

Our intention with the English edition of **The programme for the Good Hospice in Denmark** is to inspire and create renewal in the area of establishing and renovating hospices around the world. We hope that this project may profit terminally ill and dying human beings and their carers all over the world.

The programme will be updated continually during the coming years to reflect the experiences we gain. You will always be able to find the latest English version of **The programme for the Good Hospice in Denmark** on the website of Hospice Forum Denmark ([www.hospiceforum.dk](http://www.hospiceforum.dk)).

Best wishes,

*Tove Videbaek  
January 2007*

# Original Preface to the Danish Version

*Anne Nissen, Chairperson of the steering group*

Taking leave of life requires the best conditions for the dying person as well as for the relatives. The hospice is exactly the philosophy and care which 're-thinks' values and framework for the end of life in our time.

The hospice has the patient and his/her relatives in focus. The thought behind the hospice places death on the agenda, - death which we are all going to experience, but which we prefer to deny, because it hurts having to let go of life and of the people we are close to.

When the debate about the hospice in Denmark began, it was said that the 'hospitals of death' did not fit into Danish mentality. But after the opening of Sankt Lukas Hospice in 1992, the first hospice in Denmark, this attitude changed. People experienced that death in a hospice was different from death in hospital. The focus is on care and closeness and also on palliative care and relief from other symptoms. The hospice became a popular issue. All over the country the population supported local hospice initiatives.

In December 2004 a new 'hospice law' was passed in Parliament. All counties are obliged to enter into a working agreement about 12 hospice beds with a local hospice initiative. This decision has pushed the development of the hospice in Denmark forward. It means that there is now a very definite focus on the conditions which we, as a society, can offer the terminally ill and dying human being.

A hospice accommodating 12 beds cannot meet the needs of all terminally ill patients, nor is it meant to. The needs of people differ facing death and dying. Therefore the hospice is intended as an integral part of the complete package available to the terminally ill and their relatives. The hospice cannot stand alone.

The hospice is an institution and a part of our hospital system, but with a different focus. Therefore the form should be different. Contents and form must interact in a new way to reach the goal, - quality in life, both for the dying and for the relatives.

Project *The Good Hospice in Denmark* is a wish to create renewal within the Danish building of institutions. A wish to create a synthesis of form, contents and needs, which supports the users of a hospice, from the human, professional, and architectural angle. In its capacity as initiator of the project, the Realdania Fund has attempted to break new ground.

In order to stretch our understanding of what a hospice is and to ensure a multi-professional quality in this understanding, we have held two workshops with a reference group with a particular mix of members. In the group there are, among

others, representatives for future hospice projects, hospice leaders, hospitals, doctors, nurses, architects, engineers, artists, priests and relatives.

In order to ensure the high ambitions and the professional quality of the project, this has been developed in close cooperation with the steering group of the project.

Big thanks to the members of the steering group for their competent and committed work. The work and the discussions of the group have been carried by the dedication, which characterises the hospice work. Also a word of gratitude to the entire reference group, which has contributed to the manifestation of the report in various workshops held during the development of the project. We would like to express particular gratitude to the 'Kamillianer Gaarden' Hospice in Aalborg and to the English hospices we have visited: The Hospice of Saint Francis, New Farleigh Hospice, The Princess Alice Hospice, Grove House and the organisation Help the Hospices in London. These organisations have joyfully shared their vast knowledge and experiences with us. And thank you, too, to the many people who have contributed to the contents of the report in other ways.

A special thank you to the leader of the project *The Good Hospice*, Patrik Mattias Gustavsson, SIGNAL architects, for his inspiring cooperation.

We are looking forward to implementing the programme *The Good Hospice* in a number of new hospices in Denmark. The programme will be updated continually in the coming years, in tandem with the experiences we gain. You will always be able to find the latest version on the Internet at the website of the Realdania Fund ([www.realdania.dk](http://www.realdania.dk)).

Enjoy reading!

Anne Nissen  
February 2006

# Resume

The shape of the physical framework has considerable influence on the quality of care perceived by patients, their relatives, employees and volunteers, who work and stay at a hospice.

This is the main conclusion in this report, which describes how *The Good Hospice in Denmark* could look and function, with the physical framework as a focal point.

The report highlights the potential within the intentional shaping of the physical framework so this works as an active element, contributing to an improved quality of life for the patients and their relatives at the end of life, while supporting the information intensive work performed by the employees at a hospice.

The goal with the project *The Good Hospice in Denmark* was to work out a programme, which could serve as inspiration for future hospice projects in different parts of the country, and as a tool in the planning of new hospices or in extending already existing ones.

The report is aimed at consultants, decision makers, architects, engineers, project leaders and steering groups for local hospice projects; it is intended as inspiration, as a manual and a checklist to ensure that sufficient thought has been given to the purpose, function and expression of the physical framework.

The programme for *The Good Hospice* highlights eight focal areas, which are essential to focus on in order to create optimal conditions for patients, relatives, volunteers and the employees at hospices in Denmark.

1. To 're- think' and professionalize the phase of creation so this, to a higher degree, involves the users early on in the process, gathers already existing information and ensures that the initial intentions are considered, right from the first phase of ideas through to the construction of the new hospice building.
2. To create a powerful culture where the particular hospice philosophy serves as a platform for palliative care at a hospice and contributes to creating the spirit, which forms the backdrop for a good stay for the users of a hospice.
3. To improve and develop inter-organisational and interdisciplinary cooperation, as this is a condition for patients and relatives to experience palliative care as a unified whole.
4. To re-think the patients' ward so this supports the differences, wishes and needs of individual patients.
5. To work with the hospice building as an agent for active support and promotion of the desired atmosphere, which adds to the creation of a better stay for patients, relatives, volunteers and employees at a hospice.
6. To allow the physical framework to facilitate social interaction between patients, relatives, volunteers and employees at a hospice, to a larger degree.

7. To utilise the volunteers to a higher degree, as these fill an important social function for patients and their relatives and build bridges between the surrounding local community and the hospice.
8. To improve the framework for the information intensive work processes so that the hospice building supports and promotes sharing of knowledge, exchange of experience and interdisciplinary cooperation, to an even larger degree.

The focal areas and the related recommendations are used as a foundation for a group of design principles, which offers a direction for the construction of the physical framework for *The Good Hospice*.

The principles are intended as tools for the programming/planning of a new hospice and deal with the functional demands, the mutual relations of the different parts and the varying types of ambience and expressions some of the central spaces should promote.

The programme is to be seen as a living and dynamic document, which will be updated and adjusted continually, in tandem with the gaining of new experiences in the field, in the coming years.



# Introduction

In the middle of 2005 the Realdania Fund initiated the project *The Good Hospice in Denmark* with the aim of gathering the experiences which have been gained within the hospice area in Denmark, while at the same time providing a forward looking estimate of how the hospice of the future could look. The programme for *The Good Hospice in Denmark* is aimed at consultants, decision makers, architects, engineers, project leaders and steering groups for local hospice projects, and it is intended to serve as inspiration, manual and checklist to ensure that sufficient thought has been given to the intention, function and expression of the physical framework in connection with planning and establishing new hospices.

In order to create a building which functions and works optimally, it is necessary to have a deeper understanding of the actual purpose of the building, the needs and wishes of the users of the building and the work processes which are to take place in it. This is the reason we have chosen to set out the programme in a slightly untraditional way.

The first part sets the stage for the actual 'space programme' and places the concept of the hospice in a historical and future context. We are here looking at the historical roots of hospices in order to glean knowledge of why we are exactly where we are today.

Here we also look into the future and consider the developing trends we think are important to consider when planning a new hospice. Furthermore, we look at the good examples we already have in Denmark and in the international society in order to estimate what we can learn from others. The entire first part concludes with a listing of the focal areas we consider relevant to focus on in order to create a good hospice in Denmark.

The second part of the programme goes into further details in the focal areas, and here we present our suggestions for the principles which are to form the foundation of the physical framework of *The Good Hospice*. The principles are intended to be tools in the programming and planning process of a new hospice, and address the functional demands, the mutual relations of the different parts and the ambience and expressions some of the central rooms in the hospice should facilitate. Finally we bring an example of a programming of the physical framework of *The Good Hospice*, where the above-mentioned principles are put into practice.

The programme has been developed on the basis of a large number of interviews with, and visits to, representatives of Danish and English hospices, conversations, interviews and workshops with relatives, architects, priests, nurses, doctors and other consultants and users of hospices, as well as studying relevant literature within this field.

The overriding aim with the programme is to create better stays for the terminally ill and their relatives during a difficult period and a well functioning workplace for the volunteers and the staff at hospices in the country.

Enjoy reading!

# Gathering of experiences

The purpose with this section is to create a frame of reference and to set the stage for the recommendations of the programme regarding the physical framework for *The Good Hospice*.

The section consists of three chapters:

A historic overview, where we describe how the concepts of the hospice and palliative care have emerged in recent years - in Denmark as well as internationally.

A review of some trends and development within the palliative field, which could become significant in the future development of palliative care and the hospice as well as a financial analysis of *The Good Hospice*.

Finally comes an account of examples of how others have chosen to work with the hospice, both in Denmark and internationally, and a resume of what we can learn from others in the planning and shaping process of a new hospice.

# I. A Historic Overview

The development of the hospice philosophy and palliative care are expressions of a holistic approach to care, which over and above the relief of the physical symptoms of the patient also deal with the psychological, social and existential/spiritual problems of the patient and the relatives. The aim is to improve the quality of life of the terminally ill, the dying and their relatives. The two concepts, the hospice and palliative care overlap each other, and therefore it is not uncommon that the hospice is used both as a description of a concrete, physical building, which provides the framework for caring of the terminally ill, while it is also perceived as a philosophy, describing the approach to caring.

The philosophy regarding special care for the dying has existed for more than a thousand years, in a cross section of cultures and countries. The philosophy as well as the concrete approach has been developing constantly all this time.

## Palliative Care

The development in society, and the advances in the medical and medicinal/ technological area are the reason that we have far more medical treatment methods for treating seriously ill patients at our disposal today than previously. Quite simply, we have become better at diagnosing and treating diseases, and today it is possible to heal more diseases than previously. Palliative care becomes relevant when a disease is diagnosed as terminal.

The purpose of palliative care is to alleviate symptoms and suffering linked to terminal diseases. It encompasses the entire interdisciplinary nursing, care and treatment offered to the terminally ill, the dying and their relatives.<sup>1</sup> The concept covers thus both a clinical approach, a psycho-social and an existential approach, which together aim at relieving physical symptoms or suffering of a psychological, social and existential/spiritual character.

Palliative care thus encompasses more than traditional pain relief and medication. It also focuses on the psychosocial and existential/spiritual needs of the patient and the relatives. For that reason the work is based on a high level of cross-professionalism and interaction between many different professional competences; doctors, nurses, psychologists, priests, physiotherapists, dieticians, social workers, music therapists etc. Great emphasis is placed on using the individual patient and his/her relatives and their particular situation and needs as a starting point rather than offering ready-made package solutions based on the terms of the system. Palliative care is care with the patient at the centre and it emphasises the involvement of the patient and the relatives when choosing the specific treatment methods, the actual nursing and care and other important decisions, which are significant in their situation.

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<sup>1</sup> Palliation i primærsektoren, Dansk Selskab for Almen Medicin, Asbjørn Ziebell et. al., 2004 p.8

When you talk about palliative care, it relates to the period when healing (curative) treatment gradually ceases until physical death occurs. Terminal care is care offered to the dying during the last days or weeks, and it thus only represents a partial period of palliative care. Previously, the description *terminal care* was considered synonymous with palliative care<sup>2</sup>, which, time wise, shortened the period where the patient benefited from palliation.

## A Historic overview of the Hospice

The word hospice can be traced back to the Middle Ages, where it referred to a place where travellers and the sick could find hostel and protection. The word hospice derives from the Latin word *hospitium*, which freely translated means “a resort for travellers”. The hospice of the present day can be defined as “a house offering care and quality of life for the terminally ill and the dying as well as their relatives.”

From the early 1800s the hospice was used by Madame Jeanne Garnier as a description for care for dying patients. In 1842 she founded the hospice ‘Dames de Calvaire’ in the south east of France, which was followed by a hospice for the dying in Lyon the following year. In Ireland the concept was introduced in 1879 at the opening of “Our Lady’s Hospice” in Dublin. Other historical institutions were ‘St. Luke’s Hospital’ in England, which opened in 1893 and ‘St. Joseph’s Hospice’ in Hackney, which opened in 1905.<sup>3</sup>

The nurse, socialworker and doctor Dame Cicely Saunders founded the modern hospice movement. She formulated and developed the hospice philosophy, which is now a description of the specialised care of the dying. In 1967 Cicely Saunders founded the first hospice in modern time – ‘St. Christopher’s Hospice’ in Sydenham, a suburb of London.

### *The Development of The Hospice and Palliative Care in other countries*

In England the hospice developed as a concept for separate units with beds for the care of dying patients. These units were primarily available for cancer patients with complex symptoms and psychosocial problems, which did not “fit into” the traditional healthcare system. The patients were typically in the terminal phase, with an expected lifetime of a few weeks.

Two problems quickly emerged in the work around the hospice. Firstly, there were many patients who wished to be taken care of and die at home. In order to meet those needs and supplement existing services, a kind of visiting hospice team was developed, which offered help as consultants and assisted the home care. Secondly, a need was identified to establish particular teams, which were to pass on their expertise gained from the experiences with the hospice to patients and relatives in other surroundings, for example hospitals.

In England most people link the hospice concept primarily with places in an institution and day beds. A few hospices have their running costs completely covered

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<sup>2</sup> Palliation in primaersectoren, Dansk Selskab for Almen Medicin, Asbjørn Ziebell et. al., 2004 p.9

<sup>3</sup> Hospice and Palliative Care - Facts and Figures 2005, Help the Hospices, p.2

by National Health Service (NHS), but by far the most depend on voluntary work and donation of up to 80 % of the total running costs in order to exist. One consequence of this is partly that you employ professional fundraisers, but also that the choice has been made to involve many more volunteers than we are used to in Denmark. A typical hospice engages between 500 and 800 volunteers. The volunteers are also far more involved in the daily work, and there are examples of volunteers who prepare the food, work as hairdressers, receptionists or carry out chiropody etc.

Today palliative care in England has become a common description for palliative care carried out in hospices, hospice day-centres, in patients' homes (or "in the home") and in specific hospital wards.<sup>4</sup>

In 2005 there were 253 hospices in England, with a total of 3,411 beds. Of these, 33 hospices with a total of 255 beds are reserved for children.<sup>5</sup> Recently specific day-centres have been developed, which partly function as relief for the relatives, but also as a social service for the patient - with the possibility of getting help with relief of symptoms. These day-centre functions can be integrated in the traditional hospice or be independent units with close cooperation with other hospices.

### *The Historic Development in the USA*

In the USA palliative care emerged as a service in the patients' own homes. The early hospice movement was established outside the traditional healthcare system. The development was organized in 1982, when a law was passed regarding the coverage of the expenses for hospice care and treatment in the home for participants in the national healthcare insurance programme, Medicare.

An attempt was made to imitate the English model with a combination of hospice beds and visiting teams with limited success. In the beginning Medicare did not see possibilities in the extension of the hospice service, which included particular wards for patients whose needs could not be met at home.

Due to the lack of knowledge and competence in palliation in the hospitals, palliative teams experienced that it was difficult to deliver good service to those patients who needed it in connection with hospitalisation. Consequently, an effort was made to develop specific beds dedicated to this particular group of patients. In January 2001 there were approx. 2,200 hospices in the USA. It is estimated that another 200 hospices run primarily by volunteers exist, over and above this.<sup>6</sup> The development thus started in the patients' own home and from there palliative services were developed to also include hospices with specific beds.

### *The Historic Development in Denmark*

In Denmark the hospice and palliative care were placed on the agenda in earnest in the 1990s. In 1996 accession was made to the aims of the WHO for palliative care, which were to be offered to all terminally ill and dying patients, regardless of whether they were in their own home, at hospital or at a hospice. The National

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<sup>4</sup> Centre to advance palliative care (CAPC), CAPC Manual, 64.85.16.230/educate/content/rationale/evolutionofhpc.html, last visit 09.01.06

<sup>5</sup> Help the Hospices, [www.helpthehospices.org](http://www.helpthehospices.org), last visit 09.01.06

<sup>6</sup> National Association for Home Care and Hospice, [www.nahc.org](http://www.nahc.org), last visit 09.01.06

Health Service recommended a unified organization of palliative care in counties and municipalities, so the care was available on a basic as well as on an expert level.<sup>7</sup>

The establishment of specific palliative expert teams was suggested with the purpose of assisting the dying, their relatives and professionals, when terminally ill and dying patients stayed at home or in hospitals. In 1999 the National Health Service worked out professional guidelines for palliative care in Denmark.<sup>8</sup>

At a basic level palliative care includes the relief work taking place in the common hospital wards and at home. At this level professionals must know the fundamental principles and attitudes of palliative care as part of their entire work area. Palliative care at expert level is aimed at patients with complex symptoms, which demand specialised and/or interdisciplinary care. This care is rendered at hospices or in palliative units/wards at hospitals, but also in the patients' own homes or in nursing homes via visiting palliative teams. The expert care is undertaken by an interdisciplinary group of professionals, who must know all aspects of palliative care and who work exclusively within the palliative area.

Sankt Lukas Hospice in Hellerup, which opened in 1992, is the oldest in the country and it was also here the first home hospice opened in 1997, consisting of a visiting specialist team with consulting functions within palliation, aimed at the terminally ill and dying patients and their relatives. This was considered a support for care in primary sector and under hospital management.

#### *Hospices in Denmark – an overview*

In December 2005 there were seven hospices available in Denmark: Sankt Lukas Hospice in Hellerup (1992), Sct. Maria Hospice Center in Vejle (1995), Diakonissestiftelsens Hospice in Frederiksberg (1997), KamillianerGaardens Hospice in Aalborg (1999), Hospice Soeholm in Aarhus (1999), Hospice Fyn in Odense (2004) and Arresoedal Hospice in Frederiksvaerk (2005). More hospices are underway in the remaining counties.

Furthermore, Bispebjerg Hospital has a palliative care unit with 12 beds, and other smaller palliative care units exist at other hospitals.

The actual hospice idea as well as palliative care is relatively new concepts in Denmark. As already mentioned these have only been developed as a professional area within the last 10-15 years. The National Health Service has pointed out that the existing information about the possibilities available within palliative care today is not sufficiently diffused among the healthcare staff, neither is it communicated to potential patients and relatives to the required degree<sup>9</sup> One of the challenges today is therefore to develop services of palliative care for patients, so they become equally available for all patients and relatives, regardless of their physical location in the country.

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<sup>7</sup> Wagner, Lis et.al. Palliativ indsats i Danmark. DSI rapport 1997

<sup>8</sup> Sundhedsstyrelsen. 1999. Faglige retningslinier for den palliative indsats.

<sup>9</sup> Sundhedsstyrelsen, Kraefitplan II, juni 2005, p.52

In the year 2003-2004 a collaborative initiative took place between *Kraeftens Bekaempelse* [The Danish Cancer Society], *Hospice Forum Danmark* [Hospice Forum Denmark], *Foreningen for Palliativ Indsats* [Association of Palliative Care] and *Dansk Selskab for Palliativ Medicin* [The Danish association of Palliative Medicine] with the aim of diffusing the hospice idea and ensuring more hospice services to patients, so admission to a hospice can become a real alternative to hospitalisation or staying at home. Another part of this initiative aims at coordinating and developing the quality of palliative care.

#### *Palliative teams*

A palliative team is an interdisciplinary group, consisting of doctors, nurses, physiotherapists, social workers, psychologists and priests, who have specialised knowledge about palliation.<sup>10</sup> The objective of a palliative team is to contribute expert assistance to patients and relatives in the home, who need palliative care, in collaboration with practising doctors and district nurses. The palliative team can also be of support with expert knowledge to patients in hospital wards or in other institutions.

Palliative teams have existed since 1997 and their names vary, according to the nature of their link and the people they are linked to ...: "Palliative team", "Home hospice", "Hospice without Walls", "Palliative external" and "Visiting Hospice team", but the main task remains the same. In almost all counties in Denmark there are palliative teams or they are in the process of being established.

A palliative team can be linked to a hospice, a palliative care unit or to a hospital, for example to anaesthesiology or oncology wards. The palliative team is available around the clock the whole week, at least being available by telephone for referrals or advice. The palliative team has primarily a supervising, supportive and coordinating function, but is also able to take care of specific tasks to ensure that it is possible for the patient to remain at home.

The palliative team has no beds at its disposal, but because more teams are closely linked to hospice or palliative units, possibilities exist to hospitalize the patient, for a while, in the particular palliative unit at hospital or in a hospice, with regard to alleviation of symptoms or relieving the relatives.

An example of a palliative team is *Palliative network – hospice without walls*, which is a 3-year collaborative project involving Odder Central Hospital, Odder Municipality, Skanderborg Municipality, and the practice sector as well as a group of volunteers.

Among other things, the objectives of the project were to make palliative services available via the establishment of an interdisciplinary organization, and to further the collaboration between municipalities, practicing doctors, hospitals and the volunteers with a view to ensuring varied palliative services of high professional standard to patients.

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<sup>10</sup> Faglige retningslinier for den palliative indsats - Omsorg for alvorligt syge og døende, Sundhedsstyrelsen 1999, p.105

The project has now been evaluated by the Center for Evaluation and Medical Technology Assessment of the National Health Care (Sundhedsstyrelsens CEMT), which concludes that a visiting palliative team is not an alternative to a hospice.<sup>11</sup>

*Hospices in Denmark - a statistic picture (2004)*<sup>12</sup>

- The average duration of admission for the individual patient in a hospice in Denmark was 25.4 days and nights.
- The average age for the admitted patients is 67.7 years, with a variance in age from 29 to 90 years.
- There were almost equal numbers of men and women, with a slight predominance of women (47.1 % men and 52.9 % women.).
- Approx. 95% of all patients was diagnosed with cancer.

*Legislation regarding hospices*

“Free choice of hospice” was established by law with effect from the 1<sup>st</sup> of July 2000, which in practical terms means that the use of hospices is to be free and that patients are able to choose themselves which hospice in the country they wish to use.

In December 2004 it was laid down by law that a hospice be available in each county.<sup>13</sup> The law ensures a minimum of 12 beds in each of the present 13 counties, with a dispensation for the Regional Municipality on Bornholm, due to the size of the population.

The corresponding legal notice no. 945 of the 9<sup>th</sup> October 2005 mentions conditions for the running agreement, which must be in place between the independent institution and the Council of the county (later the Region) as a prerequisite for establishing and running a hospice. In the years 2003 to 2006 particular “Hospice funds” were set aside in the Budget, which projects with a running costs agreement could apply to for financial support towards establishing and running hospices during the first 2 years.

The Ministry of Interior and the Ministry of Health stipulate explicit guidelines and criteria for application.

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<sup>11</sup> Poulsen PB, Kolbye A, Rajani N, Hornemann A: Hospice uden mure – medicinsk teknologivurdering af et palliativt netværk i samspil mellem sektorer, Medicinsk Teknologivurdering – puljeprosjekter 205, p.11

<sup>12</sup> Aarsberetninger og patientstatistik (2004) fra Set. Maria Hospice i Vejle, Hospice Soeholm i Aarhus, KamillianerGaardens Hospice i Aalborg, Diakonissestiftelsens Hospice paa Frederiksberg, Sankt Lukas Hospice og Hjemmehospice i Hellerup

<sup>13</sup> Concerning individual laws, departmental orders and guidelines refer to [www.ft.dk](http://www.ft.dk) and [www.im.dk](http://www.im.dk) law no 441 of the 9<sup>th</sup> of June 2004 and law no 1432 of the 22<sup>nd</sup> of December 2004



# Resume - a historic overview

## *National differences in palliative care*

The historical development within hospice and palliative care has not developed in a parallel way globally, and therefore considerable national differences and nuances exist. In England, Denmark and the USA the development has taken two different routes. In the USA palliative care started in the home and expanded later to also include hospices with specific beds. In both England and Denmark the development went from the establishment of particular hospice institutions to creating visiting consultant teams and in England also specific day-centres. There are indications that the subtle differences are gradually disappearing, so that the entire palliative care in these countries appear more similar. However, there is still some work to be done in Denmark to ensure equal availability of specialised palliative care for all patients – regardless of where they live in the country.

Even though recommendations and guidelines have been worked out concerning palliative care, there is still a long way to go to before this area is fully developed. The consequences are that patients in different parts of the country do not have the same access to palliative care, depending on whether they live in a big city, in the country, or in a county which has given a lower or higher priority to palliative care.

## *Palliative teams are a good supplement to palliative care units and hospices*

The experiments and experiences springing from the work within palliative teams (“home hospice”, “visiting teams”, “hospice without walls”) show that palliative teams *per se* are not an alternative to a hospice with beds, but a good supplement to this as well as to those patients who either prefer to remain at home or who have been unable to stay at a hospice, for other reasons.

## *Differences in perception of palliative care in Denmark*

The hospice idea in Denmark has grown into an actual popular hospice movement with the purpose of dissipating knowledge about the hospice philosophy and to engage more volunteers in the work at hospices. Palliation as an idea requires inter-disciplinary collaboration with many different professional groups involved (which may also have different agendas, at times); from time to time a certain confusion reigns regarding what a hospice actually is, for whom it exists and in which direction it is to develop in future.

The bottom line must be that the expansion and development of palliative care take place in a way which gives priority to the needs of the patients and their relatives, thus making a real service available to them – regardless of whether palliative care is based at home, in hospices, hospitals or in other institutions.

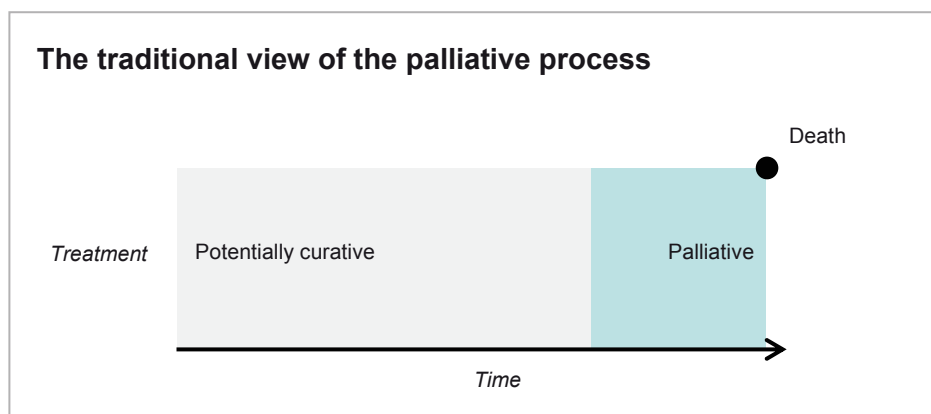
## II. The Hospice and the Future

The aim of this chapter is to highlight some trends, which can influence the future development of the hospice. Among these trends are wider perceptions of palliative care leading to having the care stretch over a longer period, to include patients suffering from diseases other than cancer who would also benefit from palliative care, changes in the demography in Denmark, new ways of using the hospice, general changes in the type of patient in future and some financial considerations which are important to keep in mind when planning a new hospice.

### The Traditional view of the Palliative Process

The first definition of palliative care as defined by WHO in 1990 was: “Palliative care is the total, active nursing of patients, whose diseases do not respond to curative treatment”. In a simplistic way you could say that as long as the patient had a potential to be cured, he or she remained in the medical treatment system, and only when cure was no longer possible “the door was opened” to the palliative services available. In other words, there was a fairly clear division between the two services available to patients.

With the initial definition of palliative care and a limited number of beds in hospices as a basis, the hospice in Denmark has in many cases become synonymous with a physical building containing a number of beds, where patients can stay particularly during their final weeks or days to end life in a dignified way. There are exceptions however: In some hospices the focus has been on temporary admissions that also emphasise palliative rehabilitation, respite care and relief of symptoms.



*Model 1 - The traditional view of the palliative course<sup>14</sup>*

<sup>14</sup> WHO, Better palliative care for older people, Elisabeth Davies & Irene J Higginson (red.), p.17

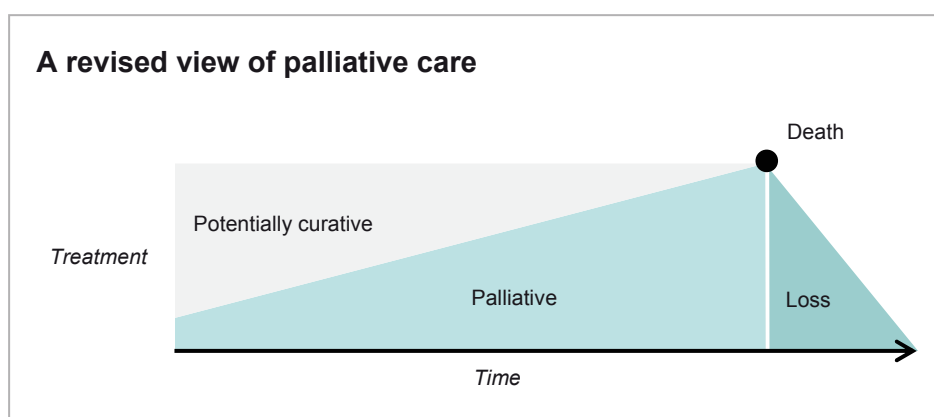
## A revised view of palliative care

In the latest revised definition of palliative care it is evident that palliative care has a far greater potential and time perspective (2002). WHO talks about “palliative care as a practice, which improves the quality of life for patients and their families, living with a life threatening disease. Care consists of preventing and relieving suffering through early diagnosis and clear evaluation of the disease as well as treatment of pain and other problems of a physical, psychosocial and spiritual character.”<sup>15</sup>

The revised definition of WHO means particularly that the sharp transition from curative treatment to palliative care becomes more blurred, because palliative care also should be considered in the phase where it is still possible to prolong life. Broadly speaking, the new definition indicates a development, where the focus moves from concentrating on palliative care to the patient and the relatives in the terminal phase with priority on giving the patient a dignified death, to now ensuring as good a quality of life as possible for the terminally ill patient and the relatives - regardless of how far the patient has progressed in the course of the disease.

### *The boundaries become less rigid...*

In the report *Better Palliative Care for Older People* WHO suggests a new view of palliative care, where the treatment works in tandem with a potentially curative treatment (see model 2). The model builds on the new definition of palliative treatment and the boundaries are thus becoming less rigid regarding which type of treatment patients should be offered. This will influence the type of services available at hospices, as the time frame that care is possible will now be extended. The report states even more clearly what is also implied in the objectives of WHO from 1990 that the services of palliative care continue after the death of the patient so that support for the relatives after the loss is included.



*Model 2 – A revised view of palliative care*<sup>16</sup>

<sup>15</sup> WHO, WHO definition of palliative care, [www.who.int/cancer/palliative/definition/en/](http://www.who.int/cancer/palliative/definition/en/), last visit 090106

<sup>16</sup> WHO, *Better palliative care for older people*, Elisabeth Davies & Irene J Higginson (red.), p.18

### *New Groups of Patients will benefit from palliative care*

Apart from palliative care extended over a longer period of time there are indications that the patient base will become wider. By far the most patients admitted to hospices today have been diagnosed with cancer<sup>17</sup>, and in Denmark the hospice is traditionally perceived to be a service primarily to cancer patients. Subsequently it has become a general perception that palliative care is primarily offered to terminally ill cancer patients.<sup>18</sup> The “over representation” of cancer patients in hospices can have several causes, among others that the course of their disease often contains a very complex set of symptoms with considerable requirements for relief. However, it may be easier to predict the course of cancer than that of other terminal diseases.

In the report *Better Palliative Care for Older People* WHO also suggests a revised view of the groups of patients who can benefit from palliative care. Recent developments indicate that an expansion of the group of patients could include patients with chronic pain (degenerative pain in the central nervous system, heart and lung conditions etc.); statistically, these groups are almost as large as those suffering from cancer, but at the present time they only represent 5-10 % of the total group of patients in the hospices.<sup>19</sup> In 2003 a conference on chronic diseases held at Bispebjerg Hospital (Copenhagen) concluded that this particular group of patients often does not have full access to care offered by the health authorities and one possible solution could be that extended palliative services become more available to patients suffering from severe chronic diseases.

### *Changes in the Composition of the Danish Population*

The number of older people in Denmark will continue to grow and in 2040 the number of older people will be 72% larger than it is today.<sup>20</sup> The prolonged lifetime will have an effect on the patterns of disease of the Danish population. We will see more people suffering from, and living for a longer time with, chronic illness linked to heart, lung, kidney and neurological conditions as well as cancer.<sup>21</sup> In other words, the potential to expand palliative care and make it more available to patients suffering from incurable, chronic diseases is vast.

### *What are the wishes of the patients and their relatives?*

Experience shows that the majority of severely ill patients wish to die at home or in homely surroundings, but the truth is that few have this wish fulfilled. Approx. 60,000 people die each year in Denmark, and of these about half end their lives at hospital, 25% die in a nursing home, hospice or sheltered housing, 4% somewhere else and only 22% die in their own home.<sup>22</sup> The reasons for this may be a lack in capacity of palliative teams in Denmark, but maybe also lack in knowledge and capacity of the health services to make palliative care in the home of the patients' possible.

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<sup>17</sup> In 2004 627 persons died at hospice. Data from the Sundhedsstyrelsen Kraeftplan II show that in 2004 627 persons died at hospice, of which the patient group suffering from cancer represented 95 %.

<sup>18</sup> WHO, *Better palliative care for older people*, Elisabeth Davies & Irene J Higginson (editor), p.17

<sup>19</sup> The National Health Service, Register for causes of Death (numbers from 2001): 15.451 deaths were registered caused by cancer, 13.850 persons died from heart diseases, and 5.339 persons died from diseases of the respiratory organs.

<sup>20</sup> Nyt fra Danmarks Statistik, nr. 224, 21st of May 2001, Populations prognoses 2001-2040

<sup>21</sup> WHO, *Better palliative care for older people*, Elisabeth Davies & Irene J Higginson(red.) p.11

<sup>22</sup> The National Health Service, Register for causes of Death, numbers for 2001. Of the 57.632 deaths in 2004, 49 % took place at hospital, 25% at a nursing home, hospice or sheltered housing, 22% in own home and 4 % somewhere else. Cancer patients comprised 26,8 %.

### *We live longer with Cancer*

Cancer patients live longer with incurable cancer today than previously, as life prolonging treatment with chemotherapy and radiation treatment has become more efficient. As a consequence this means that cancer patients need palliative/relieving care for a longer period than before.

### *The hospice day centre - a new service within palliative care*

The hospice day centre does not exist as a concept in Denmark yet, but this initiative is very widespread in England. It is a service to the terminally ill patient needing care and who would like to meet other patients in a similar situation.

Typically, the framework of the hospice day centre enables the patient to visit the facilities of the day centre once a week, with about 10 other people. The average stay varies, but typically there will be patients with a recent diagnosis of a terminal disease and with a life expectancy of one or more years mixing with patients who have got less time to go.

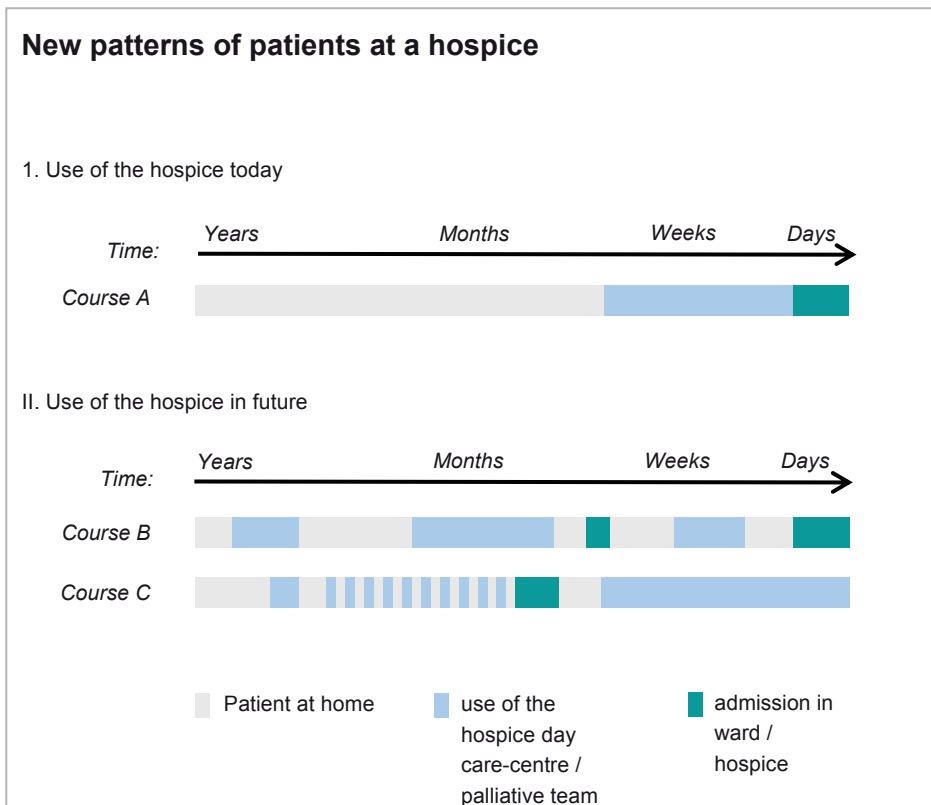
The hospice day centre fulfils a social as well as a medical/palliative function, where symptom control and consultation with a doctor or nurse are usually offered whenever the patient visits. The day centre deals with patients who would normally be too “healthy” or who are not interested in being admitted to a hospice; it provides a meaningful alternative facilitating the creation of social links between patients in a similar situation and it also relieves the relative at home.

Nor is it uncommon that the patient uses both the day centre and the home hospice department, so the two services overlap and supplement each other. The emphasis between the social and palliative services varies in different hospice day centres in England, but the tendency indicates that the service with an initial social character may now increasingly include a palliative/intervening element.

## New Ways of using hospices

A changed patient basis and wider palliative care over time will create new ways of using hospices. For one thing patients/relatives will be offered palliative care much earlier in the course of their disease than before, for another they will use the different services available to them at different times, to a larger degree.

A hospice day centre is just one possible solution. At the day centres existing in England you meet patients diagnosed with a terminal disease, but who may still live several years. Here, the day centre has a more social function at the beginning of the course of the disease, but over time its function as a provider of various palliative interventions becomes more pronounced.



Model 3 - New patterns of patients at a hospice

### *The Patient type of the Future*

The topic ‘the patient type of the future’ was discussed in a workshop in the reference group of this project in order to ascertain whether changes in patient types would place new demands on the services within palliative care in future. Among other things, the results from the workshop showed that in future we will see more patients with a higher level of knowledge (easier access to information via Internet, among other things), and therefore fewer patients will be immediately satisfied with the services available within the treatment. We will also see a patient type with a ‘conscious consumer’ profile, with high demands on personal service and ‘tailor made’ care packages; this will possibly be expressed as demands for new treatment forms and a higher degree of dialogue between staff, patients and relatives.

Another topic of discussion was two different levels of acceptance and consciousness in future patients. Those who know they are dying and who have ‘accepted’ it and those who deny the situation and still keep hoping to be cured even though this is not possible. The conclusion from the workshop was that an increase in the number of ‘denying patients’ could be expected in future.

These two patient types will have different demands when encountering the hospice. The first type will tend to see the hospice as a kind of “hotel stay” where it is possible to have space and time to talk to relatives and say good-bye properly and in a peaceful way; the other group will consider the hospice as an extension of a hospital, with demands for curative modes of treatment, as the hope to be cured still exists.

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*The perception of death is likely to become less of a taboo in future. We have to put death into a space – to become something natural, and not a taboo. The hospice works more in a symbolic function here than “just” as a provider of beds. The good thing about the hospice is that it gives a signal in the public sphere that death is here – death becomes visible.*

*Psychologist Niels Peter Agger*

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More patients with a different ethnic background than Danish will demand bigger patient lounges (recent experience shows that immigrant families typically have more relatives visiting at the same time), and possibilities to conduct other religious rituals than the Christian ones – a need which the traditional chapel or patient lounge are unable to meet.

## *Research and Development*

In the three reports concerning palliative care in Denmark (Palliation in the Primary Sector<sup>23</sup>, Professional Guidelines for palliative care - care of the terminally ill and dying<sup>24</sup> and Help to live until Death<sup>25</sup>) the relevance of research and education to the expansion and development of palliative care in Denmark was assessed. The conclusion in the reports is that qualitative and holistic palliative care presupposes the following: improving the educational and supplementary training activities, expanding and formalising the research within the relatively new field of palliative medicine, and gathering information and experience in more systematic ways. Today there are a number of suggestions regarding how this could take practical shape. One possible model is to establish a national research centre with the purpose of gathering and developing information from the whole field. The centre is to be closely linked to university and be institutionally independent from a hospice or a hospital to achieve the necessary clout and independence. Another model is to establish a centre for research and development of palliative care linked to a palliative unit at a university hospital in each of the future 5 regions and in this way take advantage of the research environment already existing at the hospital. These centres must be obliged to cooperate nationally, optimally via a national centre for research and development.

The precondition for both models is that research and development activities are taking place in each hospice, palliative unit etc. The pamphlet "Centre for Palliative Care"<sup>26</sup> suggests a possible solution, where resources are set-aside in the individual hospices for the employment of a researcher who is to gather local information and experience, initiate internal research projects and collaborate with the regional/national unit of research.

## *New technological demands on the hospice*

An increasing number of patients who are more experienced in the use of modern communication and information technology will add their demands on the technical equipment in the hospices. The use of modern communication technology in the hospices will enable patients and relatives to get more and new possibilities for communicating, working and seeking information. In future communication with relatives will not only happen through personal contact, but also via a laptop by the bed, logged on to the Internet. Here, patients will be able to maintain different degrees of social relations with family, friends and colleagues and seek and exchange knowledge and information related to their situation.

Changed work patterns with more home based workplaces and more flexible working hours combined with a technological upgrading of the hospices will enable more relatives to become 'co-admitted' to the hospice while taking care of their daily work.

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<sup>23</sup> Palliation in the Primary Sector. Dansk Selskab for Almen Medicin, Asbjørn Ziebell and others, 2004

<sup>24</sup> National Health Service. 1999. Professional Guidelines for palliative care.

<sup>25</sup> Hjælp til at leve til man gør, Report from workgroup on Palliative care in counties and municipalities, Ministry of the interior, May 2001

<sup>26</sup> Kraeftens Bekaempelse, Foreningen for Palliativ Indsats, Hospice Forum Danmark: Center for Lindrende Indsats, 2003



### *The hospice of the Future - how big is the need?*

According to English estimates, a palliative unit with a visiting team service and 5.5 beds is needed per 100,000 inhabitants.<sup>27</sup> Transferred to Danish conditions this means that the immediate need is for approx. 21 hospices with 12 beds per hospice. So far it has been decided in Parliament to establish a hospice in each county, with a minimum of 12 beds, but the actual need depends on the locality, to which the palliative services are directed and how these services are made available. If more chronically ill patients join the patient group and the timeframe of the palliative services is extended, this will change the need for beds at hospices and for an expansion of the palliative teams and the capacity in possible hospice day care centres.

## Economy

### *The Economy of sections with in-beds hospice wards*

Up to now the stipulation of the necessary financial framework for running a hospice has been marked by lack of experience in Denmark, and this is reflected in the varying fees for fulltime beds in established hospices, among other things. Likewise it has meant difficulty and uncertainty in securing the necessary financial foundation for new hospices.

For this reason, we have gathered financial data with the purpose of highlighting the necessary financial structures and pointing out key figures and particular conditions, which have to be in place for the good hospice of the future.

Furthermore, estimates have been made on varying numbers of beds, as the discussion about these has fluctuated from few places, to 8 to 12 or more beds. The estimates show that a minimum of 10-12 beds is needed to make the running costs work efficiently and to take full advantage of resources, particularly related to staff.

*Costs of running a hospice usually include the following expenses / key figures:*

- Wages (account for 72-76 % of the total expenses)
- Other running costs (account for 12-13 % of the total expenses)
- Financial obligations related to the building (account for 11-15 % of the total expenses)

Already here we see a variation in the running costs and with that also fees for fulltime beds, which are required to give the hospice a reliable financial basis. The wages account for the biggest item by far, but staff structures and variations within the individual hospices will differ in practice, which explains the absence of a defined and homogenous fee for full time beds.

With the example below as a starting point, it must be emphasised that each individual hospice must have its own budget, based on local conditions, the design of the place, services, staffing and the particular composition of the staff. The

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<sup>27</sup> Per Sjoegren, Den palliative indsats, feature article in Ugeskrift for Laeger, no. 44, 2002

amounts appearing in the tables below are therefore only estimates in order to illustrate at which financial level costs are likely to be.

### *Annual Expenses per Bed*

The following table has been worked out on the basis of expense budgets, which aim at giving an idea of the running costs of hospices with respectively 8-12-16 and 20 beds. The budget for existing hospices with 12 beds in Denmark is the starting point for the calculations of the remaining hospices sizes. Please note that this is an example only.

In a way it is obvious that wage expenses per bed in particular are reduced considerably in hospices with 12 beds or more. This is due to difficulties in taking optimal advantage of the resources with a smaller number of beds, as a basic staff function is necessary regardless of the number of beds, if sufficient quality in the palliative treatment is to be offered.

<i>Estimated annual expenses per bed</i>	
w/ 8 beds: 1,850,000 kr. (wages constitute: 1,390,000 kr.)	w/ 12 beds: 1,475,000 kr. (wages constitute: 1,105,000 kr.)
w/ 16 beds: 1,450,000 kr. (wages constitute: 1,090,000 kr.)	w/ 20 beds: 1,425,000 kr. (wages constitute: 1,070,000 kr.)

*Table 1: Outline of estimated items of expenditure per bed in the running of hospices of varying size.*

Running costs of hospices are covered by the country (region) based on an agreed rate per fulltime bed, which in practice varies from hospice to hospice, and based on individual running cost agreements and subsequent annual budgets.

The budgets will depend considerably on the composition of staff and staffing existing in the individual hospice, which again is affected by the structure of the collaboration existing with other palliative services available in the county/region.

<i>Income (approx. amounts)</i>		<i>Occupancy rate (example)</i>	
<i>8 beds</i>			
Possible number of bed days	2,920	Occupancy rate	85 %
Cost per bed day	kr. 6,000	Number of bed days	2,482
<i>12 beds</i>			
Possible number of bed days	4,380	Occupancy rate	85 %
Cost per bed day	kr. 4,800	Number of bed days	3,723
<i>16 beds</i>			
Possible number of bed days	5,840	Occupancy rate	85 %
Cost per bed day	kr. 4,700	Number of bed days	4,964
<i>20 beds</i>			
Possible number of bed days	7,300	Occupancy rate	85 %
Cost per bed day	kr. 4,600	Number of bed days	6,205

*Table 2 : Example of daily rate per bed day with 85 % occupancy in hospices of different sizes (number of beds).*

Table 2 illustrates that the daily rate per bed has to be considerably higher in a smaller hospice to ensure its proper financial running. The daily rate per bed needs to be 25% higher in a hospice with 8 beds in relation to one with 12 beds, which so far is the most common sized hospice in Denmark and also the size which is considered the legal minimum. The table shows a small decrease in the daily rate per bed when the number of hospice places increases. However, it should not be concluded from this that more beds are better, as factors other than the financial ones are key to *The Good Hospice*, with reference to other considerations in this report<sup>28</sup>

In practice an occupancy rate of 85% is possible. There is a risk that higher occupancy rates could reduce the quality of service of the hospices. In the start-up period (year 1) the occupancy rate should not be expected to exceed 80%, and in the long term a rate of 85% should be seen as realistic and satisfactory.

There is considerable variance in the results of the running costs. A deviation of just a few percent in the occupancy rate has a large influence on the running costs. The same applies to the salaries, comprising about 75% of the total running costs.

*The conclusion is: no two hospices are alike – each hospice with its own budget!*

<sup>28</sup> The tables above are worked out on the basis of detailed budgets based on different conditions. The amounts (expenses/income) do not necessarily reflect the contents of any hospice, as a variety of local conditions influences the size and composition of the numbers. Detailed budgets and conditions are the basis of the tables and conclusions.

# Resume – the hospice and the future

## *Additions to available services*

If an increase in the time of duration of palliative care becomes more common this will affect the contents of the services available at hospices, as the hospices in Denmark at the present moment are reserved for patients in the terminal phase and other options are lacking, earlier on. This is likely to become more relevant in future, as more and more cancer patients today live for a longer time with their disease; also hospices may direct their care at patients suffering from other incurable diseases to a larger degree. Likewise it can be expected that in future we will see more flexibility in the palliative services available to patients, who to a larger degree commute between their home and the different services of palliative treatment, for a longer period.

Therefore it will be appropriate to take a closer look at the contents of the palliative services in order to ascertain whether new palliative options adapted to the new patient profile and user patterns are to be added to the whole package. New options like specialised day centres, or an enlarged capacity of palliative teams could make it possible for more patients to make their wishes about dying at home come true, while experiencing a better quality of life during the last period.

## *New criteria for visitation*

The introduction of new palliative options, stretching over a longer period of time, and a larger patient group with more chronically ill patients as users of palliative services, will have consequences for the criteria for visitation giving access to hospices. The transition itself from the curative to the palliative phase can be difficult to judge as it is often rather blurred. For this reason it may be necessary to go through and possibly revise the criteria for visitation, which the individual hospices use in order to accommodate changes in the future patient profile.

## *Expand the capacity of palliative teams*

In order to accommodate the wish to remain at home during the last period, one possibility would be to enlarge the capacity of palliative teams to enable these to meet the actual need. Today different models exist, where the palliative team is located organisationally/physically: as a network structure (*the Odder Model*), located in physical proximity to the hospice, but organisationally based at a hospital (*The model from Northern Jutland*) or located in a hospital. The organisational placement is not of great importance to patients and relatives, provided the palliative options are experienced as a complete unit.

## *Longer and more flexible Developments for Patients - demands for new options of discharge*

As the patients will be offered palliative intervention over a longer period we will see more developments in future where the patient moves between the home, the nursing home, the hospital and the hospice. This will contribute to plac-

ing bigger demands on the cooperation between the institutions involved.<sup>29</sup> This tendency is also seen in England where shorter admissions and more discharges of the patients generally are becoming more common. As a matter of fact a much larger number of beds in English hospices are used for symptom control than for the final stay at the end of life.<sup>30</sup> In a similar way there will be a need for more individual options, when patients are discharged from the hospice.

### *Ensuring the experience of continuity for patients and relatives*

There is no one hard and fast solution as to where and how palliative services are to be based in future. Today we see an increase in the number of hospices in Denmark, regarding capacity as well as skills. At the same time an extension of palliative services available at the Danish hospitals is taking place. The hospice represents an expert service taking its starting point in a smaller institution, where it is possible to develop a particular hospice culture characterised by its close links to voluntary work and popular support. Generally, palliative care in the hospitals is available at a basic level, but with the possibility of offering isolated palliative intervention at specialist level.

It is to be expected that both options are relevant in future, which will increase demands on coordination and cooperation between the institutions.

The model with a palliative team (physically) linked to the hospices has the advantage that the palliative team works in communication with the hospital and the local hospice, and that the patient admitted to a hospice has often already had previous contact with the palliative team. In this way the patient meets familiar faces at the hospice, which lessens the dramatic effect of the admission.<sup>31</sup>

The sense of continuity between institutions and sectors experienced by patients and relatives is generally a theme demanding attention. Considering the municipal reform in Denmark (2007.01.01), where larger municipalities and regions are to take care of the co-ordination of the total health care in the region, it is important to ensure a coherent process for the patients, including providing relevant information about current options to the patients and the relatives.

### *Growing demands on new information - and communication technology*

In future we will see patients and relatives expecting more from the use of modern information - and communication technology at the hospices. This technology will make it possible for patients to maintain social relations with relatives, work, communicate with the surrounding world and seek knowledge and information related to their disease and situation, directly from the ward. Increased access to knowledge and information will enable a growing number of patients to acquire more information about their illness and particular situation. This will place bigger demands on palliative care, for example in the form of alternative treatment or more individually designed palliative services, which are not only related to treatment.

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<sup>29</sup> Conclusion from The Good Hospice reference group workshop on the 15<sup>th</sup> Nov. 2005

<sup>30</sup> Interviews in 2005 with The Hospice of St. Francis, Farleigh Hospice, Grove House, The Princess Alice Hospice and Nick Pahl, Development Director, Help the Hospices.

<sup>31</sup> Interviews in 2005 with staff, relatives and volunteers at Kamillianer Gaardens Hospice, Aalborg.

### *High quality costs*

The financial analyses we have conducted show that a hospice with less than 12 beds has a markedly higher daily rate per bed and therefore could have difficulties with running costs, unless relatively high daily rates per bed are charged. Furthermore a smaller unit could find it harder to ensure consistent quality in the services available.

Financial analyses and experiences from England, among other places, suggest that it is possible to establish hospice day care centres, complementing in-patient beds and palliative teams, at relatively modest costs. In order to obtain the highest possible synergistic effects, a hospice day centre should obviously be linked to a hospice and a palliative team.

Using this model will allow a better economy, and most importantly, a higher quality of palliative services, as the same group of staff will be able to cover more functions.

A combination of interdisciplinary competences brings about synergy regarding economy, dynamics, continuity and quality.

### III. What can we learn from others?

How does a modern hospice work to day? Which services does it offer and how are they organized? What is the shape of the physical framework and what can we learn from the way in which the process of implementation has been undertaken?

This chapter attempts to answer these questions. The chapter will go through and discuss what good is being done, both in Denmark and internationally; and it will, by using cases, literature and analyses of the physical structures from four different hospices, point out the most important focal areas for *The Good Hospice*.

The chapter has been divided into four parts:

The first part goes through and describes five hospices (one Danish and four English) from the angle of organisation and content, and it also describes the physical framework and the actual process involved in the realisation of the hospices (three of the five hospices are new buildings).

In the second part we conduct an analysis of the physical components of the buildings in four different hospices. One of these has existed for some years, while the three remaining ones are new buildings, being very close to completion. The analysis of the physical components of the buildings shows ways of organising physical spaces while highlighting how different priorities and choices affect patients and their relatives as well as the experience and conduct of the staff in the hospice.

The third part of the chapter takes a closer look at how information and experience are disseminated inside the hospice, in order to gain an understanding of the 'information intensive' work processes amongst the employees.

In the fourth and last part the influence of the physical framework on the users is considered from a more theoretical perspective. Among other things, this part deals with themes like privacy/overview and the physical structure of the building and the effect on social relations it could cause.

Finally at the end of the chapter, there is a resume of what we can learn from others in the planning process of a new hospice.

## What do others do - an examination of four English and one Danish hospice

England is one of the countries in the world where most experience has been gained with hospices. As mentioned earlier, it was here that the first modern hospice was established and now hospice work has been going on for nearly 40 years. In order to learn from the English experiences we visited four hospices in England, which, altogether, represent examples of typical, modern and well functioning hospices.<sup>32</sup> Three of the hospices are in the middle of alterations and extensions (2005), as it has become obvious that the existing structures did not meet the demands of the present day and that extensions and new buildings were needed. The fourth hospice is a hospice day care centre, without beds, which is 10 years old.

In spite of cultural differences some common features are apparent: all employees, relatives, patients and volunteers we have interviewed and spoken to have emphasised how crucial it is that the hospice promotes tranquillity, security and life.

It must be pointed out that other countries also have good experiences with running and developing hospices, but that our choice is to focus on the English experiences in this program.

### *The Princess Alice Hospice, England*

The Princess Alice Hospice is located about 22.5 kilometres (14 miles) south of central London in the town of Esher, a green area with the typical characteristics of an English small town. The local community appears wealthy and has one of the highest average incomes in England. The original Princess Alice Hospice has been in existence for about 20 years, but it has become evident that time has run away from the original buildings, which are neither up-to-date nor functional. An analysis showed that renovating existing buildings would not be financially viable, and it was therefore decided to demolish parts of the old hospice and replace it with a new building. The building process is in its closing phase and the final extension to the old hospice is expected to be finished during the summer of 2006.

Like most other English hospices, the Princess Alice Hospice depends on voluntary donations and a considerable voluntary care for its survival. As opposed to other hospices in the country it has been possible (at Princess Alice Hospice) to enter into an agreement with the NHS about a funding of 40% of the running costs, which is double what most other hospices receive in the country. Apart from good negotiation skills, the good funding is due to the fact that the hospice has taken on more tasks within palliative care - among others to offer teaching at the local hospitals and in home care, and today there is close collaboration with four palliative teams from nearby hospitals. The remaining 60% of the running

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<sup>32</sup> Interview with Nick Pahl, Development Director, Help the Hospices, London



costs are covered by voluntary work, fundraising and sales in the second hand shops run by the hospice. The use of the hospice is free for patients.

About 900 volunteers are linked to Princess Alice, of which 600 are involved in running the second hand shops of the hospice in the local community. The remaining 300 volunteers take care of a variety of tasks, such as work at the reception, gardening, help in the kitchen and the like. In contrast to Denmark, the volunteers are connected directly to the individual wards in the hospice, which means that the daily organisation of the voluntary work is administered by individual heads of department.



*Picture 1: View of the old main building at The Princess Alice Hospice*

#### *Organisation and Content*

Both the original and the new hospice will offer palliation in the home or at hospital (via visiting palliative teams), a day care centre where patients can come to receive pain relief and to meet with other patients and an outpatient department as well as beds for admitted patients. The beds are primarily used for symptom control of the patients, shorter stays to provide respite care for the relatives at home and also for care and nursing for patients during the last phase of life. The average stay in the beds is 10 days and the majority of the patients are discharged again. Patients in the day care centre have an average connection of more than half a year. The home hospice has a capacity of approx. 600-700 patients per year, and it is primarily these patients who are later admitted to hospital.

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*The ideal hospice should have an atmosphere that is friendly, protected and safe to be upset in.*

*/ Eva Garland, Director of Medical Services, The Princess Alice Hospice*

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Today the Princess Alice Hospice is composed of 6 beds, and this number will increase to 22 (of which two are rooms with 3 beds) with the new extension.

The day care centre service will be extended and modernised to have a capacity of 20 people in future, and likewise there will be space to accommodate visiting nursing teams of 20 people, under one roof.

### *The physical framework*

As the hospice is located in a conservation area of natural beauty, there are some restrictions regarding the space the new building is allowed to take up. According to Medical Director Andrew Hoy this is problematic, as the plan is to increase the number of beds and therefore more space is needed. The solution has become a very compact building mass, distributed over two levels. Andrew Hoy does not consider this to be optimal, as it creates a scattering of the staff, and only few of the admitted patients are able to move up to the second floor. The solution has been to place all patient wards, the reception and the nurses' office on the ground floor, and the administrative facilities like offices, meeting rooms, files and rooms for volunteers as well as the day care centre on the second floor.



Picture 2: Picture illustrating a cross section of the new main building at The Princess Alice Hospice.

In spite of the restrictions in size and the compact building, attempts have been made to maintain closeness to surrounding nature. All patient wards have a view of the surrounding forest area, something Andrew Hoy considers important, as you have a need to be able to “disappear” into nature, as patient and relative.

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*When designing a new hospice, there are three crucial key factors to be aware of: Location, location and location*

*/ John Watkins, Project Director, New Farleigh Hospice*

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Like many other English hospices, the new Princess Alice Hospice will offer wards with more than one bed, which will accommodate up to three patients at the same time. According to Andrew Hoy, this is due to a particular characteristic in English culture, based on the distinct impression that it is partly nicer for patients to have somebody else to talk to in the ward and partly that shorter distances between individual patients make the routine more efficient for the nurses. All patient wards will be equipped with oxygen and ceiling hoists to make it easier to move patients.

The hospice already has a traditional Christian room of worship, but as a sup-

plement to other religious beliefs and to patients and relatives with no religious affiliation, it has been decided to build a “multi-faith-room”, which will possibly be called a quiet room or a room for reflection and which will be available for patients and relatives needing to withdraw for a while.

There will be wall-to-wall carpets in the whole hospice and efforts have been made to use as many natural materials (which are also washable) as possible.

#### *The establishment process*

The planning of the new building began in 2002, and in 2004 the final decision was made to start the actual construction work. During the entire planning phase the emphasis was on drawing on as big a spectrum of competences as possible, involving the staff, the relatives, the patients, the architects and professional advisors, with a nurse as the project leader. The hopes are that the final result will be a functional building, designed for the future but also with an expression and form which make the stay for patients and relatives as comfortable as possible.

The quick establishment process is partly due to the relative ease with which financing has taken place; this can, in turn, be explained by the placement of the hospice in a very wealthy part of the country combined with close co-operation with the authorities, achieved over a period of time.

#### *Farleigh / New Farleigh Hospice, England*

Farleigh Hospice is located to the north east of London in Essex and has since it was established in 1982 been located in an old Victorian house. Here a process of extending the capacity is underway, because of changed patient needs, improved nursing possibilities and increasing numbers of applications for the use of the hospice. The present building is not sufficiently functional, and as only one of the ten wards in the hospice is a private ward problems arise around the privacy of the patients. Furthermore, all patients share communal toilets and bathrooms. As it is impossible to extend the existing building further, it has been decided to build a whole new hospice, New Farleigh, at some distance from the old one. The new hospice opened in January 2006.

The NHS covers 20% of the running costs of the hospice and patients do not pay for the use of the services at the hospice. The remaining expenses are covered by voluntary donations, sales in the second hand shops run by the hospice (which had 45,000 visitors last year) and fundraising. In 2004 approx. 4,800,000 Euros were collected.

#### *Organisation and contents*

Farleigh Hospice services approx. 330,000 people in the middle part of the County of Essex, and today it offers palliative care in the home via a visiting team, a ward section, bereavement assistance to relatives and a day care centre, located at three locations in the region. In the year 2003 around 1,800 people used the day care centre, of which 265 patients had been admitted. Like in Princess Alice Hospice there is a tendency that more patients are admitted for a shorter time for symptom control.

Volunteers play an important role here, both at the hospice and outside it, like in many other English hospices. On the average there are 6 volunteers per employee, and as in the other hospices, the volunteers take care of more functions than they do in Denmark.

*The physical framework*

The new hospice consists of three main parts - a day care centre, an outpatient treatment facility and wards. In addition there are the administrative facilities, filing, teaching - and meeting rooms etc. that will all be located on the first floor.



*Picture 3: Front section of New Farleigh Hospice*

New Farleigh Hospice is located less than a mile away from the original hospice and it is close to the centre of town. According to John Watkins, project leader of the building, there is some concern about accessibility, as the new hospice is not as easily accessible by public transport, but it was not considered wise to say no to the building site on offer.



*Picture 4: View of the New Farleigh Hospice chapel, shaped like a lighthouse (under construction)*

The hospice has been designed around a communal entrance hall leading to various departments in the hospice, with the most ill patients located furthest away from the hall to ensure their privacy. While the most severely affected patients are given peace and quiet in this way, it is considered important to maintain the communal entrance hall so the hospice is perceived as a complete unit. The remaining departments are each designed in order that each department is manageable

whilst achieving a coherent feeling in the building, with certain communal areas being shared by all the sections of the hospice.

The new hospice will increase the number of wards from 6 to 11, of which two will have 3 beds, which increases the total number of beds to 15. The hospice day care centre will have capacity to accommodate 10 patients. The particular out patient service will be able to offer medical assistance to visiting patients, among other things in the form of blood transfusions and advanced pain relief.

The ward section itself has been constructed like a four-leaved clover, surrounding a observation room for the nurses. In this way the distance between individual wards and the observation room is minimised, which then becomes the natural centre of the whole section. According to John Watkins this is the most appropriate model to adapt, as the building is then made use of in the most efficient way – the nurses are never too far away from the patient, and the division into individual leaves makes the ward section more compact.



*Picture 5: View of New Farleigh Hospice ward section (under construction)*

All wards have access to a garden, and the beds can be pushed out directly, via French doors. For financial reasons it has been decided not to have en-suite bathrooms in each ward, and patients therefore have to make do with a toilet adjacent to the ward, while sharing bathroom facilities with other patients. The shared facilities include 3 bathrooms with showers and one with a bathtub. The patients' relatives can choose to stay in the wards, but as these are relatively small, there is not enough space for a permanent sofa bed, and instead mattresses have been purchased, which can be taken in and out of the wards, as needed.

In order to save money it has been decided not to equip the wards with oxygen in the walls nor fit lifts to other floors.

Efforts have been made to use as many natural materials as possible, apart from the floors, which are to be made from a combination of vinyl and synthetic carpeting, for cleaning purposes.

#### *The establishment process*

As at The Princess Alice, a wide spectrum of competences have been involved during the planning process of the first sketch for the project. In this way the aim of ensuring that the final building would work well for all users: the staff, the volunteers, the patients and the relatives were consulted. The establishment process has been underway for seven years, because of problems in raising sufficient funds.

#### *The Hospice of St. Francis, England*

The Hospice of St. Francis lies in the northwestern outskirts of London, in the town Berkhamsted, and it opened in 1979. Due to shortage of space the day care centre, the palliative team, the administration and the fundraising section are located in a bungalow next to the original building, and the three day care centres of the hospice are spread out across the region. The situation here is similar to the ones at The Princess Alice Hospice and Farleigh Hospice, as the original buildings are unable to meet the new needs for quality and the increased demand for the services of the hospice. Like many other hospices in England this hospice depends on a big effort from volunteers and donations, as the NHS covers only 20% of the running costs. As extensions and alterations of the original hospice will not be cost-effective, it has been decided to start from scratch and build a brand new hospice building.



*Picture 6: Model showing the new Hospice of St. Francis*

### *Organisation and content*

Today The Hospice of St. Francis contains wards for 8 patients staying overnight, an outpatient department, a visiting team taking care of the home hospice department and a day care centre, which is open two days a week with a capacity of 8 patients. In 2004 about 500 patients had used the services of the hospice day care centre, and nearly 480 patients had used the outpatient department of the hospice. The length of stay for patients has been decreasing and has now reached 8 days, on the average. At the present time approx. 60% of the admitted patients choose to return to their own home to die. In 2004 the visiting palliative team of the hospice visited more than 3,500 patients in their own home, and conducted more than 1,200 consultations via the telephone. The total number of days of admission was 1,975 in 2004. With the new hospice the capacity will increase to accommodate 14 patients, and the day care centre will be able to have 12 visiting patients at the same time. The majority of the patients at the hospice suffer from cancer diseases, but patients suffering from chronic diseases also take advantage of the hospice.

### *The physical framework*

The new hospice will be located on top of a slope in a green area, just outside the town Berkhamsted. The overall stylistic theme of the hospice is a copy of an old English farm, and as at New Farleigh the building is to be divided into more wings in order to make the building appear less imposing. The drive to the hospice building itself winds its way up the slope. This is intended to give visitors to the hospice an immediate experience of its particular atmosphere - the buildings and the surrounding gardens are revealed little by little, as opposed to seeing everything from the start as one would from a straight access.

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*Our patients and their relatives appreciate the day hospice very much – it is one of the few breaks you have as a relative, and one of the few times you as the patient come outside your own doorstep.*

*However, we don't see a day hospice as an essential part of hospice care, but as a service that provides extra value for the patients that wish to stay in their home, rather than stay at the hospice itself.*

*/ Sharon Chadwick, Associate specialist Palliative Medicine,  
The Hospice of St. Francis.*

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The patient wards and the palliative team will be based in one half of the building, and the day hospice, the educational facilities, the chapel and the outpatient department in the other half. In the middle, the communal canteen and the scullery are located, thus linking the two parts. Minimising smoke and smells from the kitchen to the surrounding areas has been of vital importance, as these could otherwise become a nuisance for the users of the hospice.

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*It is vital to ensure a well-functioning IT-system, that works well both internally but also externally. It could help us work more effectively, avoid too much paperwork and speed up the process for the patients, for example when working with test-results.*

*/ Roger Sharp, Community Appeals Manager, The Hospice of St. Francis*

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Most of the administrative facilities have been located on the 1<sup>st</sup> floor. The Hospice of St. Francis has also chosen the four-leaved clover design for the patient wards in order to minimise the distance to patients and to create a department, which does not appear too big or confusing. Two of the 12 wards have been designed with two beds, and all wards have their own toilet. However, patients have to share 3 communal bathrooms with showers.

The difference between St. Francis and New Farleigh is primarily that St. Francis will operate with two different entrance halls, so that patients in the hospice wards use a different entrance to the users of the day hospice and the outpatient department.

A special inner courtyard will be designed, a so-called healing garden, planted in such a way that there will always be flowers/herbs to look at, touch and smell - regardless of the season.

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*You can find solutions, where the hospice is closely connected physically to the local hospital, and you could easily find arguments for a location further away. The further away, the easier it is to create that special ambience and feel, closer by, and you could more easily share and draw upon the hospital's medical expertise.*

*/ Gordon Yearwood, Hospice Development Manager,  
The Hospice of St. Francis*

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#### *The establishment process*

A specific project leader has been employed to manage the enterprise and development of the new building. The choice has been made to operate with a high level of user participation, and the entire process can best be described as an iterative process, where continual discussions, sketching and improvement of individual parts of the new building have taken place. The users involved range from staff at the existing hospice, building engineers, architects, relatives etc. The first turf was cut in May 2005 and the new hospice building is expected to open at the end of 2006.

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*The ideal hospice should promote laughter and normality.*

*/ Alison Briant, Director of Clinical Governance,  
The Hospice of St. Francis*

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### *Grove House, England*

Grove House day hospice lies in the northern outskirts of London and was established in the middle of the 90's. Compared to Danish conditions Grove House can hardly be regarded as a hospice service, but rather as an open patient house. In the beginning it was called Macmillan Runcie Day Hospice, but in 2000 it was decided to change the name to Grove House, with the result that the number of patient referrals increased by 65%. The reason for the name change was the impression that the word hospice had a discouraging effect on many patients, as this is linked with dying. However, the word hospice is still used when it comes to fundraising, as this attracts larger donations than the name Grove House.

#### *Organisation and content*

Apart from the day hospice, Grove House includes an outpatient department, catering for patients and relatives as needed. This offers family support and survivor programmes, where cancer sufferers are given help to handle their new situation. Other things available include cancer information, support to patients and voluntary home assistance. The day hospice itself has a capacity of 150 patients per week with a set day in the week for the day patients. On Fridays the day hospice is reserved for young patients (young at heart - the age of the patients on Fridays range from 18 to 65).

Grove House has about 8,000 calls per year. Of these around 1,000 patients are looking for information on cancer and the remaining 7,000 take advantage of the other services offered at Grove House. Between 1,200 and 1,300 patients of the 7,000 use the day hospice.



*Picture 8: Picture of Grove House, exit to the sense garden*

Today (2005) the cancer patients represent 75% of the total number and the remaining patients typically suffer from heart and lung problems and neurological diseases. The collaboration between Grove House and the nearby hospital is

limited to a number of volunteers in the cancer ward of the hospital, who act as a contacts to and mediators with, Grove House, but no formalised collaboration takes place otherwise.

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*People come here to live. But it is a decision you have to make for yourself:  
Will you wait until you die, or live until you die?*

*/ Joan Follet, Day Hospice manager, Grove House*

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Grove House has about 30 employees (most of them part time) and 300 volunteers at its disposal. Of the employees 5 work as fundraisers, 4 in administration and 21 as nursing staff. In the beginning the focus was more on the social aspect in the day hospice, but today the work is increasingly centred on medical intervention.

The day hospice has a capacity of 16 patients per day, with one nurse to four patients.

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*The mere fact that the patients go through the same thing helps them to support each other.*

*/ Joan Follet, Day Hospice manager, Grove House*

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The day hospice primarily fulfils three functions: Pain and symptom control/relief, respite care for the relatives and in ways to help patients break their isolation. The patients in the day hospice are very different, ranging from those whose diseases have progressed quite far to those who have been recently diagnosed. Both patient types supplement each other, as the fact that everybody goes through the same things contributes to mutual support among patients.



Picture 7: Picture from Grove House, creativity room.

As in other English hospices, many volunteers have been drawn into the work in the hospice. On the day we were visiting, a volunteer was working with chiropody, something she had been doing for about 10 years, another worked in the garden, and yet others were laying tables for lunch or taking care of drinks for the patients.

#### *The physical framework*

Grove House has been purpose-built (as a hospice) and it consists of a plastered brick house with details in wood and a healing garden located on one side of the house. The house has a Japanese touch with an entrance hall in wood with tall reeds and bamboo, and at the same time there is a typical English feel, with wall-to-wall carpets in all the rooms and with colours in light beige and pastels. Inside, the day hospice takes up most space, with a large communal room equipped with kitchen, fireplace and bookcases with books and games. The walls are decorated with art made by the patients. There is an art therapist attached to the hospice, who assists the creative abilities of the patients to grow through painting, drawing, working in clay and the like, something which Joan Follet, head of the day hospice, describes as being very successful.

Grove House has attempted to create and support social relations between patients, through the use of a large communal space, where most patients naturally spend much of the time. Furthermore, activities take place, which are considered meaningful for patients, in the hope of stimulating these more. Grove House has no chapel, but a specific quiet/reflection room, full of religious artefacts, which can be used as needed.

#### *KamillianerGaardens Hospice, Aalborg*

KamillianerGaardens Hospice in Aalborg is a good example of a modern, well-run Danish hospice. Kamillianer Gaarden is located in the centre of Aalborg, close to the Limfjord, in the old building of the catholic Kamillianer Order. The building dates back to the beginning of the 19<sup>th</sup> century and was originally established as an eye clinic. When the order came to a close in the beginning of the 50's, it was rented by the Nordjyllands Amts Sygehusvaesen (the hospital service of Northern Jutland), and later the Red Cross rented the building in the middle of the 70's. In 1998 the alterations began for what is today KamillianerGaardens Hospice, which opened in 1999.

In 2004 there were 166 admissions, with an average length of stay of 21.8 days. Of the admitted patients by far the most were admitted as terminal (56%), but patients are also admitted for symptom relief (30%), respite care (9%) and sometimes rehabilitation (5%). In 2004 approx. 95% of the admitted patients had cancer as the main diagnosis.<sup>33</sup>

#### *Organisation and content*

Kamillianer Gaarden is an independent institution, and the hospice and the palliative team represent an interdisciplinary group of employees consisting of doctors, nurses, social and health assistants, a priest, a music therapist, psychologist,

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<sup>33</sup> Kamillianer Gaardens Hospice, Annual report 2004

physiotherapist, social worker, dietician/catering officer, service employees and volunteers.

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*The circumstances we work under now are close to the ideal – with the interplay between the hospice and the palliative team. In a sense we in the palliative team become part of the food chain for new patients in the hospice, as we already know the patients. This flow works really well and provides more continuity for the patients.*

*/ The palliative team in the Kamillianer Gaardens Hospice*

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As in the already mentioned English hospices the service of visiting the patients' homes is available as are certain examination facilities, where the patients have access to symptom control and examinations done by a doctor.

As opposed to the English hospices described earlier, in which these services are organisationally separated from the rest of the hospice, both the home hospice department and the examination facilities are taken care of by a particular palliative team, which is organisationally attached to Aalborg hospital. The physical location of the palliative team is in the other wing of the building and it works closely with the rest of the hospice every day.

KamillianerGaarden has trained a number of hospital nurses in palliation. This ensures that there are always palliation nurses in all hospitals and in the admission area of the hospitals in the county, who can partly support patients, but also contribute to creating a link to the hospice and the palliative team for patients and their relatives.



*Picture 9: KamillianerGaardens Hospice, seen from the garden*

As the palliative team also comes to the hospice, patients and relatives meet familiar faces. Another advantage is that it is possible to take advantage of the economical synergy effects linked to having different competences gathered so closely together, as it would otherwise require a much bigger number of patients to cover running costs, with the services available today.

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*It is important to picture the hospice as part of the actual county – in order to make the whole thing work, you depend on a lot of interdisciplinary collaborative relations.*

*/ The management, KamillianerGaardens Hospice*

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KamillianerGaarden has about 50 volunteers working with a variety of tasks, like gardening, laying of tables at meal times, taking care of a range of smaller tasks and being available for patients and relatives, who would like to meet someone from the world outside the hospice. A specific co-ordinator for the volunteers has been employed to organise voluntary care, which is highly appreciated by patients, relatives and staff, as in the English hospices. Several relatives express that the volunteers participate in creating a bridge between the outside world and the hospice<sup>34</sup>, an impression, which was also mentioned in the interviews with the English hospices. When comparing the ways volunteers are integrated in the English hospices and in KamillianerGaarden, some fundamental differences are obvious. In Kamillianer Gaarden the role of the volunteers is structured in a more narrow way and is less varied than in the English hospices. In KamillianerGaarden the volunteers are not involved with nursing of the patients, as they are in the English hospices. Furthermore, the volunteers in KamillianerGaarden are attached to a separate co-ordinator and are not directly integrated into the different wards at the hospice. The reason for this could possibly be due to cultural differences between Denmark and England regarding the perception of the relationship between paid and voluntary work.

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*The patients could be seriously ill and frail and finding it difficult to participate actively in the life they were used to. But that does not mean that they do not feel like following life outside.*

*/ Nursing staff in KamillianerGaardens Hospice*

*An important experience we wish to pass on is to make 'space' for the volunteers – physical space as well as organisational space.*

*/ The palliative team in KamillianerGaardens Hospice*

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#### *The physical framework*

As the hospice is restricted by the physical size of the original building from the early 1900s, it has been necessary to prioritise the utilization of the spaces. Creating patient wards of a reasonable size with a nice view has been the first priority, followed by communal rooms, and finally support services like offices, filing, medicine and storage rooms have been allocated the remaining space. As a consequence the existing patient wards are fairly big, while offices, meeting places and storage have limited space. Fortunately, it is possible to share some of the facilities of the palliative team, and bigger meetings usually take place in the meeting room of the team.

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<sup>34</sup> Interviews conducted with all staff groups, relatives and volunteers in Kamillianer Gaardens Hospice during September/October 2005



Picture 10: KamillianerGaardens Hospice, communal area  
(Photo: Tom Soendergaard Lauritzen)

The building is L-shaped and has four floors, out of which three are used by the hospice. In the basement there is a café, which was originally intended for the use of everybody at the hospice, but it became apparent over time that patients and relatives very seldom used the room, and today the café is therefore mostly used by the staff for breakfast/lunch, and for get-togethers and presentations with the support group of the hospice, among others.

The kitchen is also located in the basement and the caretaker has his office there. The actual hospice is on the ground floor and on the first floor, with patient wards, offices, rooms for medicine and laundry, bathrooms with bathtubs etc.

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*The physical contact relieves physical tensions, which can lessen psychological tensions. The contact is often perceived as a comfortable 'free space' and it gives patients more body awareness. The different professional groups at the hospice overlap each other: a physiotherapist can make a difficult talk about inheritance or problematic family relations run more smoothly.*

*Many patients have procrastinated practical paperwork, and suddenly they are not strong enough to manage the practical things. There may also be unresolved relations in the family or other problematic relations, and we help the patients open up and work at these things, so there is energy available for things other than the practical ones.*

*/ The palliative team at KamillianerGaardens Hospice*

*The initial phase itself is very important. To lay a good foundation, to listen to the experiences of other people and to create space for those discussions, which are part of creating the culture upon which everything else rests. We also must remember to keep it alive and ensure that new colleagues also have access to and influence on the very particular culture we have.*

*/ The nursing team at KamillianerGaardens Hospice*

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The 12 wards face a courtyard and from the wards you can see and hear sounds from the school adjacent to the hospice. Sounds from playing children have been mentioned in particular as something positive by the relatives, as these contribute to creating the impression of being in touch with life outside, in spite of ill-health.

The wards are painted in light, warm colours and the upholstered furniture is made from dark wood. It is possible for patients to bring their own furniture to the ward and some take advantage of this offer, while most use the specially designed frames on the walls to put up pictures and drawings.

Along the passageways by the wards there are built-in niches, providing semi-private space for reading or talking. If the patients or the relatives need a bit of time alone or wish to have a more intimate conversation, they can use a vacant ward or a special room in the hospice/playroom.

In contrast to the English hospices the choice here has been to use wooden floors, in the patients wards as well as in the communal spaces and the passageways.

## Analysis of the physical properties of the buildings

In order to get an even better understanding of how a hospice can be shaped and work, we have chosen to conduct an analysis of the physical properties of the buildings, where we go through four different hospices from the angle of the physical details of the buildings. To have the widest possible representation in the data material, we have chosen to focus on hospices which differ from the perspective of the building (three are new buildings, one is located in an existing building); they also represent cultural/geographical diversity, as one hospice is located in the middle of a town, two are outside town and the last one is located in an area of natural beauty.

Furthermore it has been of importance to find hospices with a variety of services available, ranging from only beds to palliative teams (home hospice), day care centres and outpatient departments. Two of the four hospices are in England and two are in Denmark. Some of these hospices have already been described above while others are introduced here for the first time. We have chosen to make the following source material anonymous, as our aim is to learn from possible variations and differences in the size of individual services contained in the buildings, rather than evaluate the hospices mentioned.

### *Conditions and limitations*

Comparisons of the physical properties of these hospice buildings have certain obvious limitations. There are some cultural differences between the two countries, as the tradition for voluntary work and wards with several beds etc. is more deeply rooted in England and the financial systems and the construction of the English and the Danish hospital systems also differ. Subsequently, the administrative section takes up more space in the two English hospices to meet the physical requirements of the fundraising staff and the much bigger number of volunteers.

In the two English examples the services are much more sharply divided, and a particular team takes care of home visits and telephone consultations, while another team works with the reception of patients at the hospice (outpatient department).

<i>Hospice</i>	<i>DK1</i>	<i>DK2</i>	<i>UK1</i>	<i>UK2</i>
Type	New building	Existing building	New building	New building
Contents of Services and patient capacity:	Beds: 12	Beds: 12 Palliative team (Year): 517	Beds: 14 Day-centre: 12 Palliative team (Year): 560 OP dept. (Year): 575	Beds: 15 Day care centre: 12 Palliative team (Year): 250 OP dept. (Year): 119
Number of employees <sup>35</sup> :	30	42 <sup>36</sup>	91	163
Shape of building:	T-shape	L-shape	XO-shape	XX-shape
Floors:	2 - patients and employees on both floors	2 - patients and employees on both floors	2 - patients on the ground floor and administrative departments on the first floor	2 - patients on the ground floor and administrative departments on the first floor
Position:	In an area of natural beauty, at a distance from other buildings and bigger cities	Located in the middle of town	Close to the centre of town	At the outskirts of town
Gross area (approx. areas):	2,423 m <sup>2</sup>	1,776 m <sup>2</sup>	2,689 m <sup>2</sup>	2,792 m <sup>2</sup>
Net area (approx. areas):	1,704 m <sup>2</sup>	1,015 m <sup>2</sup>	1,701 m <sup>2</sup>	2,181 m <sup>2</sup>

Hospice DK1 is a new building, located further away from town than the three remaining hospices. The development of this hospice has been based on the experiences from other hospices inside and outside Denmark. Hospice DK2 is a highly regarded and well-run hospice, which has been running for a while, located in an existing building in the middle of a larger Danish town.

Hospice UK1 and UK2 are new buildings, where existing hospices were used previously but which have now become outdated. The establishment of these two hospices has been underway for a couple of years and it has been based on experience and information gained from running hospices for nearly 20 years.

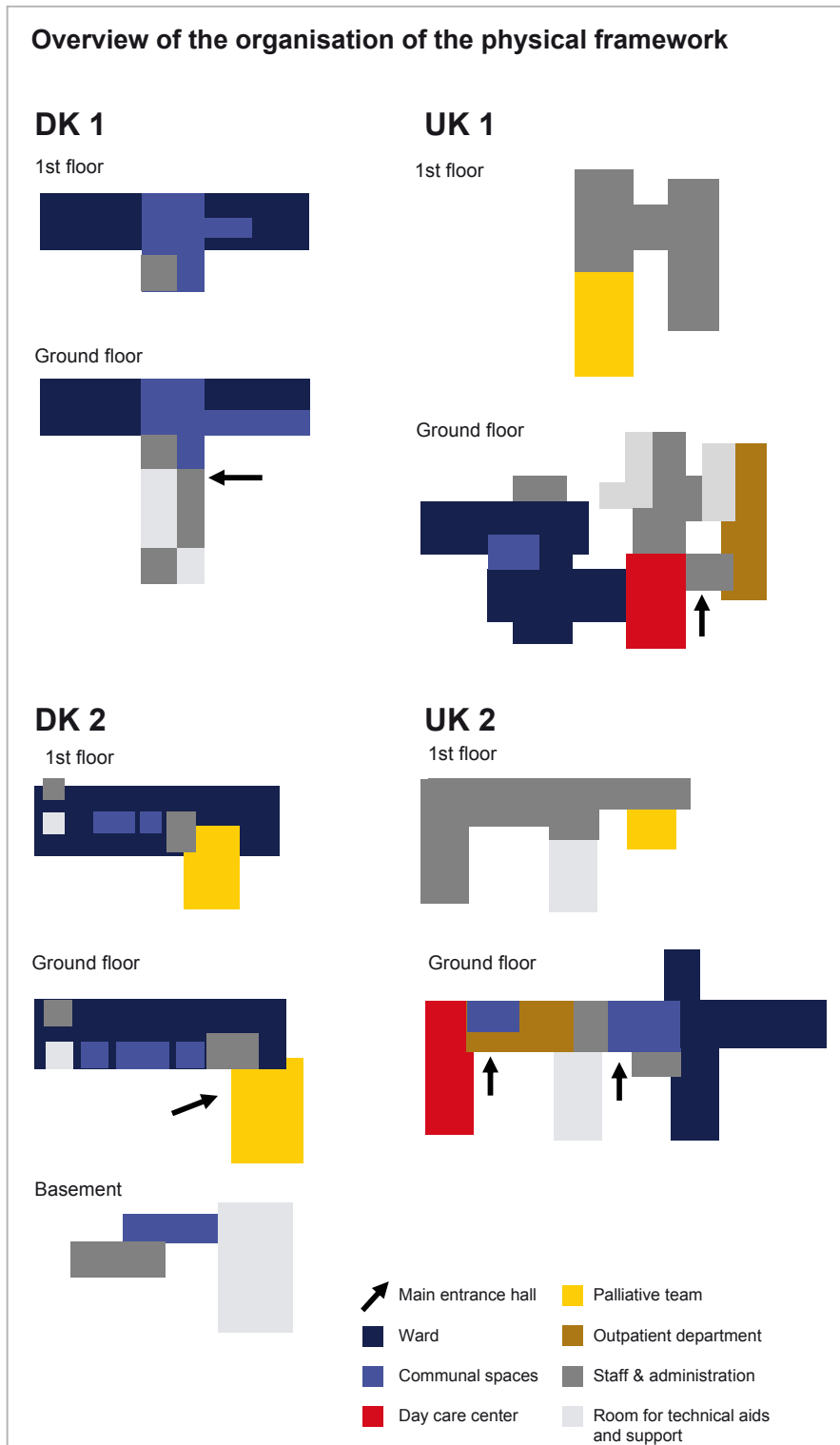
<sup>35</sup> Number of employees recalculated into fulltime positions

<sup>36</sup> Incl. employees at the palliative team



*Overview of the organisation of the physical framework.*

The physical framework of the four hospices has been organized in different ways. However, they do have one thing in common, as attempts have been made to divide individual departments into smaller sections, so that the wards, the palliative teams, a possible outpatient department and day hospice are separated. When we have asked questions about this, the answer is that the aim was to create a building that gives a coherent impression, while also maintaining manageability and intimacy for the users, so these do not have the experience of “drowning” in the building.



*Diagram 1:  
Organisation of the physical  
framework in the four dif-  
ferent hospices*

Hospice UK1 and UK 2 have larger patient capacities than the two Danish ones. The division has been emphasised more in order to maintain a feeling of intimacy in the individual sections. Likewise, the administrative areas have been located on the first floor to give patients as much moving space in the hospice as possible, and at the same time keeping the footprint of the building as small as possible. This enables social interaction between patients and relatives to take place primarily on the horizontal level, because patients are situated on one level. At the two Danish hospices social interaction between patients and relatives will happen both on the horizontal and vertical level. Here communal and support areas have been established on both floors, while the two English hospices make do with less space for communal, support and therapy rooms.

Another interesting detail is the way the four hospices have laid out their wards. In DK1 a solution with the wards divided into two wings with 3 beds located on two floors has been chosen. Due to restrictions in the original building, hospice DK2 has divided the wards into two sections with 6 beds, and the two English hospices UK1 and UK2, with bigger patient capacity than the Danish ones, have divided the wards into three wings, with 4-5 beds in each.

The wish to create wards which do not appear so large, while at the same time keeping the number of adjacent support and communal areas at a minimum is shared by all four hospices.

### *Overview of utilisation of space*

The gross space is the total space of the building, including de facto space (external walls, lifts, passage ways, stairs etc.). When the de facto space is deducted from the gross space you get the net space.

The space factor, which gives an indication of the degree of efficiency in the utilisation of square metres, is calculated by dividing the gross space by the net space. A building requiring many passage ways in order to function will, by nature, be more 'wasteful' of square metres than a building shaped in such a way that passageways, stairs etc. take up less space. It is important to point out that operating with a low space factor is not always a goal in itself; by way of example, wide passageways may be necessary to enable transport of beds and the like, and the actual shape of passageways, stair towers, small pockets where people can meet and the like, contribute to the creation of a particular experience of the building for the users, and in this way fulfil a service which is larger than the purely functional one.

The degree of space utilisation depends on many factors, including the shape of the building mass and whether it has been necessary to take the physical properties of existing buildings into account, as that can make it more difficult to utilise the building in the most optimal way.

It goes without saying that if there are no limits regarding the size of the footprint of the building and the means to establish it are unlimited, the degree of efficiency in the utilisation of space matters less than when you have to prioritise harder.

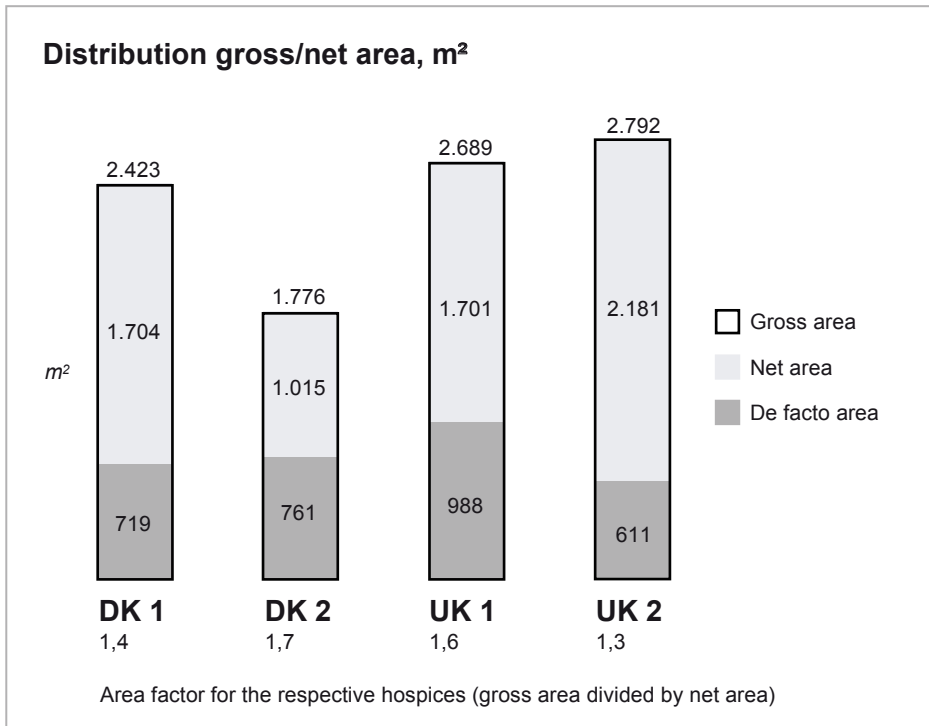


Diagram 2 – Overview of gross-, net- and de facto area for respective hospices

The overview shows that the actual area utilisation varies a lot, with the UK2 hospice as the most ‘compact’, with approx. 1.3 m<sup>2</sup> gross areas per m<sup>2</sup> net area. In hospice DK2 the de facto area is the biggest, with approx. 1.7 m<sup>2</sup> gross areas per m<sup>2</sup> net area. Actually almost half of this building is used for de facto area.

The differences in the size of the de facto area in the two new buildings UK1 and UK2 are partly due to the different shapes of the building mass; hospice UK1 has placed a courtyard in the middle of one section of the building. This courtyard contributes to the size of the stairway space in the hospice and thus the total share of the de facto space. However, it is interesting to notice that hospice UK1 has had limited financial means, and that this particular choice of shaping the building has given more de facto area than another choice would have.

### *Distribution of net area according to function*

The overview below shows the distribution of areas, in relation to function. Obviously, the size of the areas depends on the capacity of beds, day hospices, palliative teams, outpatient departments and number of staff, respectively. The section reserved for bedridden patients and their relatives takes up more space in the three new building projects. This does not necessarily mean that larger areas for patients provide a better stay for the patient and the relatives, as interviews also show that a smaller, more intimate building could be preferable – the building could quite simply appear too big.

Furthermore, it is worthy of note that the day hospice section takes up almost double the amount of space at the UK2 hospice than it does at the UK1, in spite

of the fact that UK2 has a lower capacity of patients. One of the reasons for this is the choice made at hospice UK2 to place the staff in team based communal offices, which has contributed to freeing more space for the day hospice section, among other things. Apart from the size, the only functional difference between the two day hospices is that UK1 has a special bathroom with a bathtub, which does not exist at UK2.

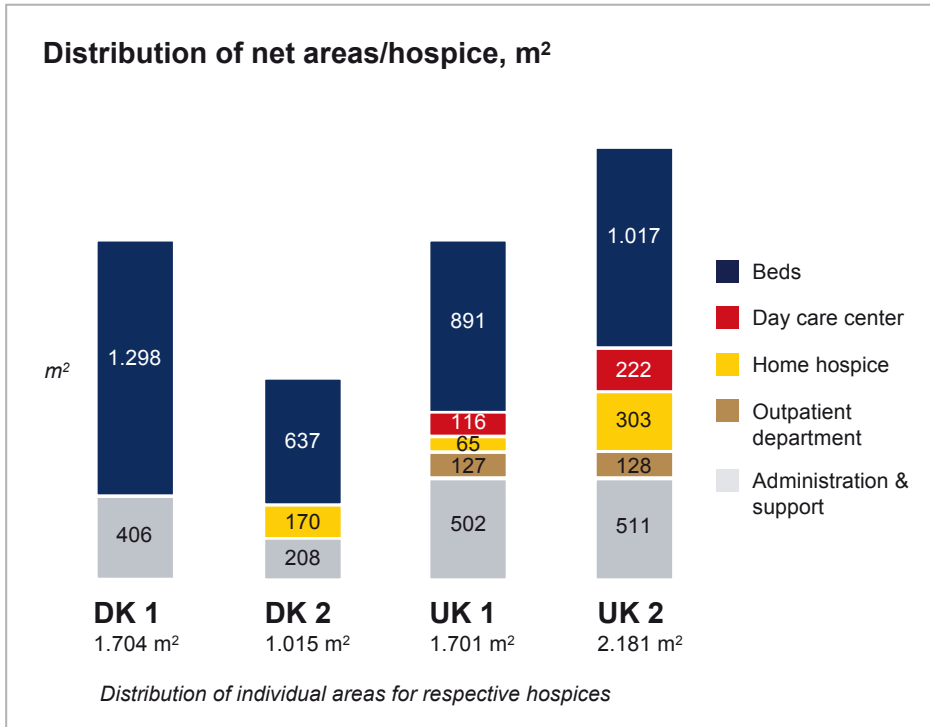


Diagram 3 - Distribution of net areas and sub functions for respective hospices

### *Distribution of net area according to user type*

When you group the areas according to accessibility and user type, (areas for patients and relatives, areas for staff, administration and support) it appears that hospice DK1 has relatively little space reserved for staff. At this hospice the choice has been to give high priority to areas for patients, both in the form of considerably bigger wards, but also in the form of more and bigger public areas for patients and relatives, as well as more space for storage.

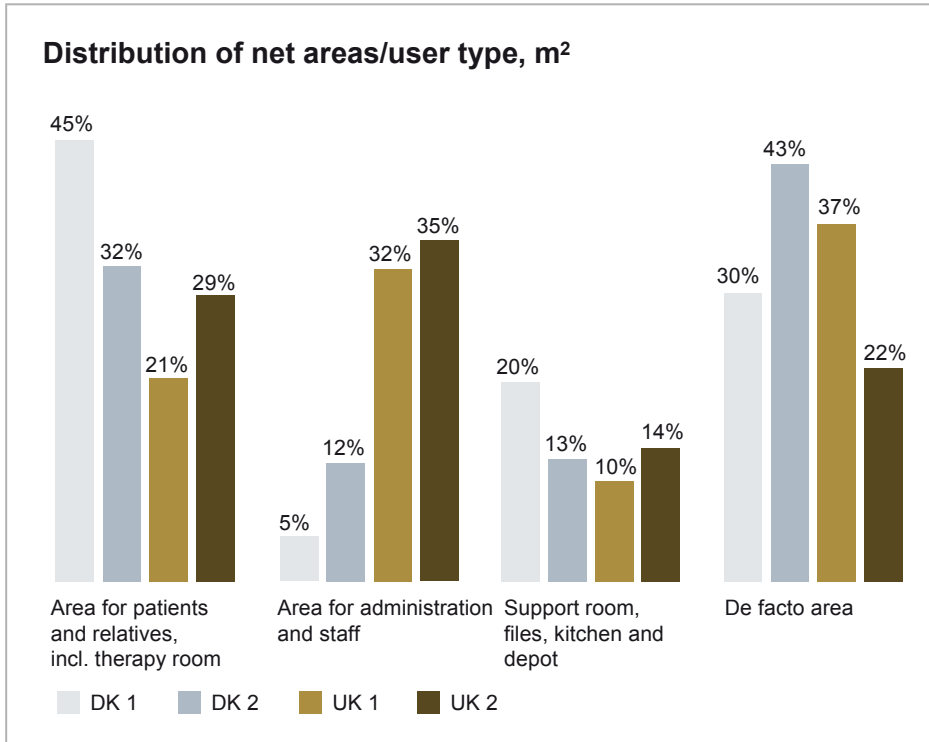


Diagram 4 – Overview of distribution of net areas according to user type

The high proportion of space reserved for administration and staff for hospice UK1 and UK2 is due to larger staff, including the employment of many fundraisers, a type of employee, which does not exist in Danish hospices. When shaping the administrative areas, different strategies have been chosen by UK1 and UK2; UK1 has established many small offices for one or two people, while UK2 works with larger communal offices, divided according to the teams operating at the hospice. This contributes to freeing areas to be used for more meeting rooms for the staff or more space for patients, relatives and volunteers, at UK2.

<i>Distribution of areas for administration and staff</i>				
	DK1	DK2	UK1	UK2
Areas for administration and staff, total net m <sup>2</sup>	111	216	863	978
Share of total net area, %	5%	12%	32%	35%
Number of employees	30	42	91	163
(recalculated as full time positions)				
Number m <sup>2</sup> (net), / employees	3.7	5.143	9.484	6.0
Share of total net area, / employee	0.2%	0.5%	0.6%	0.3%

At the four hospices the workplaces for the staff have been shaped in different ways. Hospice DK1, DK2 and UK1 have chosen the more traditional solution, with single or double offices, while hospice UK2 has chosen to concentrate more employees in the same room. There are actually more than double the amount of employees per room in hospice UK2 than in the remaining three hospices. The

use of team based communal offices contributes to creating space for the many employees while at the same time freeing areas for other functions – bigger patient wards in the bed section (with wards one and a half times the size of the ones at UK1), a bigger day hospice and more space for the palliative team.

### *Distribution of net area according to sub function and patient*

If we take a closer look at the bed and day hospice department and divide the number of square metres by the number of patients in both departments, it becomes obvious that hospice DK1 makes considerably larger public areas available to patients than the other hospices. Included in these public areas are dining and coffee rooms, informal conversation and meeting niches, waiting rooms and the like. At the same time hospice DK1 also has the biggest wards – in point of fact, the wards are more than triple the size of those in UK1. These wards contain a particular room for relatives.

It is also interesting to note that the areas for staff in the wards generally take up more space at the two English hospices, with a factor of 5-7 times. Yet the reason for this is that the two English hospices have a specific reception for the ward section and also specifically designed rooms intended for conversations and interviews with patients and relatives.

In the three new buildings (DK1, UK1 and UK2) the support areas of the wards take up almost the same amount of space, but twice as much as in hospice DK2. According to the interviews conducted at hospice DK2 the size of the support areas is perceived to be a bit on the low side. Converted to square metres the support areas at the hospices DK1, UK1 and UK2 take up between 6,5 and 10 square metres per patient.

The generally smaller wards in the two English hospices are to be seen in relation to the tendency described previously. Patients at English hospices are more often admitted for much shorter periods for symptom relief and respite care so that they can return home again. As the length of stay is shorter, it can be argued that the wards do not need the same amount of space as in a hospice where patients stay for a longer time. Besides, relatives can be accommodated on a sleeper couch /bed in the two Danish hospices, while mattresses can be brought in for relatives wishing to stay the night in the two English hospices.

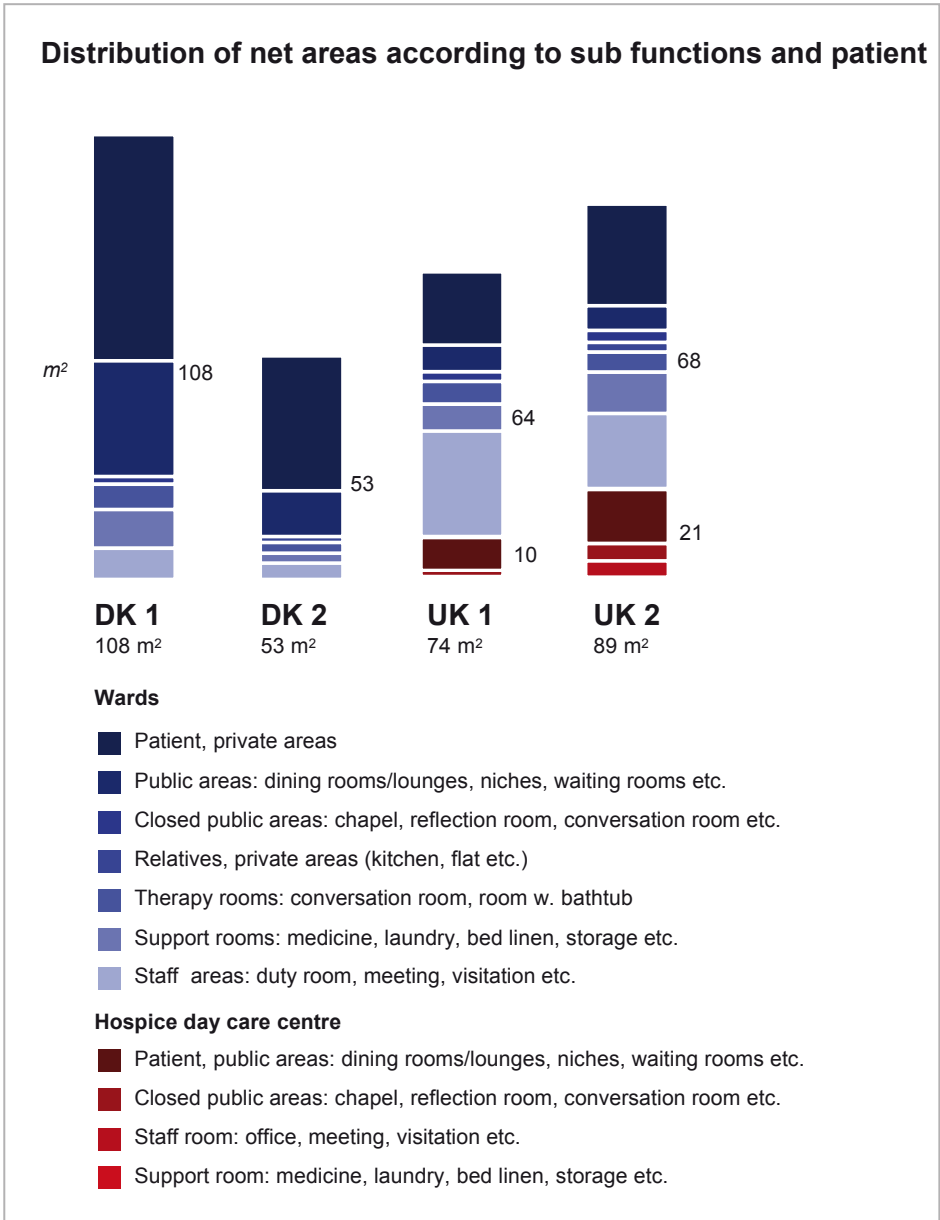


Diagram 5 - Distribution of net areas/ patient for respective hospices

## How is information circulated in a hospice?

As we realised that the work at a hospice has a distinct information intensive character, we set about analysing how information circulates between patients, relatives, volunteers and staff at a hospice. The diagram below illustrates the circulation of information among the staff, the volunteers, the patients and the relatives at KamillianerGardens Hospice in Aalborg. Individual users are divided according to function in order to make clear whether information is exchanged between the individual services or internally within the service/department. Information exchanged within the specific department is marked with dark red, and information exchanged across the department is marked with a lighter red.

It is probably not so surprising that a fair amount of information is exchanged among for example the staff at a ward or internally in the palliative team. A good exchange of experience among the nursing staff or between the doctors and the palliative nurses is the very condition for good care and treatment of the patients. It is more surprising that so much information is circulated between the palliative team and the staff on the wards. A good exchange of information between these two departments seems almost as crucial as the internal one within the respective departments, for the work to be done well.

The density of the lines indicates a higher degree of circulation of information. Exchange of information within the individual departments is marked with red and exchange of information between the individual departments is marked with blue.

**Diagram illustrating circulation of information, KamillianerGardens Hospice, Aalborg**

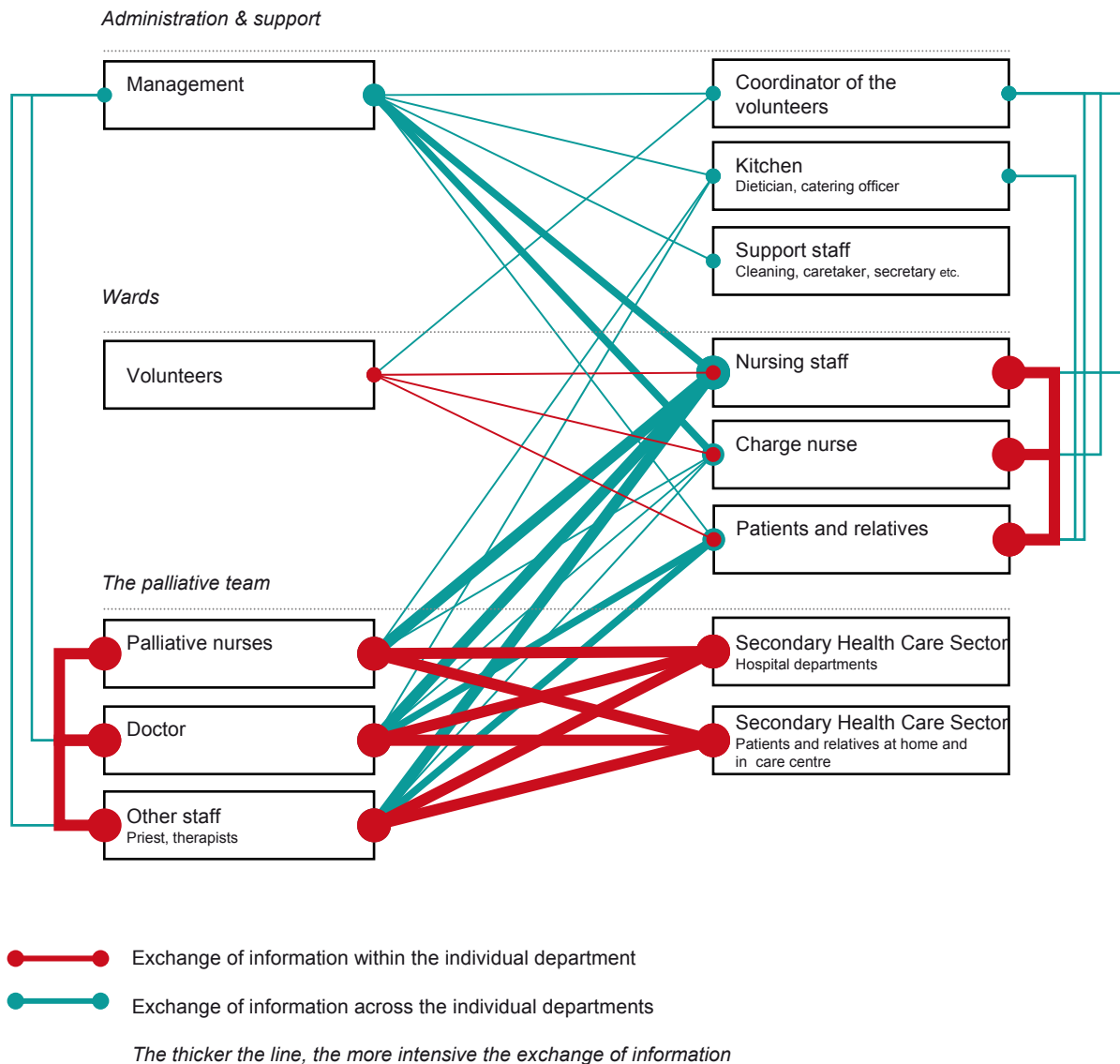


Diagram 6 - Overview of circulation of information at KamillianerGardens Hospice, Aalborg



# The Influence of the Physical Framework on the Users

## *Privacy and spatial awareness, light and air*

After the alterations of the English hospital, Mill View Hospital, Hove<sup>37</sup>, a survey was conducted regarding the influence of the physical framework on the patients. This was undertaken to gain insight into which factors patients considered to be conducive to a good or bad atmosphere. The research showed that there are two characteristic groups of factors influencing the users. The first, and most obvious group, has to do with the relation of space to the user. In this group factors like choice of colours, materials and the room temperature are to be found.

The second group of factors has to do with the way the physical framework influences relations between people. Examples of these factors might be how the physical framework restricts or promotes privacy, or how the physical framework could be a catalyst in establishing communities or social relations.

The survey rejected the general impression that the value of good design is closely linked with the first mentioned factors like colours and materials. Of course, this could be an important element for a particular type of person with a well-developed aesthetic sense, but the fact remains that typically, the second group of factors means most for the majority.

The result indicated that the most important factor for wellbeing was related to privacy, to be able to withdraw and to be able to influence the degree of privacy oneself. The second most important factor was linked to having a view. The possibility to be able to keep an eye on life outside was considered important and this was pointed out to be typically lacking.

The interviews we conducted in various hospices in Denmark and England confirmed this survey; in one of the English hospices there was an inbuilt facility to open up or to block the view to and from the actual ward. Experience also shows the importance of having light and air in the room, and to have the option to control how much light is let into the ward oneself. In this context air is to be understood as the experience of having plenty of air around oneself, which must be linked to the fact that respiratory problems are very common in the admitted patients. A room perceived to be much too 'close' could have a negative influence on the patient and cause feelings of panic if the patient has difficulty in breathing.

## *The balance between privacy and spatial awareness*

The book *Designing for Aging - Patterns of Use*<sup>38</sup> analyses the use of public and private areas in three homes for the elderly in the USA. Here the inhabitants express the opinion that too many visual contacts in the building could create feelings of being under surveillance. This is interesting in regard to the balance between spatial awareness and privacy, because on the one hand the aim is to create a building

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<sup>37</sup> Bryan Lawson, article about healing architecture in *The Architectural Review*, March 2002

<sup>38</sup> Sandra C. Howell, *Designing for Aging: Patterns of use*, The MIT Press, 1980

which is not too much like a hospital or a nursing home whilst on the other hand the risk that the user has feelings of being small, exposed and ‘lost’ due to lack of spatial awareness of the building must be minimised. This obviously makes it extremely relevant to consider the placement of passage ways and public areas in relation to what is to be the natural centre of the hospice, where a model with a centrally placed observation room could add to the impression of being under surveillance and thus deprived of personal responsibility.

### *The physical structure and social relations within the building*

In his book *Livet mellem husene (Life between the Houses)* Jan Gehl points out that the physical structure of the building reflects and supports the intended social structure among the users.<sup>39</sup> This means that the way in which we choose to shape the urban space and the buildings contributes to promote or restrict potential social interactions. When transferring this to the physical structure of the hospice of the future it means that we must be aware of which social interactions we wish to promote, and shape the public and semi-public areas accordingly. For instance, the placement of small ‘pockets’ closely linked with the passageways could encourage shorter, informal meetings among the patients, the staff, the relatives and the volunteers.

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*The patients are curious and often take an interest in the situation of their fellow patients regarding their well-being, and who has died etc. This is not a taboo.*

*/ Hans Henriksen, Specialist*

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At a hospice there are primarily four types of users with a potential to interact with each other: the patients, the relatives, the staff and the volunteers. The interviews we have conducted show that the patients and their relatives benefit greatly from the social interactions taking place at the hospice, but also that different users have their individual need for privacy. In the case of the patient this has to do with being able to ‘back off’ from the surroundings, and when it comes to the staff and the relatives it is related to the possibility of ‘taking a break’ away from the patients or the work for a while.

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*The patients need easy access to other patients, easy access to the staff and to support facilities. At the same time they need to have the option to withdraw, close their door and say ‘no thank you’. Sometimes the only thing needed not to feel isolated is the sound of other people.*

*/ Arne Kolsum, Head of Sankt Lukas Hospice, Hellerup*

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The limited number of social relations among patients at the Danish hospices could be caused by the actual criteria for visitation to a hospice. To day admission to hospices are to a far extent only available to terminally ill patients. This means that the patient withdraws from the external world and only focuses on saying

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<sup>39</sup> Jan Gehl, *Livet mellem husene*

goodbye to the closest family, while there is no energy for or interest in establishing new social relations. Most of the relatives we have spoken to express joy in having had the chance to meet with and talk to other relatives at the hospice, as the shared experiences and thoughts are a source of support for the relatives during a difficult time.

As the patients and their relatives often come from very different backgrounds, are of different ages and from different social classes, the relations happening in a hospice could be described as dictated by the situation; they are established because of the specific situation people find themselves in, and not because of a communal social circle or social network. Therefore it is true to say that the hospice holds the possibility of creating new social relations, which normally may not occur.

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*The wards have to be absolutely soundproof, so that sounds from one ward cannot be heard in the ward next door. It has only happened once that a patient did not like the noise from the school on the other side of the yard. But then we just closed the window, and it was OK again.*

*/ Nursing staff at KamillianerGaardens Hospice, Aalborg*

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It is important to remember that the more energy needed to move oneself to the communal public/social rooms, the bigger the chance that these will get a low priority from the users. Using the communal social rooms places a demand on the user, who becomes very visible, partly while moving towards the room, partly by the very choice of using the public space actively. As security is precisely one of the key words for the patient and the relatives when encountering the hospice, and as many patients move with great difficulty, the placement of the public areas has to be considered very carefully to make these easily accessible to all types of users.

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*The question is whether you can have too much space. Maybe you run the risk of getting too far removed from what is happening in a hospice. It could probably become too big, and you risk getting isolated. Distance and big rooms need not always be positive.*

*/ Arne Kolsum, Head of Sankt Lukas Hospice, Hellerup*

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### *The Good Hospice - a metaphor*

In order to get a better understanding of what a hospice actually is, we asked a number of relatives, volunteers and employees at a hospice to suggest which metaphors could be used to describe what *The Good Hospice* is. Here follows an extract from some of the answers:

- *A spare home or a kind of hotel*
- *A kind of home where there are specialists taking care of people during their final period in life*

- *A refuge, a hiding place – a place, where you can withdraw*
- *A place providing space for the family to say goodbye properly*
- *A shelter or hostel*
- *A form of shared living*
- *In any case it is not a hospital!*
- *It is not a nursing home, but it is also not a home*
- *A final anchorage, sheltered from wind and storm*
- *One's last residence, where I will spend the last part of my life*
- *As 12 private residences, which are organised so the needed services are available*
- *A hospice is a hospice. You see, it is not a home or a hotel or a hospital*  
  - *– it is in fact a hospice.*

The conclusion is that we are unable to find one particular metaphor describing what a hospice is. However, all the persons in the interviews agree that a hospice is not to be seen and experienced as a hospital. The shape of the physical framework could further this experience of something more homely, partly through the choice of materials, colours, furniture and equipment, but also through the overall planning of the physical framework, and so, long, uniform passages are avoided and the building invites a more informal meeting style between people.

# Resume - what can we learn from others?

Not altogether unexpectedly it can be concluded that the planning of the physical framework of the hospice depends on the priorities which have been made in relation to how the contents of services are to be expressed, the particular method of organisation and whether you are dealing with a new building or a hospice which is to be converted from an existing building.

By and large, the biggest differences between the Danish and the English hospices are linked to the size of administrative areas, which take up considerably more space in England, because of a bigger number of fundraisers employed, and a significantly higher number of volunteers.

However, certain communal topics repeat themselves, across national borders and nature of services offered. Those are topics like culture and soft values, the contribution of volunteers, sharing of information among staff, the patient's perception of continuity and the high degree of involvement of the participants in the establishment process.

The hospices we have visited, interviewed and analysed all have in common that much time has been spent considering the basis for the facilities at the hospice, including the criteria on which visitation to the hospice rest, the nature of the services offered to patients as well as the way in which the facilities are formed into specific palliative teams, out patients departments, wards etc.

On the other hand, the appearance of the physical framework varies a lot between England and Denmark. In the English hospices strong colours on the walls are more common, as are bolder patterns on the curtains and an overall more romantic style than the minimalist, Scandinavian style we know. Nonetheless, the hospices we have visited share the specific intention of not wanting to look like a hospital.

## *Sharing of information, interdisciplinary and inter organisational cooperation are conditions for good palliative care*

When looking at how the work in a hospice is done, it becomes apparent that palliative care depends a great deal on the sharing of information and the utilisation of other people's experience in order to function optimally – both internally, at the individual hospices and externally, across institutions. As the patients often suffer from complex symptoms, and as complete package solutions for the individual patient do not exist, sharing of information and good interdisciplinary co-operation are a condition for being able to provide adequate relief. Likewise, good sharing of information is a basis for the smooth running of shifts between the day, evening, night (and sometimes also afternoon) teams. An interesting observation is that the physical presence at the individual workstations is relatively low, as most of the staff work 'out' among the patients.

It is therefore obvious to work with more flexible workstations, which could be

shared by more users, something which will also make the staff gel more, while encouraging further interdisciplinary sharing of information.

Good inter-institutional co-operation is a condition in which the patients and relatives experience palliative care as a unified whole and not like a mass of fragmented, disconnected services. Inter-institutional co-operation could also be of a more strategic nature, for example in the form of research, education, teaching and collaboration in gathering of data and statistics etc.

If a palliative team is linked to a hospice institution, it is important to realise that a substantial amount of information and experience will spread across the team and the staff in the wards.

### *Safety, tranquillity, dignity and continuity are essential for the patients and the relatives*

Safety, tranquillity and dignity are key for the patients' and relatives' good stay at the hospice. These conditions can be met via three different parameters: In the shaping of the physical framework, in the way in which the staff carries out the work and in the actual meeting with palliative services, which often involve a number of competences, people and institutions. Therefore the continuity perceived by patients and relatives is important, as this adds to the quiet atmosphere, which is so highly valued. In other words, the different palliative services must be experienced as unified, regardless of their institution of origin. Obviously, this places bigger demands on unified, co-ordinated palliative care and on the co-operation between the individual institutions with which the patient and the relatives will be in touch during the process.

### *The specific hospice culture as a platform for palliative care at a hospice*

All relatives, volunteers and employees we have met, talk about the specific spirit, or philosophy, which permeates the hospice and which contributes to the creation of a good stay. There are subtle differences in the perception of this spirit between the individual hospices, which, in a few words, is about using the needs of the patients and the relatives as a starting point, involving them in the decisions affecting them and basing the palliative work on the terms of the patients and the relatives themselves.

A good culture is, among other things, supported by the fact that the staff has more time with the patients than the nursing staff at hospital typically has, and that there is in fact, more time for reflection at a hospice.

In other words, the culture becomes a platform for palliative care at a hospice, and if a good culture is absent, the choice of furniture, colour of the walls etc. does not play a significant role in the total experience of the patient and the relatives regarding their interaction with the hospice. However, it can be argued that the physical framework could contribute towards nurturing a particular culture, which is the reason that the shape of the physical framework plays an indirect and supportive role in relation to the particular hospice culture. It is also considered

essential that this culture must never be allowed to crystallise, but is to be developed continually. The culture is not a static concept, but something that is up for discussion and revision on an ongoing basis.

### *Informal social meetings are important for the patients and their relatives*

The patients and relatives declare that the social meetings taking place at a hospice have a considerable influence on the total experience of the hospice. The specific situation patients and relatives find themselves in, promote frequent sharing of experience and mutual help and in this way new social networks are created. The physical expression of the building could support this via conscious design of communal areas like lounges and dining rooms, but also via protected spots in the garden and special niches in the passageways. Our analyses showed that social relations take up more space at St. Francis, The Princess Alice, Farleigh and Grove House than at KamillianerGaarden, but this could possibly be due to the conditions of the actual patients and to slightly different criteria for visitation; at KamillianerGaarden more patients are admitted to terminate life than at the above mentioned English hospices.

### *Different strategies to promote social relations*

The size and shape of the wards and the public areas have an effect on the social relations, which develop (and which are given 'space' to develop). When building a new hospice, you can talk about different strategies regarding the social relations you wish to encourage. Very big wards can result in the patient's home universe becoming limited to the ward itself, as this meets existing needs. There is actually a risk that patients and relatives choose to remain in the ward rather than take advantage of the public areas. On the other hand, relatively small wards will force patients and relatives into the public areas to a higher degree, with more social interactions as a consequence. The home universe of the patient is here extended to include more than the ward itself, and in this case it is important to give consideration to the public areas to enable their natural 'assimilation' into the patient's own home universe.

In all the hospices we have studied, creating space for informal meetings between patients/relatives/staff and volunteers has been emphasised. But when we delve into the examples we looked at in the analyses of the physical properties of the buildings, it becomes evident that the prioritising of the areas for patients and relatives varies considerably from hospice to hospice. One of these hospices (DK1) operates with much bigger wards and communal areas than the other three hospices (DK2, UK1 and UK2). A big ward has some obvious advantages – there is space for more relatives and more private things, and it is probably easier for the staff to work there. But there is also a risk that a room of that size may appear very big to a severely ill person, who could easily 'disappear' in the room.

Therefore it is important to realise which degree of social interaction is intended between the patients, the relatives, the volunteers and the staff at the hospice and then plan and shape the rooms and the relations between these accordingly.

### *The volunteers fulfil an important function at the hospice*

It is obvious that the role of the volunteers is defined more widely in England than in Denmark, and that the English hospices use volunteers more extensively than the Danish ones do. This is probably due to differences in the financing systems of the two countries. In England there is a far bigger dependency on fundraising, voluntary work and donations, which is the likely reason that the volunteers have been given a bigger role in the daily work. The ways the volunteers are led also differ. In the English hospices you often see volunteers directly linked to a particular department, where the responsibility of leadership is delegated to individual heads of department.

The hospices we have visited and spoken to all have in common that the volunteers participate in building bridges to the local community, something which the relatives, the patients and the staff see as adding to the feeling of still being able to follow what is going on in the outside world. It seems however that the majority of the volunteers are elderly women, and if the intention is for the hospice to play a role in making death less of a taboo in future, ensuring the involvement of more younger people and more men in the voluntary work is obvious, so that the volunteers reflect the local community increasingly.

### *The Good Hospice has a high degree of functionality*

The hospices we have visited and conducted interviews with all point out the necessity of remembering the functional aspects in a hospice. These could be things like plenty of storage space, a sufficient number of parking spaces for visitors and the staff, designing the laundries with windows (or equipped with very good ventilation), that the meeting rooms are big enough to hold general meetings for the staff, that cleaning is relatively easy, that patients have easy access to the garden and that there are enough electric sockets in the rooms etc. Even so it is important that the functional perspective of the hospice does not take over when shaping the physical framework, as there is a risk that putting too much weight on functionality at the expense of the work with atmosphere and appearance could damage the overall impression of the hospice. This is particularly relevant when, for example, fitting ceiling hoists, and oxygen and suction in the individual wards. These types of installation should be concealed as much as possible, to avoid direct associations with hospitals.

### *Securing ownership and management of the initial intentions through the entire establishment process*

In hospice projects at the planning stage and in the hospices we have visited and interviewed, it has been essential to involve all users and other interested parties in the work, right from the first idea phase, before the building has even started or the house has been designed, and further into the process. This user participation has two purposes: to 'tap' the users (who are actually the real experts) for valuable input regarding how to ensure a higher degree of functionality, but also to secure ownership and management of the initial intentions of all the implicated parties right through the establishment process.



### *Activating the passageways etc.*

As it is often necessary to prioritise the use of physical areas, it is relevant to look into how the de facto areas can be utilised so that they also fulfil a function other than the purely functional one. If a building which already has a big footprint also has big de facto areas in the form of passageways, stairs, lifts and the like there is a risk that the perceived size appears bigger to the users than the actual size, something which can be problematic if you intend creating a building with a homely feel and a more intimate atmosphere. In this case a solution could be that the de facto areas become utilised to a larger degree, for example through shaping passageways and the like in a manner which also contributes to giving the users an experience and creating an atmosphere. Another way of doing this is by operating with more flowing transitions between passageways and public/semi-public zones, which 'attach themselves' to the passageway.

### *Personification and degree of privacy means a lot for the well-being of the patient*

To be able to change the atmosphere and expression of the ward is a factor, which has an influence on the well being of the patient during the stay at a hospice. At many hospices the patient can bring his/her own pictures and, to a limited degree, his/her own furniture. But our analyses show that factors like being able to control the degree of privacy (view in /view out), the perceived size of the room, light, heat and sound play an even more significant role in creating a comfortable stay.

### *A hospice is not a hospital – avoid direct associations with it*

All the hospices we have visited and spoken with share the wish to create an institution, which holds minimal associations with a hospital. This can partly be promoted through the choice of materials, which a hospice has more influence on than a hospital. Many of the hospices we have visited, have chosen to work with wooden floors or carpets, which may enhance a homely atmosphere. This could also happen through the layout of the physical framework, which can enhance the feeling of intimacy to a larger extent than in a hospital. An example is the planning of the ward sections, where a more intimate, close and homely atmosphere is created when dividing these up into 2-3 smaller parts.

# Focal areas and Recommendations

In the previous chapters we have presented a total up-to-the-minute account of palliative care in Denmark in 2005, given a resume of the experiences available in the running and development of hospices in England and Denmark and pointed out some tendencies in relation to the future development within palliative care.

The conclusion is that the potential for expanding palliative care is large, and that a big group of people diagnosed with an incurable illness will need palliative intervention in the future. However, changes in patient types and demography will cause new expectations of, and demands on, palliative care and therefore also on the physical expression of the buildings in the coming years.

Palliative care in Denmark is still in a growth phase and it holds potential for further development in future. Part of this potential can be found in the way in which the physical framework is shaped, as this could contribute towards creating a better stay for severely ill patients and their relatives during a trying period. Other areas with potential for improvement are of a more strategic nature with expansions of the contents of services, a full implementation of existing strategies for palliative care in Denmark, a higher degree of involvement of volunteers and even better inter-institutional and interdisciplinary co-operation.

Before we present our suggestions regarding an environment – and layout programme for *The Good Hospice*, a summary of the conclusions from the previous chapters and all focus areas follows, which are, in our opinion, essential to consider and incorporate into future hospices.

In the subsequent chapter - Space and Relation programme for *The Good Hospice in Denmark* - we look at some focus areas and their related recommendations and transform them into a number of design principles regarding the way to construct *The Good Hospice*.

*Focus area 1:*

## Re-think the establishment process and make it professional

- *The Good Hospice* has a high degree of functionality.
- Securing ownership and management of initial intentions throughout the entire establishment process.

### *Description of the focus area*

The functional aspects of the hospices are important. From the start a number of things need to be part of the planning process, like sufficient storage space, enough parking spaces for visitors and staff, that bedridden patients can actually use the entrance to different rooms and that the meeting facilities can accommodate interdisciplinary conferences at the hospice etc.

As the work at the hospice depends on a wide combination of competences and professionalism, it is also important to ensure that workspace has been set aside for these and that the rooms are designed to support the high degree of interdisciplinary and flexible work taking place at the hospice.

A high degree of user involvement starting in the idea phase contributes to creating ownership and a good database for important decisions. Likewise, an earlier involvement of professional consultants and a wider involvement of different interested parties add professional quality to the establishment phase itself. This contributes to ensuring that the initial values are managed well throughout the entire establishment phase, so the finished building does reflect initial ambitions and visions.

### *Recommendations*

- Involve all interested parties early in the establishment process in order to create a joint vision and ownership of this for the new hospice.
- Listen to and involve the users early to ensure a high degree of functionality at the hospice.
- Make important decisions as late as possible in the process, as the database is stronger at that point than at the start of the process.
- Think about the process from idea to initial use as a whole, and revise the process continually to ensure that initial values are managed throughout the entire realisation process.

*Focus area 2:*

## Build a strong Cult

- The specific hospice culture as the platform for palliative care at the hospice.

### *Description of the focus area*

Soft values take up a lot of space at a hospice. All relatives, volunteers and employees we have spoken to, talk about the unique spirit, or philosophy, which permeates the hospice, and how this spirit contributes to creating a good stay for all of them.

In other words, the culture becomes a platform for palliative care at a hospice, and therefore the staff fulfils an important function as carriers and mediators of this culture, as it is the staff that manifests the basic ideology and attitude of the hospice in their daily work.

All hospices we have visited and spoken to work actively in maintaining and developing this particular culture and consider an ongoing process essential, through which the staff continues to reflect on and redefine the attitude and philosophy of the hospice in relation to the work to be done.

### *Recommendations*

- Spend time and attention on creating a good culture among the staff at the hospice. This could happen via regular internal workshops where specific problem areas are discussed, and via a decision by the leadership not to see the culture as a static concept, but as something alive which needs to be discussed and revised continually.
- Involve volunteers and the local community in the discussions, partly to get inspiration and reflect assumptions and possible prejudices engrained in the hospice culture, but also to spread information about the hospice as an institution and philosophy outside the physical boundaries of the hospice.

*Focus area 3:*

## Improve and develop cooperation between organisations

- Safety, tranquillity, dignity and continuity are crucial for the patients and the relatives.
- Ensuring the perception of continuity for the patient and the relatives.

### *Description of the focus area*

The experience of security of the patient and of the relatives depends directly on the experience of continuity in the different palliative services available to them. That continuity does not get lost becomes extremely important with palliative care stretching over a longer period of time, with more kinds of flexible patient processes and with new contents of services.

A sense of continuity is experienced when you see the same faces in the wards at the hospice as you have already seen at home or at the hospital. In this way palliative services appear to be coherent – regardless of their organisational base. Today, a big number of external contacts work at a modern hospice, and with increasing demands and the intention of co-ordinated research, a further increase in co-operation between institutions can be anticipated.

### *Recommendations*

- The patient and the relatives will experience a higher degree of continuity in the content of services available, when staff from the palliative team circulate in all the departments of the hospice.
- The nursing staff of the wards could, with advantage, also take care of a possible day hospice department, as some of the patients from the day hospice are very likely to be admitted to the wards at the hospice later.

#### *Focus area 4:*

## Re-think the ward

- Bigger demands on new information and communication technology.
- Individuality and degree of privacy mean a lot for the well-being of the patient.

### *Description of the focus area*

The ward is naturally the most intimate sphere of the patient and relatives in the hospice and a lot of attention should be given to designing and shaping it.

Research shows that the well being of the patient is influenced positively by the possibility of altering the atmosphere and expression of the ward. Factors like degree of privacy (internal/external views), the perceived size of the room, light, temperature and sound are important to consider.

More patients and relatives who are used to modern communication technology will likewise place bigger demands on the technological equipment of the hospice, so it becomes possible for the patient and the relatives to work directly from the ward, to initiate and maintain social relations seek new knowledge and information related to their situation and to be in virtual contact with family members and friends.

### *Recommendations*

- The ward must support the diversity of the patients. Make it possible for the patients to influence the surroundings easily, for example by changing the degree of sound insulation, ingress of light, internal and external views, temperature, perceived size and the degree of exposure or privacy.
- Implement new technology in the ward, so that the patient and the relatives can work more easily and create social relations via for ex. the Internet.
- Fit out the ward in a very simple way, as severely ill patients are often more sensitive to new sensory impressions and fewer means are needed to create an effect.
- Let the ward have its own soul: as the room works like an extra home which the patient borrows for a limited period, it is important that the ward already from day one signals homeliness, rather than presenting an empty shell, which the patient has to fill with his or her own things. Yet it should still be possible for the patients to give the ward their personal touch.

## *Focus area 5:*

# Use the hospice building as a mediator

- A hospice is not a hospital – avoid direct associations with it.

### *Description of the focus area*

The physical framework plays an important role when it comes to promoting an atmosphere of intimacy, homeliness and individuality at the hospice. A hospice is not a hospital and should not appear like one – something to consider when planning and shaping the physical framework. Choice of materials and furniture can contribute to minimising the impression of an institution and instead create an atmosphere of homeliness and individuality.

A building deconstructed into minor parts, with for example a division of the wards into smaller sections, can make it easier to have an overview of the building, while preventing the user from “disappearing” into it.

### *Recommendations*

- Avoid creating an institutional feel to the building. Work with textured materials. Focus on the details, including choosing materials of high quality.
- Avoid working with too big areas, including passageways, as these can add to the impression of being exposed, experienced by patients and the relatives.
- Deconstruct individual sections of the hospice into smaller parts to create a more intimate and informal atmosphere.
- Installation of and access to oxygen, suction, possible ceiling hoists and other auxiliary appliances should be done as discretely as possible.
- Work towards lessening or removing sounds and smells, which could be disturbing or associated with a hospital, like alarm bells, sounds from other inhabitants, from air-conditioning systems or appliances, the smell of surgical spirit, vinyl floors or institution soap etc.

## *Focus area 6:*

# Use the physical framework to facilitate social relations

- Informal social meetings are important for patients and relatives.
- Different strategies to further social relations.
- Utilise the passageways etc.

### *Description of the focus area*

Experience shows that staff, volunteers, patients and relatives benefit a lot from meeting and sharing their experiences with each other. Typically, social relations springing from current situations come about spontaneously, and therefore informal meeting places need to be thought about when planning a new hospice. A well-planned design of the private, public and semi-public areas will contribute towards promoting social relations among individual users.

You can talk about different strategies with regard to the social relations you wish to promote, as very big wards could result in the “home universe” of the patient being limited to the ward itself, if this meets all the patient’s needs. The consequence could be that the patients and the relatives choose to remain in the wards, instead of making use of the public area, which subsequently will become drained of life. On the other hand, relatively small wards will to a larger degree “force” the patients and the relatives into the public area, with more social interactions as a result. There is something to be gained by giving attention to the design of the passageways of the hospice, so that these do not only work as distribution areas, but as places “where things can happen”. This adds to the creation of a good atmosphere, supports ad-hoc meetings and creates a good experience for the users.

### *Recommendations*

- The communal areas should be upgraded so they promote social relations to a higher degree, including possibilities for bigger gatherings as well as smaller, intimate meetings.
- Plan the communal areas so that these are well connected to the rest of the hospice and are easily accessible for all inhabitants.
- Avoid too many and too big communal rooms, as this will increase the risk of fragmentation of the social activities.
- Establish smaller, informal “pockets” linked to passageways and the like to support spontaneous meetings among the users of the hospice.
- The garden should be planned to also include a number of semi-public pockets into which you can withdraw as a patient or a relative.
- The passageways take up a lot of space in people’s awareness, and therefore it makes sense to concentrate on how to upgrade these so that, to a higher degree, they represent an architectural and pleasurable experience throughout the hospice.



*Focus area 7:*

## Utilise the Volunteers

- Volunteers fulfil an important function in the hospice.

### *Description of the focus area*

Volunteers fulfil an important function in a hospice. Partly in the form of a social function for patients and relatives, partly in the form of relieving the staff of individual tasks, but also as bridge builders between the local community and the hospice.

The volunteers also play an important role as ambassadors for the hospice-movement, as these contribute to strengthening the link between the hospice and the local community and spread information about palliative care to the local population.

Today, the majority of the volunteers at hospices in Denmark are elderly women, and if the volunteers are to reflect the actual make-up of the population, it makes sense to look for ways to involve larger numbers of younger people and men in the voluntary work. This will make it even more possible to abolish taboos and drama surrounding death, and the patients and the relatives will have a chance to meet more different people.

Therefore, there is a large potential in looking for new ways to involve volunteers to a much higher degree than today, and to look at the tasks which the volunteers can and must take care of in future.

### *Recommendations*

- Engage the volunteers more at the hospices. Look at their task portfolio with the view of expanding this into new functions.
- Place a possible co-ordinator of volunteers in the hospice leadership to support better integration of volunteers at the hospice, or alternatively, to work with the same model as in the English hospices, where volunteers are directly linked to the individual wards.
- As volunteers at a hospice today primarily consist of elderly women, it makes sense to develop approaches to recruitment, which to a higher degree attract more young people and more men as volunteers.

## *Focus area 8:*

# Improve the framework for the information intensive work processes

- Sharing of information, interdisciplinary co-operation and collaboration between organisations are a condition for good palliative care.

### *Description of the focus area*

There is a large potential for improving and re-thinking the physical framework of information intensive and interdisciplinary work processes taking place at hospices. One possibility is fewer, but bigger team-based administrative areas and another is staff areas, which to a higher degree support sharing of information and quick meetings across professional groups without giving up the opportunity for concentrated individual work. Subsequently, there is a need for a physical framework enabling interaction as well as autonomy.

This kind of design contributes to freeing up areas, which could be used for other uses and activities. Experience shows that a better sharing of information is typically obtained by placing different professional groups in the same area. The level of quality is increased as everybody has easier access to the same documents and journals.

### *Recommendations*

- Re-think the design of the staff areas in hospices. Work with open team-based staff areas with space for both the palliative team and the staff from the wards and the day hospice to promote sharing of information and interdisciplinary work.
- Revise the use of individual offices, which often stand empty, as much of the work takes place somewhere other than at the desk.
- Work with flexible multi-function rooms, which could be used by different professional groups to support different work processes at the hospice and to free up space for other purposes.
- Place the administrative services, including the co-ordinator of volunteers, in a unit by itself but closely linked to other staff areas to ensure an optimal framework for the daily running and development of the hospice.
- Divide the staff area in two sections: an externally oriented section, where visitation, consultation and therapy take place, and an internally oriented section, where internal meetings, confidential telephone conversations and concentrated individual work could take place.

# Space programme

In this section we make suggestions regarding how to shape *The Good Hospice* with the physical framework as a focal point, so this gives optimal support to the ideal hospice model. Our suggested approach to the layout of the physical framework allows this to play an increasingly active role in creating a better stay at the hospice for the patient, the relatives, the volunteers and the staff.

## *Our understanding of the hospice of the future:*

It is important to point out that in the following chapters, we do not equate the hospice only with a ward, where patients can stay until the termination of life; we operate with a broader understanding of the concept, in which the hospice becomes the description for the particular platform through which palliative care could be expressed via a number of services with different content.

Therefore we use the term hospice as a description of the physical building, which could hold a number of different palliative services - like a ward, facilities for examination, a palliative team and a day hospice. For political and financial reasons, these departments could be based in different places, but for the sake of perceived continuity by the patients, and to ensure good sharing of information and interdisciplinary co-operation, we encourage very close co-operation between the different departments. Consequently, we have chosen to ignore where the different services are based organisationally in order to keep the focus on how the patient and relatives experience the hospice and the different services available.

The suggested solutions presented here need not have huge financial implications; however, they require that more users are involved in the planning of the development of a new hospice at an early stage, and that particular attention is given to how the physical framework may fulfil a role larger than purely functioning as walls, floor and roof.

This section consists of 3 chapters:

A review of the design principles for *The Good Hospice*. The principles show how the relations between individual parts of the hospice should be and they also suggest the kinds of atmosphere and expressions, which may be promoted with advantage in some of the most vital rooms at the hospice. These design principles can work as a checklist contributing to ensuring a high degree of functionality in the planning of a new hospice, and as a concrete tool in the programming and in the arrangement and layout of the individual rooms by the hospice. As a further tool we have drawn up a functional space programme, listing the necessary rooms to be found in *The Good Hospice*, their estimated size as well as the functional demands placed on them. The functional space programme is enclosed.

An illustration of how programming of *The Good Hospice* might be done, taking its starting point in the above mentioned design principles. The example contains

a diagrammatic review of the hospice, its departments and their relations, and it shows in detail how the programming of *The Good Hospice* might appear. This section is illustrated with collages, providing a visual impression of the kinds of expression and atmosphere selected rooms at the hospice should promote.

To conclude, a suggestion for the ideal implementation process for *The Good Hospice* follows - a process working with a higher degree of user involvement than the average building process. This process contributes to ensuring better management of initial values and visions, so these are in fact reflected in the expression and functionality of the final building.

## I. Design principles for The Good Hospice in Denmark

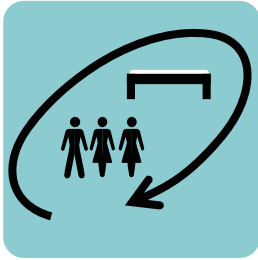
The following are the overall design principles we consider fundamental for *The Good Hospice in Denmark*. These design principles build on the previously mentioned focus areas and the related recommendations, and touch on the programming of the hospice and the relations between separate components of the building, the functional requirements of individual rooms as well as the kinds of atmosphere and expressions to be promoted by some of the rooms.

These principles are expressed as pictograms indicating specific points of attention in the programming of the building; they review some of the considerations which are closely related to the planning and programming of the building as a whole, in the design of the wards, the staff areas and the communal areas. In order to indicate the atmosphere and expressions to be promoted in some particularly vital rooms and areas at the hospice, the design principles have been supplemented with a set of visual analogue scales, which indicate the tone and atmosphere to be found in these rooms.

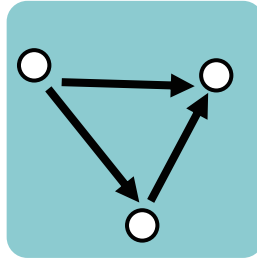
These tools have been chosen specifically to function as useable instruments for decision makers, hospice staff, architects and engineers in the planning of a new hospice, indicating a direction rather than dictating one specific solution. From this perspective, the design principles are to be seen as overall guidelines, which might be applied in the individual hospice – regardless of placement, size or other local conditions.

Pation in a spiritual atmosphere without any obvious references to any particular religion.

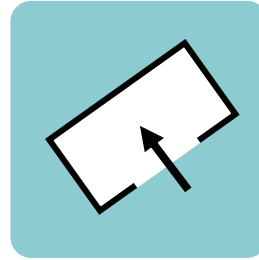
*The building as a whole and the relations between individual parts*



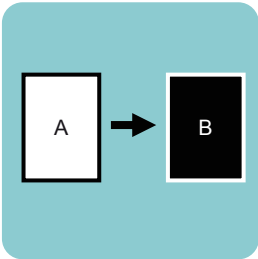
Let the building encompass the hospice.



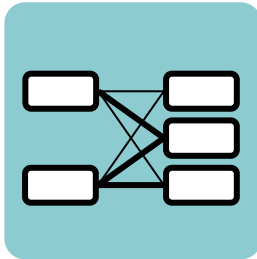
Create close proximity to make moving between a and b easy.



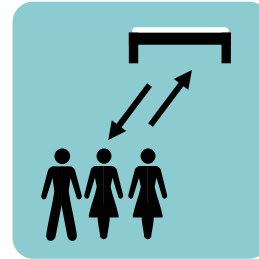
A communal main entrance for all the departments of the hospice.



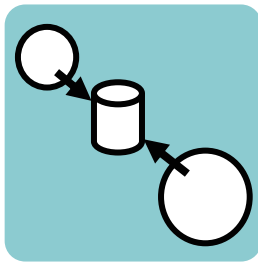
Work with flexible areas, which may accommodate different functions. Avoid rooms that are not used for a period of time.



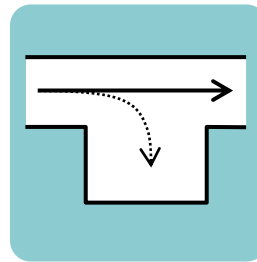
Disposition of the physical plan is to further interdisciplinary co-operation - both within and across different departments.



The ward should be perceived as a separate zone.



If possible, the different departments in the hospice should share communal rooms and support facilities.



Extend the public areas with spaces more suited for privacy.



Provide access to or include green areas.



Avoid creating an impression of being watched.

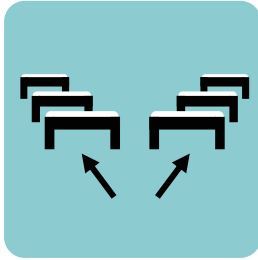


The communal areas and the public spaces should encourage social relations between users.

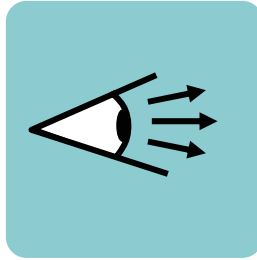


Integrate the volunteers more in the daily work at the hospice.

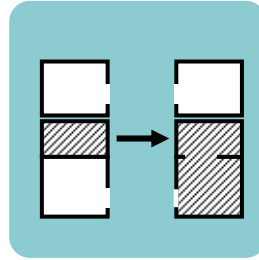
*The patient's area / ward section*



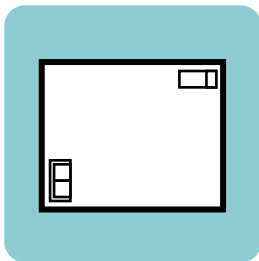
The ward is divided into two or three smaller units, to maintain an overview and a sense of intimacy.



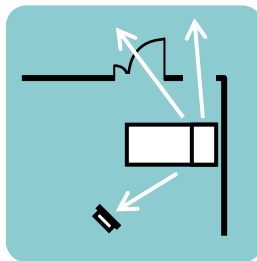
It should be possible for the patient to keep an eye on life around him/her.



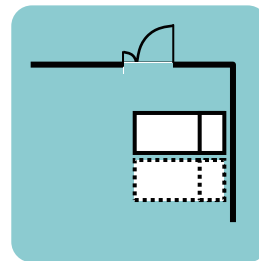
Wards of varying sizes; possibly via adjoining subdivided areas.



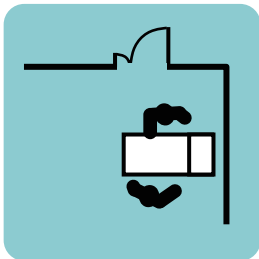
The room should not appear too large to the patient.



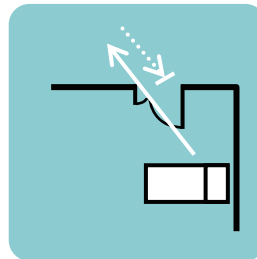
From the patient's bed it should be possible to watch TV, look through the window and possibly see the passage way.



Spending the night in the ward should be possible for relatives.

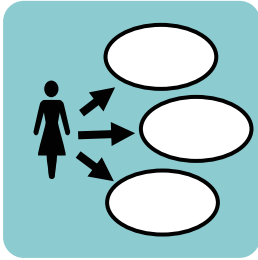


If there's no ceiling hoist, space for a bed fitted with mobile hoist.

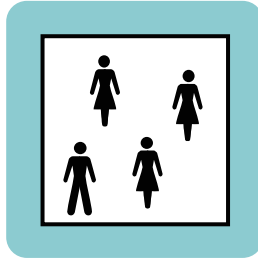


The door should open without placing the patient in the ward directly on public view. It should be possible to keep an eye on life outside the ward when the door is open towards the passageway.

## Staff areas



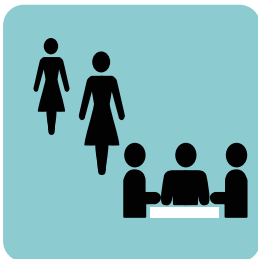
The staff should be as close to wards, possible day care centre and examination facilities as possible



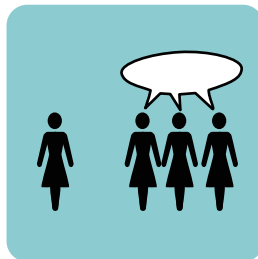
The rooms should encourage exchange of information among the staff. The work areas should be team based. No/few personal offices.



Administration, research and co-ordination of the volunteers by the nursing staff and the palliative team should be divided into zones.



Possibility of dynamic types of meeting with many simultaneous conversations.

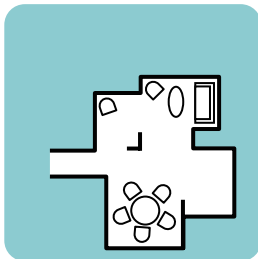


The staff area should be planned with a view to the type of work, which is to take place at the individual workstations.

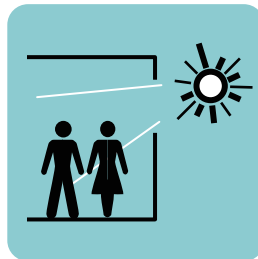
## Lounge – and reflection rooms



Create a natural communal focus, such as a piano, a library, a fireplace, a play corner, TV, an aquarium etc.



Divide the room into different coherent zones.



Space for reflection and contemplation in a spiritual atmosphere without any obvious references to any particular religion.

### *Expression and atmosphere*

The charts below show the kinds of atmosphere certain chosen rooms and areas in *The Good Hospice* should promote. The charts indicate the kinds of atmosphere to be found in the individual rooms and are represented by a number of visual analogue scales, where the respective rooms may lean towards one extreme or the other. All the scales make up the total expression of the room and the atmosphere to be promoted. The scales should be seen as guidelines and as starting points for the final layout of the physical framework.

The visual analogue scales we have chosen to work with are:

#### *Externally oriented - Internally oriented*

Whether the room is to be open in relation to the surroundings or to have an inward focus.

#### *Public - Private*

Whether the room is to have a public or more private character.

#### *Solitary - Social*

Whether the room is intended for reflection or for social interaction.

#### *Close - Remote*

Whether the room is to be located close to or far away from other rooms.

#### *Impersonal - Personal*

Whether the room is for “everybody” and without personal features, or with a personal character.

#### *Order - Disorder*

Whether the room is to appear neat and tidy or whether some degree of untidiness is acceptable.

#### *Rigid - Flexible*

Whether the room is to be flexible in relation to the activities taking place in it or not.

#### *Light - Dark*

Whether the room is to be light or dark.

#### *Energetic - Calm*

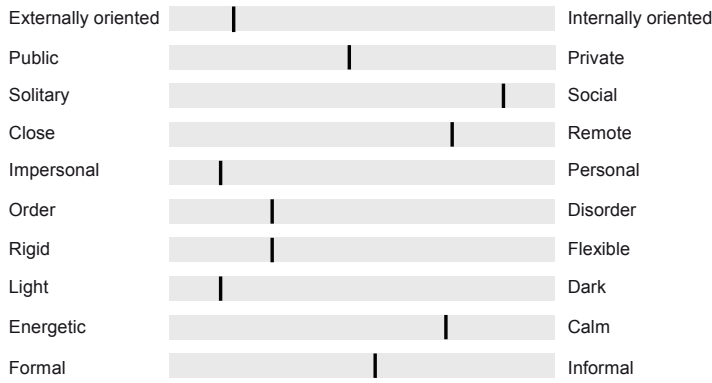
Whether the room is to be conducive to active energy or silence.

#### *Formal - Informal*

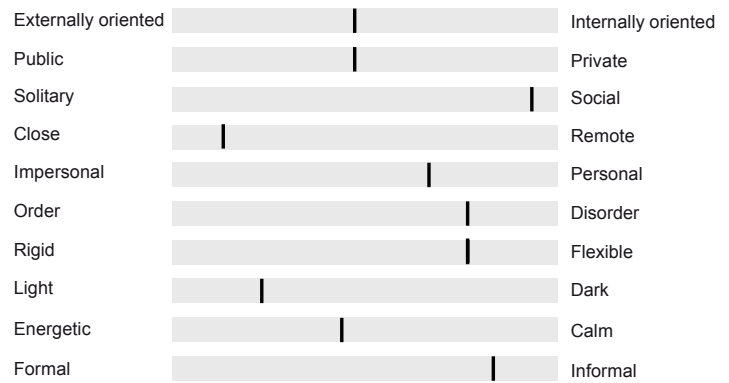
Whether the room is to have a formal or informal character.



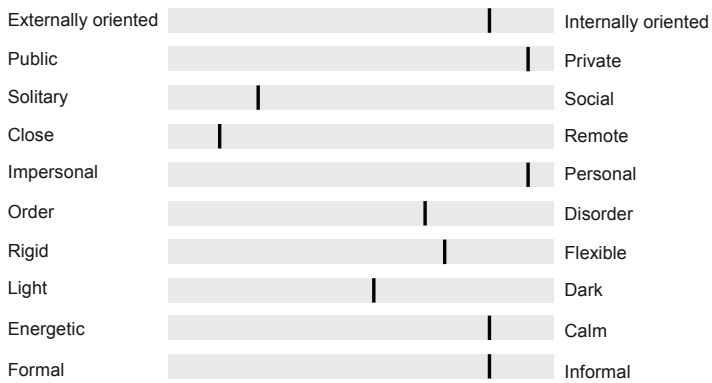
## Arrival area



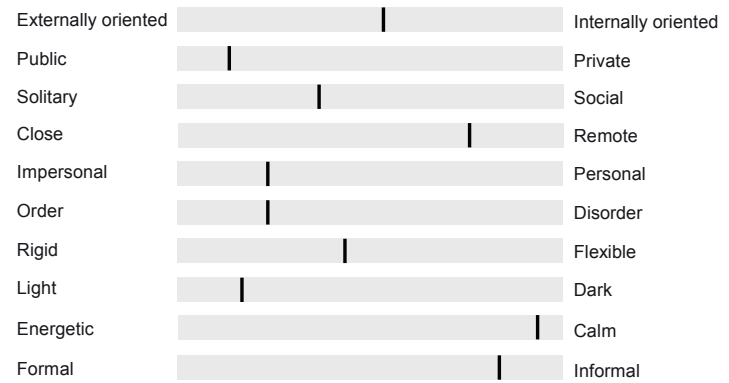
## Lounge



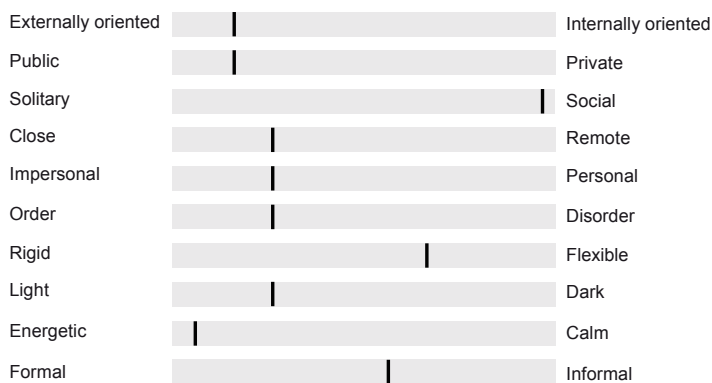
## Ward



## Reflection room



## Staff area



## II. Examples of programming

The following programming arises from the earlier listed design principles. The purpose is to exemplify how to organise the physical framework in a hospice. The programming starts by looking at the layout of the individual sections of the hospice and their mutual interrelation (wards, staff area, communal area etc.) and then subsequently goes into detail with individual components. Below appears which design principles have been the basis for the choices made during the process. To illustrate the kinds of atmosphere some of the most important rooms in the hospice should promote, we have chosen to supplement the visual analogue scales and the text with diagrams, providing a visual image of the desired expression of the rooms.

It is important to point out that no one model exists for the hospice of the future. The outline and composition will always depend on how palliative services are organised, the neighbourhood (town/countryside), economy, organisation of the process, whether the plan is to reuse an existing building or build a new one, land value, choice of architects and consultants etc. The example is thus only one suggestion among many possibilities regarding how programming of *The Good Hospice in Denmark* could be done.

In the following example we have chosen to list a number of conditions, which form the basis for programming the physical framework of the hospice. The conditions build on previous conclusions, focus areas and recommendations and from there they take the development of needs and requirements of palliative care in future into account.

*The hospice in the example contains the following departments:*

1. A ward with 12 beds
2. A palliative team, which is partly serving patients at home and in a nursing home, partly supervising practising doctors and hospital staff
3. A day hospice
4. Facilities for examination, where patients can be referred to for consultations and examinations

The work in the wards of the hospice and the day hospice is taken care of by the same staff, for example following a rotation order. To ensure perceived continuity by the patients and relatives, and to take the fullest advantage of resources, the palliative team will work throughout all departments of the hospice.

The leadership of the hospice has the overall responsibility for the running of the hospice, co-ordination between individual departments, development and research. A high degree of co-operation between disciplines and organisations will take place (including research), both internally based and across individual departments, but also externally directed towards other hospices, hospitals, educational institutions and the surrounding local community.

## *Subcomponents*

*The Good Hospice consists of following subcomponents:*



### *Communal arrival*

One main arrival hall for the whole house. The parking lot is located close to the main entrance, but hidden, so that the visitor is not met by cars as the first thing, when visiting the hospice.



### *Wards*

Need closeness to the staff area to make the patients feel safe and to avoid long walking distances for the staff. Should be constructed so that they are perceived as an independent unit in the whole hospice, as the patients need more peace and quiet than the patients who use the day hospice.



### *Reflection room*

The room will primarily be used by in-patients and their relatives, but should be available for all the users of the hospice. A multi-religious room, which replaces/supplements a traditional chapel.



### *Staff area, minus administration*

Should be located close to the wards, the examination facilities and the day hospice, as the staff work across the individual sections.



### *Administrative staff and personal welcome*

Should be located close to the main entrance and is a part of the staff area as a whole.



### *Palliative team*

The palliative team is integrated in the staff area in order to support sharing of information and exchange of experience between the rests of the nursing staff. As the department requires quiet, e.g. telephone conversations, the palliative team is located at the periphery of the staff area.



### *Examination facilities*

The examination facilities are located at a distance from the wards, but in connection with the day hospice and the staff area. The palliative team and users of the day hospice will primarily use the examination facilities.



### *The day hospice*

Should be close to the staff area and the examination facilities. Should be able to accommodate bigger functions (open house, conferences, theme evenings) and could with advantage be located close to the kitchen of the hospice.

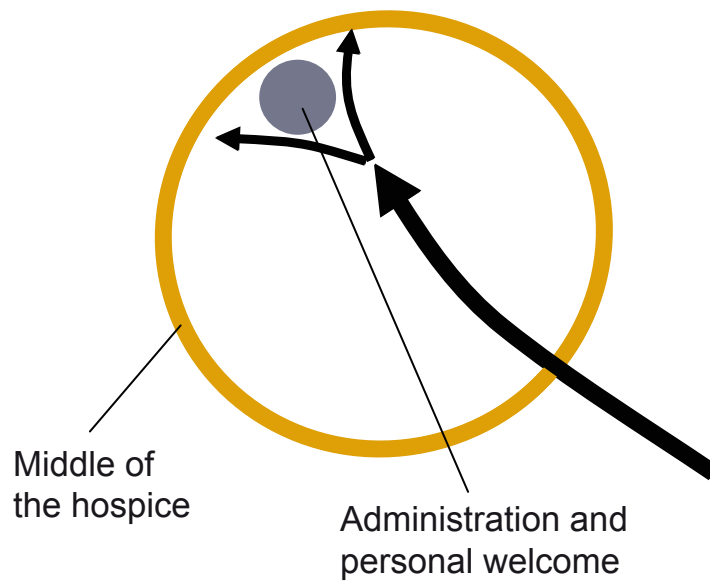


### *Kitchen and service departments*

Independent units, which could advantageously be located near the day care centre.

### *Entrance and access to the hospice*

There is one communal entrance to the hospice. The entrance could possibly be divided into different areas, so that there is an entrance to the wards, and another entrance to a possible day hospice. The entry crosses the middle of the hospice, which is represented by a garden, a green courtyard or an atrium. The personal welcome could beneficially be taken care of by volunteers, by the nursing staff who will be the contact nurses of the patient or by a secretary. The administrative departments (management, secretary, co-ordinator of the volunteers) are located close to the main entrance.

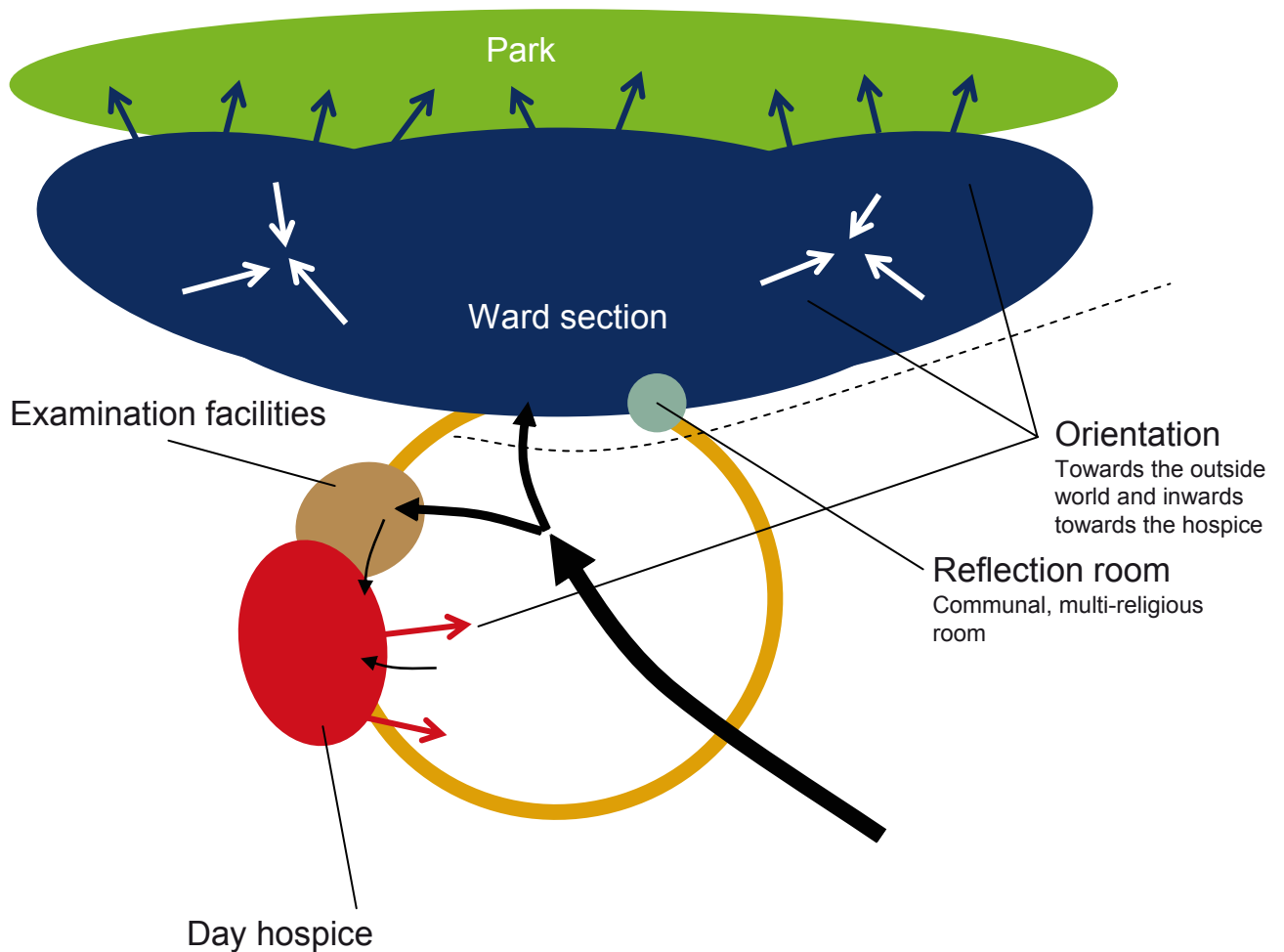


*Ward section, day hospice and examination facilities*

The ward section has a capacity of 12 patients and is divided into 2-3 smaller parts, to maintain a clear view and intimacy for the patients and the relatives. The ward is separated from the rest of the hospice to promote safety and tranquillity and is located close to park/green areas. The wards are oriented outwards towards a garden or a green area and inwards towards the communal lounge of the wards.

A reflection room is located close to the ward, designed for prayer, quiet conversations and rituals. The reflection room works as a multi-religious room.

The day hospice is separated from the ward section. The department is partly taken care of by the in-patient nursing staff, partly by the palliative team, and possibly involving a number of volunteers. The day hospice is oriented inwards towards the middle of the hospice. A number of examination facilities are located in the day hospice, which may be used by the palliative team and the patients from the day hospice.



### *Staff area, support facilities and palliative team*

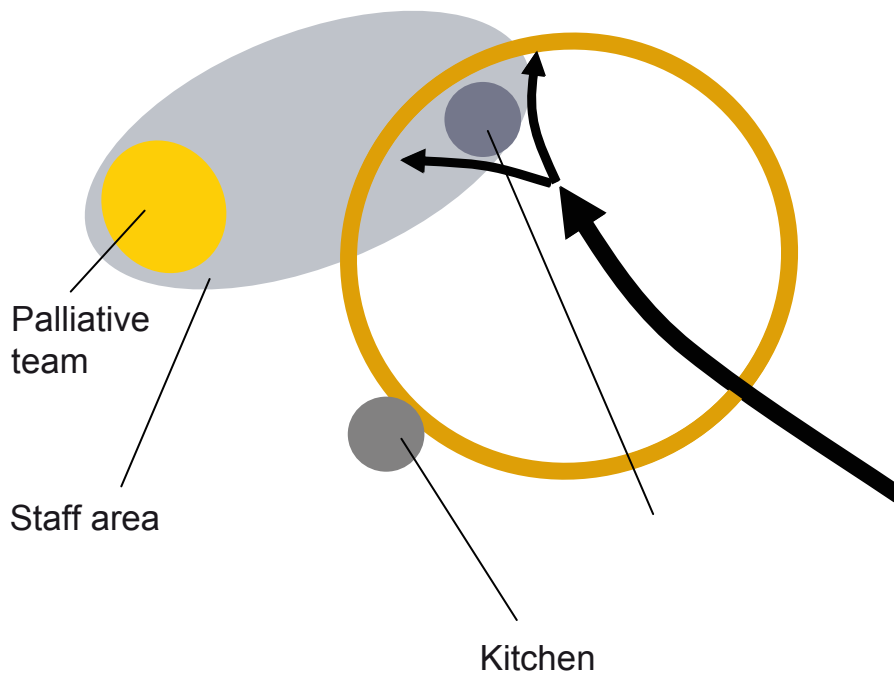
The staff area consists of a communal, team based work area in a confidential zone, close to the examination facilities, the ward section, the day hospice and the administration.

The staff area is the base of the palliative team and the nursing staff from the ward section, the administrative staff, possible co-ordinator(s) of volunteers and research staff .

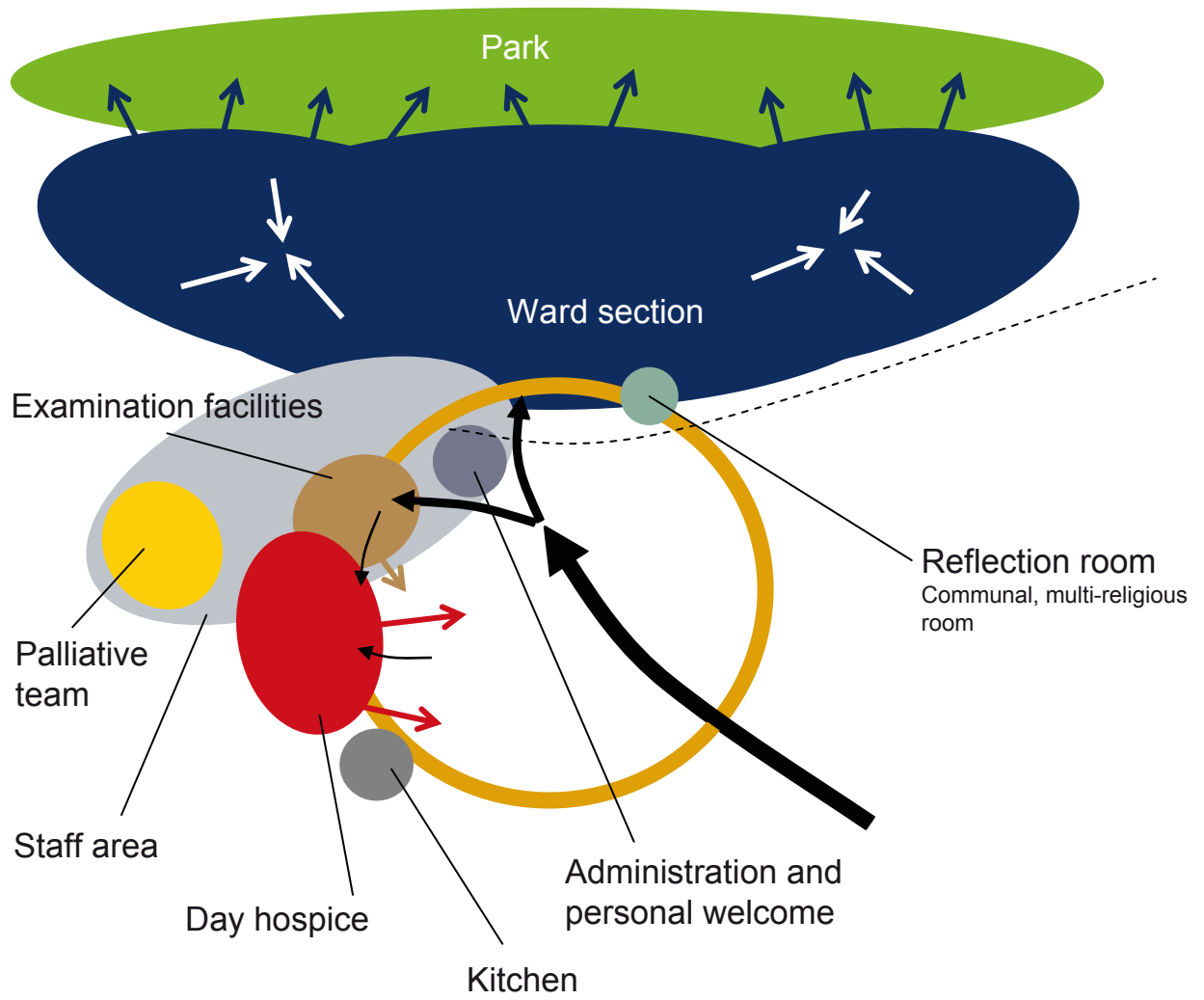
As much co-operation will take place across individual services, and the palliative team will also use the ward section and the day hospice on a daily basis, the palliative team is integrated among the rest of the staff, but located in a more secluded area to avoid disturbing the staff with telephone conversations and the like.

The staff area should be connected with the wards without giving patients and relatives a feeling of being watched.

During planning of the staff area, particular consideration should be made regarding possible confidential demands of employees, who have no direct contact with patients (like researchers and coordinator of the volunteers).

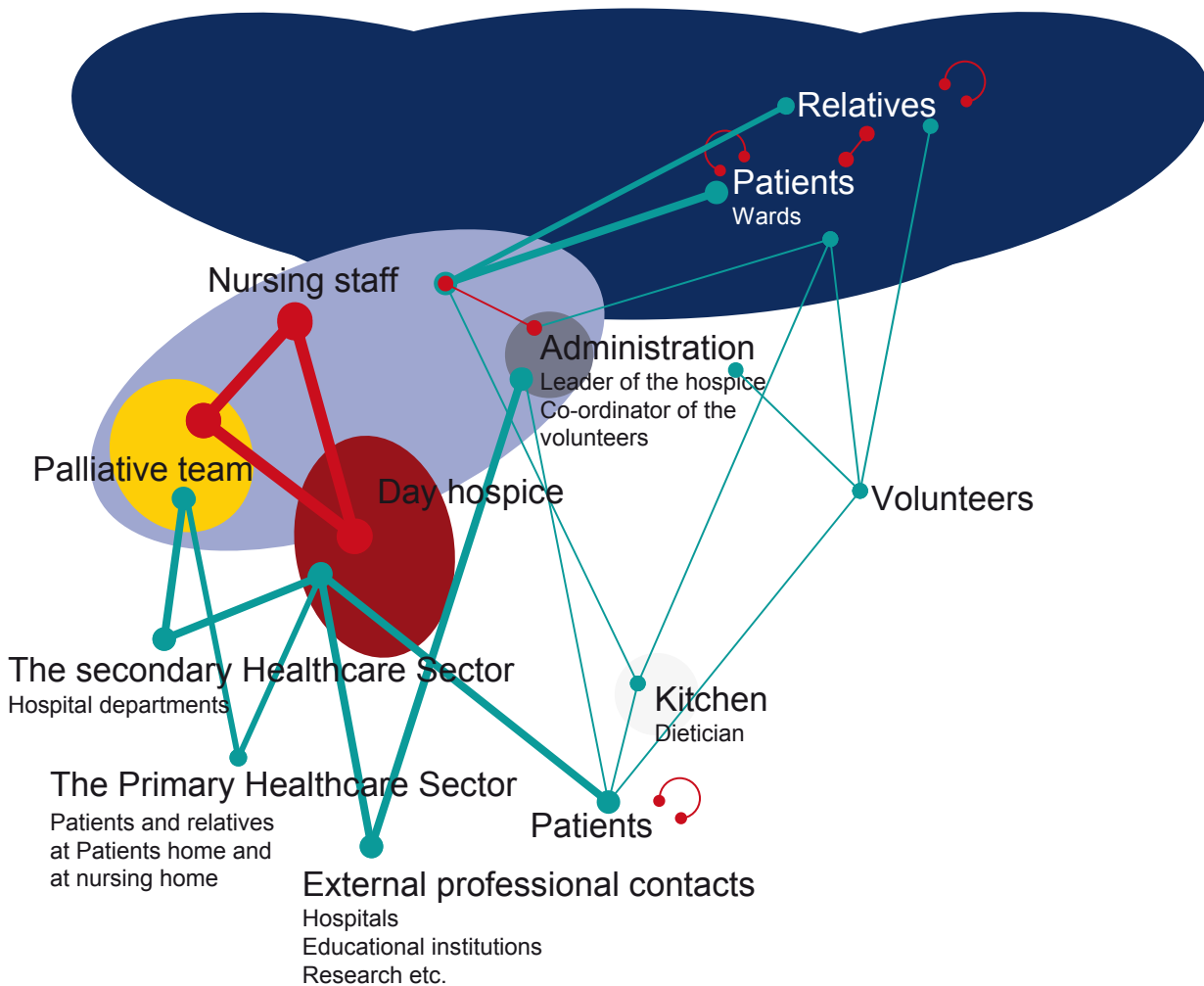


*Combined disposition diagram*



### Sharing of information

How will information be exchanged in *The Good Hospice*? The lines indicate supportive interrelations and how information is exchanged between the individual departments/users at the hospice. The thicker the line, the larger the quantity of information expected to be exchanged. Information exchanged across services/departments is marked with a light blue line, and information exchanged within the individual service/department is marked with a red line. Ensuring optimal sharing of information necessitates that both the working procedures and the organisation of the work as well as the building support regular and ad-hoc meetings, formal relations and informal meetings between the individual department and the users.





### *Description and visualisation of six rooms in The Good Hospice*

In the following pages we describe six rooms in *The Good Hospice in Denmark*: The actual entrance, the whole building, the ward section with the lounge, the room for reflection and the staff area. The descriptions are supplemented with collages, which provide a visual impression of the atmosphere and tone to be promoted in each room. The collages are not meant to be read literally, but to be used for inspiration and in association with the layout of the physical framework for *The Good Hospice*.

# The entrance



The first encounter with the building, as a relative or a patient, will considerably colour the entire impression of the hospice. There is an advantage in planning the arrival at the hospice itself in such a way that the user encounters the building “bit by bit”, so that the building unfolds gradually as a person arrives. This will lessen the dramatic impact of the entrance and the building itself, and the visitor has longer to get used to the hospice. Therefore it is important that this area conveys a friendly, positive and open impression.

A softly curving driveway into the hospice, which may be located in a park or a green area, makes arriving at the place an experience. You can drive by car right to the entrance, but the parking area itself is located alongside the building (is not seen in the collage) and therefore does not mar the open façade of the entrance area with its clearly marked entrance. It is important that the hospice signals life, activity, openness and homeliness. This could for instance be facilitated through placing public areas like a park, a garden or the like in close to the hospice.

A beautiful and attractive park or green area provides an important breathing space for patients, relatives and staff alike. It is to be planted in a varied way and with the intention of creating experiences throughout the year, so for instance, allowance is made for evergreen plants and other evidence of life in the park during the winter months. The mixture of plants should include tall and short plants in the form of trees, shrubs, flowerbeds or flowerpots. Natural resting places should be located at strategic points in the form of benches. Pieces of art could also be placed in the grounds or in the park. Obvious resting places are water features such as a lake, a stream, fountains or birdbaths, and (animal) life could be watched from nearby benches. All pathways in the park or the green area are tarred or covered with material which makes it possible to take patients outside in their beds.

The park or the green area could with advantage be divided into two sections, one for the public and another reserved for patients and their relatives, so they can move around in the park without being disturbed. This also creates better possibilities of privacy for patients when lying in their beds, either in the park or on the terrace.

As an exciting addition to the park or the green area, a sense garden could be laid out, creating experiences for all senses. The patients could smell, look at, touch and taste the herbs, flowers, fruits etc. They could also look at and listen to the water, gurgling from the water feature or listen to the birds chirping from the bird table.

An attractive park or green area makes visits to the park from people other than the hospice patients’ possible, something that is usually a welcome distraction in the patients’ daily routines. Therefore it makes good sense to also make the park usable, attractive and accessible to the surrounding community, so life and closeness are added to the local area.

Where to go as patient, relative or volunteer should be clearly sign-posted, unless this is obvious from the physical appearance of the building.

# The building



As a whole, the building should promote life and interaction amongst its users via its shape language, choice of material and architectural elements. The curved forms and the breaking up of big surfaces into smaller parts create small pockets for interaction between patients, relatives and staff groups. These pockets make natural meetings and pleasant experiences possible in the building.

The building should be worked out on a human scale and be proportioned without dizzy heights or narrow rooms or passageways, as these will not promote the needed safe and intimacy, which the hospice demands. The architecture of the building relates to its surroundings. This applies both in an area of natural beauty and in an urban setting.

The building is to be experienced as inviting and open both in the daylight and in the evening.

# Wards and lounges for patients



The individual wards will be the primary base of the patients and the relatives, and in some cases the patient will spend all his/her time here. The ward is to promote a safe, warm and homely atmosphere. This atmosphere could be created via a number of different elements.

The patient bringing his/her own pictures and other small belongings could partly achieve this, but in addition a combination of colours, materials, surfaces, furniture, light, textiles, plants and the like creates a homely atmosphere in *The Good Hospice*.

On a bigger scale, the colours are kept in a warm palette and light shades. Earthy colours, orange, golden, beige and reddish colours create a warm and safe atmosphere for the patient.

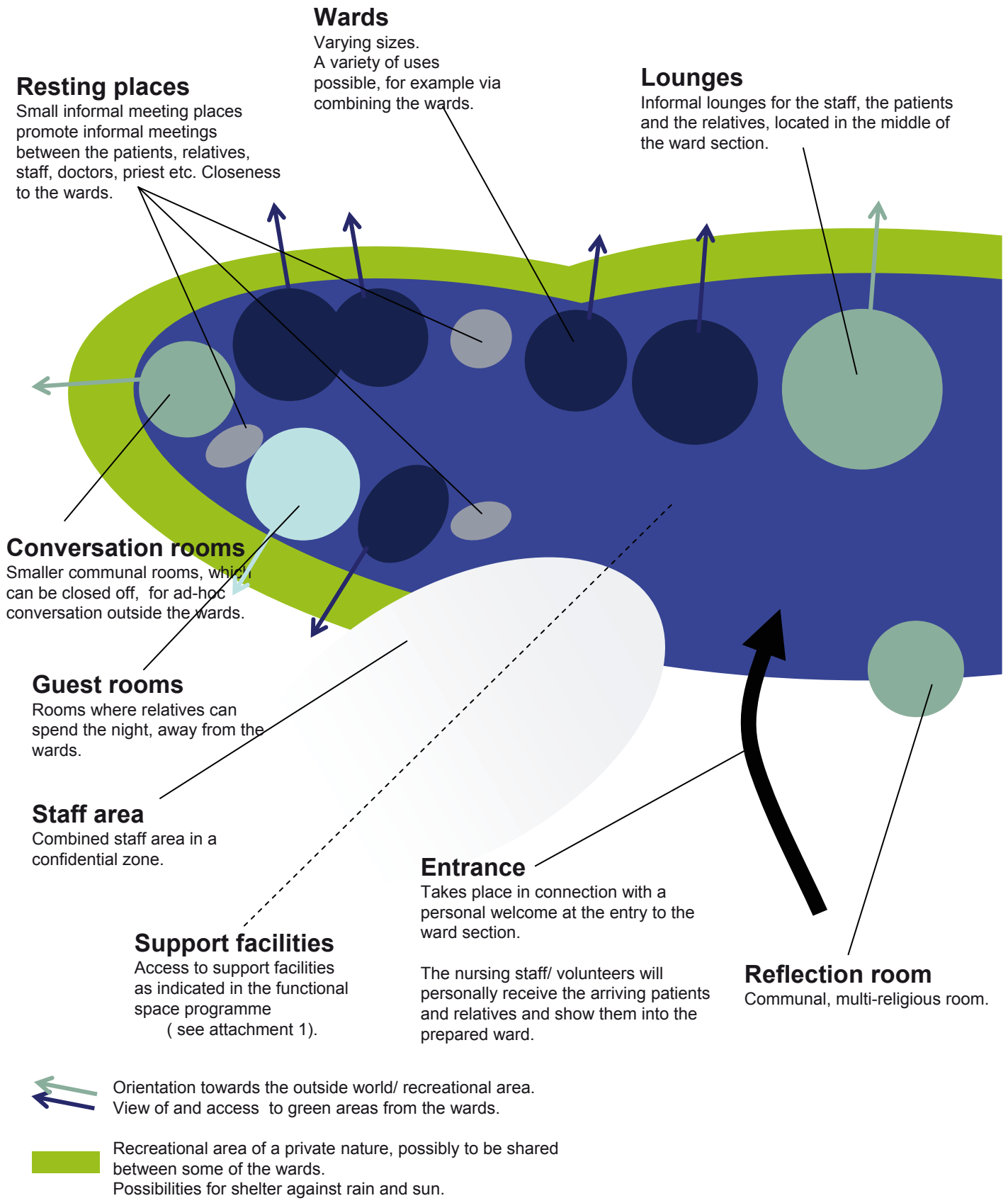
The ward has big window areas with a balcony door, which opens up to a terrace or a green area, so the ward can be experienced as open and extended into the outdoor area in summer. The door must be wide enough to allow a bed to pass through.

The window area can be shielded variably in relation to the patient's wish for privacy and in relation to filtering of sunlight. This could for instance be done using panelled curtains with varying degrees of transparency, Venetian blinds or a bamboo curtain, or a combination of these modes, so different degrees of openness and transparency could be created, and in such a way that internal and external views can be restricted.

Considering that the patients are bedridden during much of their time at a hospice and therefore lie down while looking up, it is important to take the layout and the decoration of the ceiling into account. This could be in the form of roof lighting, stucco tiles, mobiles hanging from the ceiling, lamps, wooden panels or the like. The reason that the decoration of the ceiling is suggested as a choice of material rather than an actual decorative project is to avoid creating very intrusive decoration, which could disturb the patient. The aim is to create an environment, which could either help time to pass or create an atmosphere.

The walls are wallpapered or painted. The essential point is to choose paint or wallpaper with colour or patterns, which give the walls both a soothing and lively feel, so that an institution-like atmosphere is avoided. If wallpaper is chosen this effect could be achieved by a pattern consisting of simple graphic elements in harmonious warm colours. If the walls are painted, a certain dynamic may be created by not painting all four walls and by keeping a white edge around all corners, so the painted area becomes a field on the wall. The colours should be warm and their tone not too dark.

A big part of the sensuousness of the room derives from its textiles. The bedcover is of a soft, natural material, which makes it pleasant to touch. The bed linen has a pattern or an appealing colour, as it would have in a private home. Also scatter cushions and rugs on the sofa play their part in creating a homely atmosphere.





The floors in the ward are laid with wood. It is furnished with modern, comfortable, functional furniture, without an institutionalised feel, if at all possible. The bed is wooden with a headboard, and must be electronically adjustable regarding height and length. The upholstered furniture in the room can be used for rest and work, and the atmosphere in the room should encourage it to be used in the same way as in private homes. The sofa may possibly double up as a sofa bed for relatives spending the night.

For the entertainment of the patient and the relatives a TV should be installed in a good position in relation to the patient in bed, and the TV should be adjustable to other positions in the ward, as some patients choose to reorganise their ward to make it more personal.

The patient's and relatives' wishes and need for privacy should be accommodated. For that reason, the area around the bed can be partly shielded off by a freestanding wooden screen, which may be placed and shaped as needed.

Permanent shelves, a chest of drawers and inbuilt cupboards are available for storing the patient's personal belongings.

Apart from providing general light and work light, the electrical lighting can also add to the atmosphere in a significant way. By placing many small sources of light, which give off a warm, yellow light around the patient, a cosy atmosphere is created. The design of the lamps should resemble that in private homes.

Obviously, good conditions for the relatives should also be created, so they can maintain a routine as much like that in their daily life as possible. An Internet connection in the ward, or a wireless network in the entire hospice makes it possible to work from there.

The ward is to support the needs of different users via options for giving the room a personal feel. This may happen by means of bringing personal belongings like paintings/photos/furniture for instance, but also by changing the expression of the room through screen walls, curtains, regulation of light etc.

Because of great variety in the number of relatives, it is considered an advantage that the wards are not all the same size, or that their size is adjustable. This is possible by adding extra rooms, screening or mobile furnishing.

Good interaction between the bed and the surrounding area in the room is essential. The patient should be able to look out through the window, and a possible balcony, or terrace doors, should allow for beds to be wheeled outside easily.

It should be possible for relatives to spend the night in a specific guest room as an alternative to sleeping in the ward itself.

# Lounge



A communal lounge for informal gatherings of patients, staff and relatives is located centrally in the ward. The lounge should preferably create a contrast to the quieter wards, and encourage activity and energy. Ideally it represents one unified area, broken by columns, semi-walls, passageways and other types of room dividers, so it appears and is experienced as a row of independent rooms. Thus small intimate pockets, views outside as well as an overview of the whole area are created simultaneously, promoting security. With a string of connected lounges comes a high degree of contact and interaction between different relatives and subsequently also possibilities for sharing grief, joy, concerns and impressions with each other.

In these rooms natural rallying points like a fireplace, a TV, a library, a piano, a play corner, a patio, an aquarium etc. may also be integrated.

The lounge includes a family room consisting of an informal kitchen with a central hob and dining area for patients, relatives, volunteers and staff.

A sofa group is located adjacent to the family room, so more groups can use the kitchen at the same time, making it possible for dialogues to occur spontaneously. The adjacent areas and rooms consist of various soft seating - and meeting places, all openly linked with each other. Furthermore, it is important to include a play space for kids, so they get floor space to play on in the same room as the adults instead of getting a space far away from the life and the focal points of the house. Children wish to be where other people are.

The rooms have big window sections, which also include a balcony door opening out to a terrace or a green area. In summer, a terrace can be used for pleasant gatherings among patients, relatives, volunteers and staff. The colours in these rooms are lively, warm and primarily in light tones. They may, however, be supplemented with a single wall in a darker colour. The colour palette is composed of golden, orange, beige, Bordeaux and green colours.

In order to create as homely and inviting an atmosphere in the rooms as possible, it is important to include decorations and knick-knacks. Easily accessible art and posters depicting positive situations and recognisable things are an advantage, as they appeal to the majority and do not confuse or upset exhausted patients. Green plants also contribute to a lively atmosphere. Modern, comfortable and functional furniture without an institutionalised feel is preferable. Books, journals and magazines in bookcases and on tables also add to a lively atmosphere. Apart from general lighting and work light in the kitchen, electric lighting plays an essential role when creating an atmosphere. By placing many, small sources of light, which spread a warm, yellow light around seating areas, an intimate atmosphere is created. The design of the lamps should resemble that in private homes.

Apart from social activities, the room will be used for eating, potential services, relaxation, children's play, art exhibitions, communal singing, concerts, reading aloud, film shows, TV etc.

# Reflection room



As a contrast to the more action oriented lounge there is a smaller reflection room. Relatives and staff, as well as patients who need a place for reflection, grief work or a quiet conversation will use this room, together with the conversation room.

The room has a spiritual character without specifically emphasising one particular denomination. The room will probably not be used as a chapel or for ceremonies with coffins, as the last farewell most often takes place in the ward. Gatherings for smaller religious ceremonies can happen here, but it is suggested that larger services go on in the communal area.

A main feature of the room is a high degree of light ingress, possibly supplemented with light from above, which may all be shielded off or filtered with panelled curtains or the like. There are no permanent religious symbols in the room, pointing in one particular religious direction. It will, however, be possible to keep some religious artefacts, which may be brought out according to need, but the fundamental idea is that the room has a non-denominational religious character. The room should convey a feeling of security, serenity and inner silence.

The room faces a park or a green area to enable visual contact with nature and through that, with the sublime. The room is divided into levels to emphasise the spiritual element - a symbolic ascending and descending of the stairs of consciousness – and to highlight the experience of the sublime. In a more practical context, these levels also serve as informal seating.

Water is an integral element of the reflection room. Water is a classical symbol for purification and peace. Furthermore, it is a powerful symbol for change and transformation processes and the whole dying process is maybe the biggest change we human beings go through, apart from birth.

There is space for many candles, as a lighted candle is also a powerful symbol of the living soul. Flowers and green plants are a natural part of the room as well, and particularly during the winter months these play an important role in giving the room colour and life.

The walls are light or partly covered with wooden panels in a warm tone. The floor is wooden and the room is furnished with soft, comfortable, upholstered furniture, which invite leaning back or lying down, while reflecting on life.

The room is expected to be open to all patients, relatives, volunteers and staff at the hospice twenty-four hours a day.

# Staff area



The staff area is an open, team-based work environment, where the staff from the wards, the palliative team and the administrative team sits. The idea is to support the information intensive work processes taking place at the hospice, with a high degree of sharing of information and interdisciplinary co-operation within the respective teams, as well as between the individual teams.

The staff area should include a more active and extrovert zone, which is in contact with the wards, the facilities for examination and the day hospice, for instance through visual contact. The active part borders these areas via a number of meeting rooms/consulting rooms, which may be used both internally and externally. There is also a more secluded part, where the palliative team is located. This staff group needs to exchange information with the rest of the staff, but does not participate in the shift change meetings nor does it work twenty-four hours a day in the same way as the nursing staff in the wards.

Where the staff will be externally connected to different patient groups, it will be perceived as one coherent group internally. This is substantiated by the fact that most of the staff will have contact to all patient groups.

The staff area is divided into different workplace types, each of which supports different work tasks. Modern work desks are placed in a mixture of competence spaces, where more employees sit in small groups, and solitary workspaces, where you can sit alone and work.

The placement and shape of workstations should vary and support the individual work processes (attendance, meeting types, working together etc.). Staff groups whose paperwork does not represent as big a part of the total workload could, to advantage, share workstations.

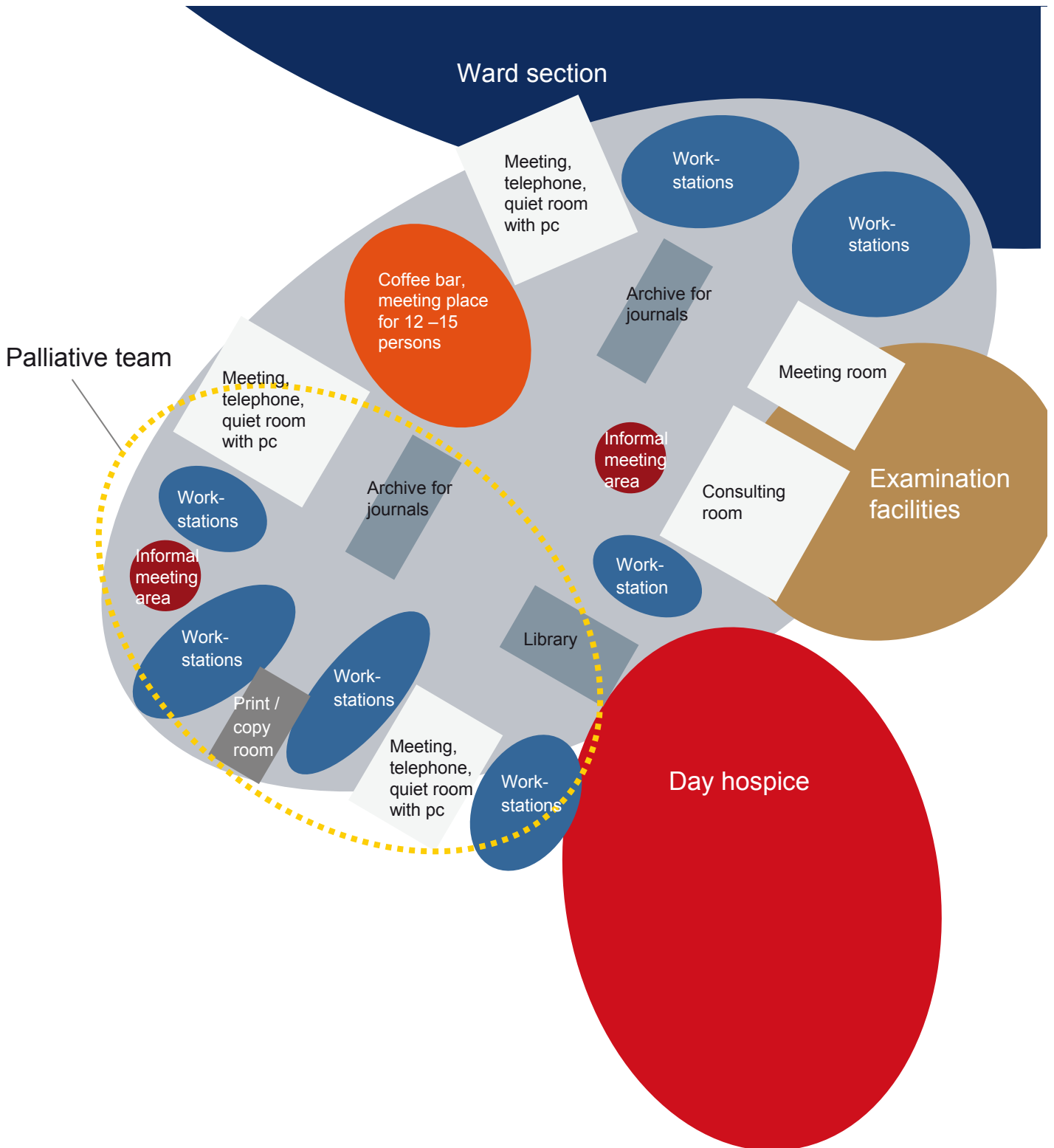
In addition, the area consists of a mixture of formal and informal meeting areas, as well as open and secluded meeting facilities, which may be used according to need. These rooms also break up the staff area, so better acoustics are achieved and the room does not feel too big. The integrated kitchen bar and kitchen nook also function as an informal, open meeting place, while providing a space for coffee and lunch breaks. The kitchen bar is also the place where the staff meets 2-3 times daily in connection with nursing conferences and duty rosters. This is a short intense type of meeting, where the majority of the staff meets to review journals in smaller groups, and where experience is exchanged in all directions. Some of the participants are expected to move into meeting rooms for a short time before returning to another conversation.

There is a secluded meeting area for confidential conversations or types of meeting requiring quiet and concentration. A café table with café chairs are placed in the room for informal meetings of the members of staff. Last but not least, there is a corresponding open, informal 'soft' meeting area, consisting of a sofa and a small table.

The furniture style is modern and functional, while the colours of the room are

energetic and dynamic. The modern office furniture suggests a flexible organisation, geared for change, while the strong colours lend a positive and cheerful atmosphere to the room.

There is air around the different workstations and good passageways, which makes the overall impression open and inviting. All flooring is made from wood or lino.





### III. Suggestions for an ideal implementation process

Establishing a new hospice can be a long process involving many parties and interests who do not always share the same starting point. Many wishes and needs create the overall picture, and there is always a risk that the initial aims are lost in the process, so that the final hospice does not live up to the original intentions. We aim to create a building which is both characterised by a high degree of functionality, and concurrently reflects and carries the particular hospice culture described previously; therefore, it is important to keep in mind how the implementation process should be approached, so that it contributes even more to maintaining initial values and visions from the initial idea to the completed building.

In general, a normal building process consists of four phases:

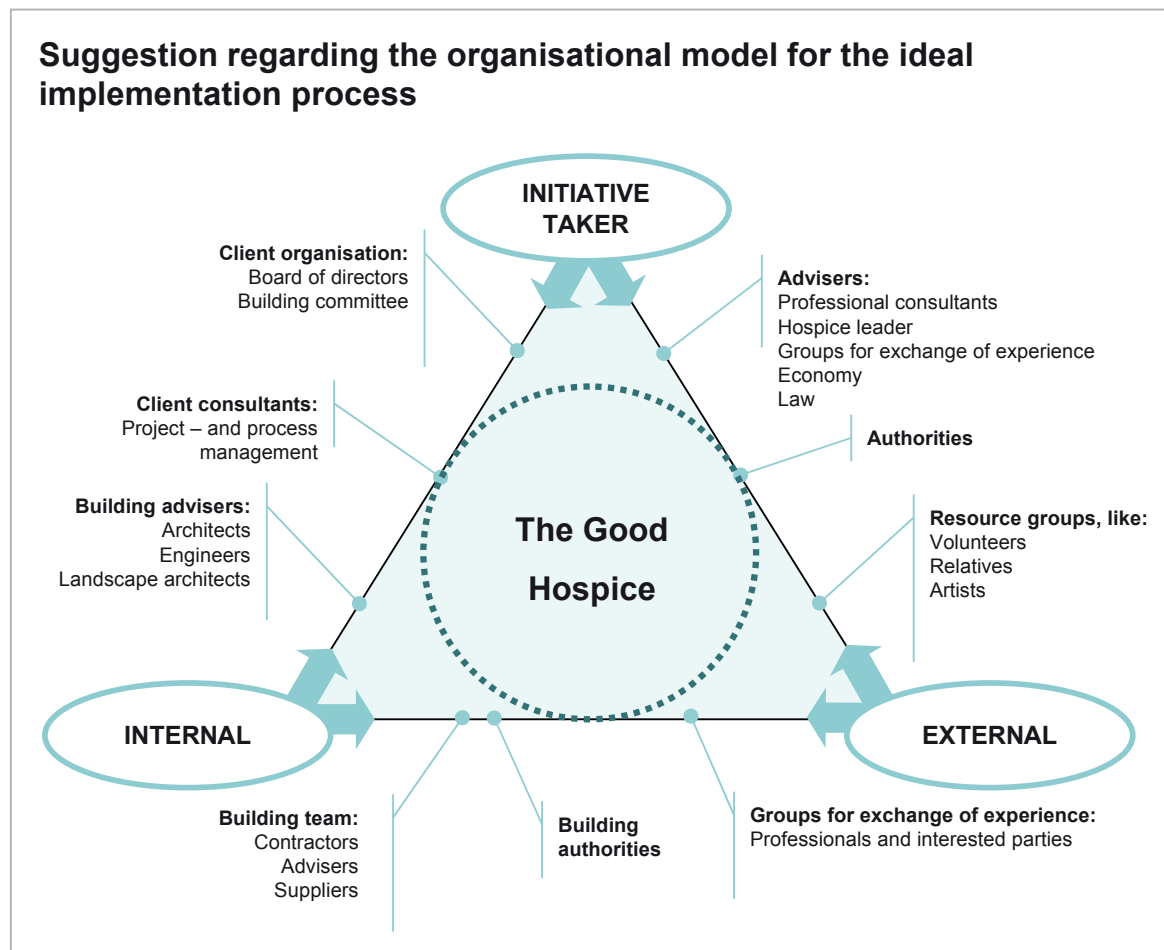
1. The idea phase – where the idea is conceived and fundamental values are worked out, success criteria, visions and parameters for the ongoing process are defined.
2. The implementation phase – where the idea is tested and the building is implemented.
3. The construction phase – where the building and the organisation take form.
4. Running and handing over to the client phase – where the completed building starts to be used, first experiences are made and the result is evaluated and possibly revised.

Usually, the respective phases are separated, so that various interested parties get involved during the process. This means that architects, engineers and other consultants seldom participate in the formulation of the vision and the fundamental values of the hospice, that the user (patient, relatives, volunteers and staff) typically only get involved at the end of the process and that actively interested parties are drawn in after the implementation has been completed.

When working in this way, there is a risk that valuable knowledge about what the hospice actually is, the necessary services, the way in which the work will be organised and the visions and values set out at the beginning of the process are not taken care of along the way; for that reason, you risk ending up with a building which at best is well functioning, but where the framework does not live up to and express the initial intentions and visions.

Therefore, we suggest another approach to the actual establishment process, which places the user more in focus and which works with the different interested parties in a kind of partnership model. The process can best be described as an iterative process, where you continually review, test and revise the shaping of and visions for the physical framework.

In order to ensure good functionality we suggest that the real experts – the users – are involved and listened to at an early stage. These could be staff at other hospices, volunteers and relatives as well as architects, artists and other consultants. All functional requirements, wishes and needs can be gathered in a functional specification of requirements and a description of concepts, which formulates the softer aspects of what the new hospice is meant to promote, visions, success criteria and chosen priorities. Besides, we suggest that the team which will be working at the hospice is put together as early as possible, so that the staff also get a chance to bring their points of view across and get involved from the early stages of the project. Enterprise and management of user involvement is to be taken care of by a professional project leader along the way. He/she is to make sure that budgets and deadlines are met and also that the above-mentioned experts are involved and heard throughout the process. Continuous evaluations with all interested parties are to take place throughout, to make sure that the necessary adjustments are integrated into the process quickly. These evaluations will work as landmarks along the way and contribute to maintain the quality of the final solution.



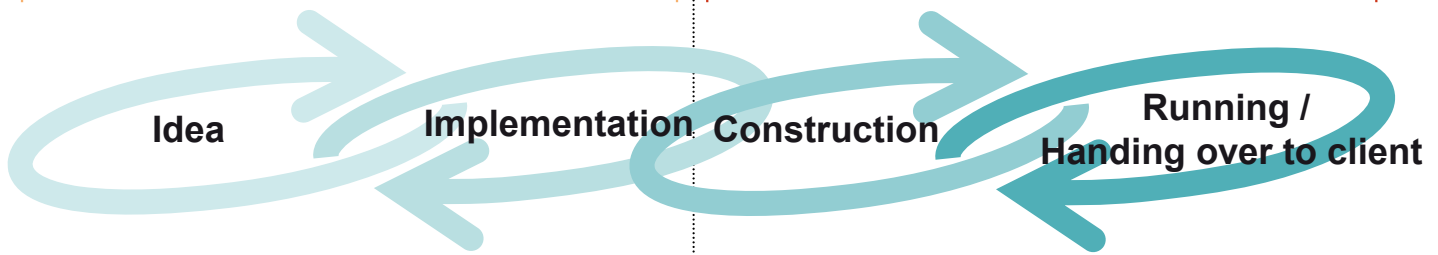
*Model 4 - Suggested organisation of the establishment process, where all interested parties form a kind of partnership*

The following model shows how the ideal establishment process of a new hospice might look. The process will contribute to ensuring ownership for the individual interested parties and to a higher degree of user involvement at an early stage, which will increase the likelihood of high functionality in the final building. The model suggests that a professional building committee is elected early on, to take care of the daily management of the further development of the project, and that a client consultant is employed with the ability to lead both the project and the process management in subsequent stages of development. It is important to use time and resources to create the best possible database for decisions (the value formulation phase). When this database is in place, decisions are taken quickly without necessarily compromising the initial intentions (the value management phase). The activities are divided into external and internal activities. The internal activities contribute to maintaining the energy of the external activities so that the process does not peter out.

# Suggestion regarding an ideal implementation process for The Good Hospice

## Formulation of Values

## Management of values



### Interested parties

Composition of board  
Establishment of a professional building committee to take care of 'daily' management of the development of the project.  
Election of client consultant (to manage the project as well as the process)

Board  
Authorities  
Building committee  
Client consultant  
Architects & engineers  
Financial & legal advisers  
Volunteers  
Relatives  
Landscape architects  
Artists  
Support organization  
Group for exchange of experience

Ditto

Board  
Hospice leader  
Building committee  
Client consultant  
Contractors  
Architects/engineers  
Financial adviser

Marketing people  
Staff  
Potential users and external collaborators

Board  
Building committee  
Staff  
Patients  
Relatives  
Volunteers  
Service staff  
Architect & engineer  
Client consultant  
External collaborators

### External activities

Obtain support from county or region

Obtain financing and running costs agreement with county or region  
Contact persons with experience from other hospice projects to establish group for exchange of experience and evaluation of programme.  
Study visits to other hospices according to own choice

Public arrangements to draw attention and support from the local community  
Hold a possible architectural competition and/or clarification of invitations for competitive tendering; E.g. partnering, reverse tendering, lump sum tender?  
Recruiting of volunteers  
Obtain financing/running costs agreement

Agreement with building team

Marketing  
Marking of opening in local community and for potential users and external collaborators  
Joining network with other hospices

Possible adaptation and adjustment of the building  
Communication of experiences to network  
Feedback to *programme for The Good Hospice* according to actual progress.

### Internal activities

Clarification of overall vision, success criteria and structures for hospice in question.  
Use the programme for *The Good Hospice in Denmark* as introduction to a debate and as a checklist.  
Work out process plan.  
Work out description of idea, which explains the intention and main idea of the hospice, its contents and organisation.  
Clarification of needs.

Transform the presentation of ideas to actual building programme

Clarification of forms of invitations for tender/competitions.

Evaluate building programme with people with experience from other hospices to bring in a professional perspective early in the idea phase.

Bring in group for exchange of experience  
Evaluation of project & process - do we still live up to the vision, structures and success criteria?  
Is any adjustment needed before building?

Grounding of the vision, success criteria and structures in building team and with the appointed hospice leader.  
And later in the process before taking over: appointment of remaining staff.  
Communication of vision, success criteria and structures via workshop with staff/ hospice leader, building committee and building team.  
Evaluation of project & process - do we still live up to vision, structures and success criteria?  
Is any adjustment needed before taking over by user?

Establishment of internal co-operative relations.  
Qualification of staff  
Running of internal workshops to create a good culture  
Carry out evaluation in relation to vision, success criteria and structures after a suitable period of functioning.

Listing of focal areas according to evaluation – follow-up and adjustment  
Are we able to do what we wanted?

*Model 5 – Suggestions for an ideal implementation process in establishing The Good Hospice*

# Conclusion

The programme for *The Good Hospice in Denmark* is at the level of a presentation of ideas and does not provide answers to all questions. We have attempted to work out a programme with concrete ideas regarding how the physical framework of the hospice of the future may contribute to the creation of the most comfortable structure for the last period for terminally ill patients and their relatives. At the same time, we have focussed on the potential for improvement to be found in the physical working environment of the staff, and the information intensive work processes taking place at the hospice.

The design principles for *The Good Hospice* outline a direction rather than dictate solutions; hopefully, they will be challenged and revised in future, in tandem with new requirements of palliative care and new patient types coming into contact with the hospice.

Our message is that a good hospice must work with a holistic perspective in relation to the physical framework, as well as in relation to how the hospice co-operates and works with the surrounding local community, hospitals, research institutions and others.

The programme is an up-to-the-minute account, developed on the basis of the knowledge we have to day, and, as far as possible, it takes into account the tendencies we can see in the near future. Having said that, it is obvious that the hospice as a concept and the programme you have before you (as this will be on internet, not in hand!), will be challenged in a number of areas in future.

A change in the patient and relative type of the future will have an impact on the way in which palliative care takes place at the hospice in future. More flexible patient processes with patients who increasingly alternate between the individual services, growing demands for individual treatment processes, which to a larger degree may include alternative treatment, wishes and demands for curative treatment in spite of a disease having been diagnosed as terminal, relatives bringing their work into the hospice - all these things add new requirements to the physical framework of the hospice of the future.

A larger research effort, further developed co-operation between organisations and the introduction of electronic patient journals and similar IT-tools will also increase new demands placed on the staff and the organisational structure.

As a result, new requirements on the physical framework will ensue, as this, to a higher degree, has to accommodate an even more flexible and interdisciplinary form of co-operation.

Further involvement of the volunteers at the hospice and an intention to make the hospice a natural part of our environment will require more space for the staff and various arrangements; in addition, this will necessitate that the hospice embraces the local community to a larger degree, as a physical building as well as an institution.

We invite future users of the recommendations in this report to contribute with comments, suggestions and recommendations which may be incorporated in coming versions.

We look forward to monitoring developments in future.

February 2006

*The Steering group of The Good Hospice in Denmark*

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# Annex

## *Functional Space programme*

Ward section, 12 beds			
Number	Type of room	Estimated net area per room (m <sup>2</sup> )	Description and functional demands
12	Ward	25- 35	<p>There should be access to personal bath and toilet. Mirrors should be small and possibly placed so they could be turned away.</p> <p>Lockable door to the ward.</p> <p>Cupboard for personal toiletries.</p> <p>Box for valuables fitted with lock.</p> <p>Control of light (artificial as well as natural), ventilation and opening/ screening towards the outside world.</p> <p>The ward should be handicap friendly and suitable for working. Access to bed from both sides.</p> <p>Possibility to use hoist (see note at the back).</p> <p>All doors with access on one level - also the one opening outside.</p> <p>TV to be placed so it is visible from the bed.</p> <p>Electricity, telephone and data plugs should be located with treatment situations in mind, which demand the use of extra machines like a humidifier, and relatives wishing to work during a visit.</p> <p>Good acoustic regulation between wards, passageways and toilets.</p> <p>Light fittings should be suitable for bedridden patients. Air conditioning should make extra individual ventilation possible, and it should be possible to open windows.</p> <p>Possible installation of oxygen and suction in the ward should be done as discretely as possible, that is, no large visible panels with oxygen supply in the wards.</p> <p>Intimate lighting and work lighting should be separate.</p> <p>Avoid the use of "institutionalised materials" as much as possible, while still considering hygiene and cleaning. Experience shows that, for example, varnished wooden floors are fully functional in the wards and in the communal areas.</p> <p>Patient intercom should be installed in such a way that other patients are not disturbed by possible sounds.</p>
1 or more	Room for relatives (possible extra ward, which could be used by relatives)	15-20 (25-35)	<p>Relatives who do not wish to spend the night in the ward with the patient or where this may not be possible could use the ward for relatives.</p> <p>Separate room for spending the night with bath and toilet for relatives. Space for a double bed, cupboard and a small table for computer work, for example.</p>

Number	Type of room	Estimated net area per room (m <sup>2</sup> )	Description and functional demands
1	Lounge	Min. 40	<p>Meeting place for patients/relatives and staff.</p> <p>Handicap friendly.</p> <p>Flexible design, is meant to support activities of varying size and character, like birthday parties, Christmas arrangements, smaller lectures, small concerts etc.</p> <p>Should be located centrally and easily visible in the ward section</p> <p>Close to and preferably integrated with service kitchen, also used by relatives (see below)</p>
	Service kitchen used by relatives in connection with lounge		<p>Smaller service kitchen for serving food arriving from the kitchen. Facilities for making coffee, washing up and preparing light meals, if the relatives wish to do so.</p> <p>Space for eating for patients, relatives and volunteers.</p>
1	Reflection room	Min.20	<p>Spiritual, multi-religious room.</p> <p>Accessible for disabled people and bedridden patients</p> <p>Possibility of keeping religious artefacts.</p> <p>Good sound insulation.</p>
1 or more	Conversation room	10-15	<p>Smaller room for private ad-hoc conversations outside the ward/meeting room and the public communal areas.</p> <p>Possibility of closing and locking the door.</p> <p>Primarily for the use of relatives and staff.</p> <p>Limited exposure to maintain discretion.</p>
1 or more	"Resting places"	24	<p>A number of smaller informal open meeting places/niches for informal conversation between patients, relatives, staff, doctors, priest, and on the mobile phone.</p> <p>Space for armchairs or sofa arrangements, café table etc.</p> <p>Should be close to the wards.</p>
1	Medicine room	15	<p>For communal storage and dosage of medicine.</p> <p>Locked and undisturbed.</p>

Number	Type of room	Estimated net area per room (m <sup>2</sup> )	Description and functional demands
1	Bathroom with bathtub	20	<p>For bath and pain therapy for patients. The use of the room should be relaxing and soothing for the patients. Green plants, music, fragrances and candles may be part of the therapy and should be in the room.</p> <p>Acoustic regulation should be considered when playing music.</p> <p>Should be equipped with adjustable bath, which can be operated from both sides, cupboard with mat for the bath and a bench/chairs.</p> <p>It should be possible to dim the light, and fittings should be located with the bedridden patient in mind.</p> <p>Large full figure mirrors should be avoided.</p> <p>There should be natural light and a washbasin, but attention should be given to minimizing the view directly into the room from outside.</p> <p>The room should not be combined with other functions, like washing room or laundry.</p> <p>Possibility of using hoist (see note at the back).</p> <p>The room could be linked with the rehabilitation/therapy room (see below).</p>
1	Rehabilitation/therapy	15	<p>For massaging the patients. Use of the room should be relaxing and soothing for the patient.</p> <p>Green plants, music, fragrances and candles could be part of the therapy / room. Acoustic regulation should be considered when playing music.</p> <p>Should be equipped with adjustable massage table and moveable massage chair (possibly stored in a depot), which can be operated from both sides, cupboard with sheets/small pillows/linen and possibly a small microwave and a freezer (cold/warm compresses) and a bench/chair for relatives.</p> <p>It should be possible to dim the lights, and fittings should be placed with the bedridden patient in mind. Large full figure mirrors should be avoided.</p> <p>There should be natural light and a washbasin, but attention should be given to minimizing the view directly into the room from outside.</p> <p>The room should not be combined with other functions, like washing room or laundry.</p> <p>Possibility of using hoist (see note at the back).</p> <p>The room could be linked with the bathroom with a bathtub (see above).</p>
1	Linen room	15-20	For storing clean linen/ bed pads.

Number	Type of room	Estimated net area per room (m <sup>2</sup> )	Description and functional demands
1	Cleaning room	8	<p>Good ventilation, preferably divided into clean/dirty sections via sluice.</p> <p>Space for boilers, for bedpans, washing and slop sink.</p> <p>Good ventilation to prevent troublesome smells, preferably with a window for ventilation.</p> <p>Central placement with a minimum of one on each floor.</p>
1	Laundry - possibly connected to the door to the cleaning room	8	Space for washing machine and tumble drier, rubbish bin and various cupboards for washing, linen and other equipment.
2 or more	Local depot	15	Storage for hoists, wheelchairs, mattresses, indoor machines and oxygen bottles.
1	Distant depot	50	<p>Could possibly be located in the basement (with access to lift for transport of bigger machines/beds).</p> <p>Possibility of washing beds.</p>
1	Entrance to the ward section	-	<p>Same entrance and exit for patients, relatives and coffins.</p> <p>Clear signposting.</p>
1	Patios	-	<p>There should be good access to south facing patios for patients and relatives, for example via a communal garden, individual garden, sense garden, terrace, balcony or a combination of these.</p> <p>Beds should have level, free access to the patio.</p> <p>Electricity supply in the area</p> <p>Floor covering and doorframes should be installed with this in mind.</p> <p>Possible patio with shelter against wind, sun and drizzle.</p> <p>Some patients wish to take a nap outdoors, and patios should be equipped with lighting.</p> <p>The construction of the patio may create associations to smaller 'rooms' where groups of 4 - 6 persons can gather.</p>
<b>Sum: 570 - 720 m<sup>2</sup></b>			

Staff area			
Number	Type of room	Estimated net area per room (m <sup>2</sup> )	Description and functional demands
1	Communal staff area  Meeting/conversation/telephone room integrated into the staff area	Approx. 17 m <sup>2</sup> per workstation	<p>Communal team based work environment for nursing staff, palliative team, administrative staff, possible volunteer co-ordinators and research staff.</p> <p>Contains work groupings of differing sizes. Access to meeting/studio/consultation and print/copy rooms.</p> <p>Possibility for 10-15 people to have short, intense meetings close to the journals.</p> <p>Coffee/meeting/snack bar providing possibility of 12-18 persons eating at the same time.</p> <p>Establishing of glass walls or other visual contact with the rest of the ward section, facilities for examination and day hospice.</p> <p>Estimated need for archives (based on experiences from Kamillianer Gaardens Hospice, Aalborg): Ward section, total: 5 lbm. Library: 12 lbm. Leader of Hospice: 2,5 lbm. + 10 lbm. distant archives. Estimated for the palliative team, total: 10 lbm</p> <p>(A larger degree of use of electronic records can be expected to influence the above numbers, reducing the need for archives). Estimated space per workstation is approx. 17m<sup>2</sup>, which covers meeting room, coffee bar and print/copy.</p> <p>Number of workstations and meeting rooms will depend on actual staffing.</p> <p>Smaller study, meeting, telephone and consulting rooms in connection with the open office. Located so that they screen off individual workstations. Location and number related to work function.</p> <p>Possibility of controlling internal and external views.</p> <p>Acoustically regulated to prevent disturbance of sensitive conversations.</p> <p>The section in the staff area where the palliative team is situated should be secluded from the rest of the staff area to avoid disturbances during telephone consultations and the like.</p> <p>Estimated size for study, meeting, telephone and consulting rooms approx. 7 –12 m / room (included in the total area/workstation).</p>
<b>Sum<sup>40</sup>: 272 m<sup>2</sup></b>			

<sup>40</sup> Calculated on the basis of 16 workstations in the work area.



<b>Examination facilities</b>			
Number	Type of room	Estimated net area per room (m <sup>2</sup> )	Description and functional demands
Min. 1	Consulting room	10-15	<p>The rooms reserved for the examination section will be used by all the patients in the hospice.</p> <p>The consulting room will be used by the palliative team for examination and treatment of patients living at home during consultation at the hospice, patients at day hospice and to some degree patients in the ward section.</p> <p>The consulting room should be equipped with massage table, desk, 2 chairs and a washbasin.</p> <p>If the massage table is moved to the middle of the room, it should be possible to access it from both sides.</p> <p>Journals are expected to be placed in the staff area.</p> <p>The room should be located in close proximity to the staff area.</p>
Min. 1	Waiting area	5-10	<p>Smaller area for patients waiting for consultation, preferably with visual contact to the staff area.</p> <p>Space for chairs/sofa</p>
<b>Sum: 15 - 25 m<sup>2</sup></b>			

<b>Day hospice centre, 10 –12 patients</b>			
Number	Type of room	Estimated net area per room (m <sup>2</sup> )	Description and functional demands
1	Communal area	Approx. 120 m <sup>2</sup> <sup>41</sup>	<p>The staff of the day hospice centre sit in the communal staff area, which is located adjacent to the day hospice centre.</p> <p>As the day hospice centre fulfils a social function, this area should have capacity for social activities and arrangements.</p> <p>There should be a tea/service kitchen and the possibility for patients to share a meal.</p> <p>It is expected that, on a daily basis, a maximum of 12 patients and 2-3 employees are there at the same time.</p> <p>Handicap friendly, but no need for access to beds.</p> <p>As the day hospice centre should also function as a space for events in the hospice outside opening hours, the room should be able to accommodate gatherings of 40–60 persons at the same time.</p> <p>The room should preferably access external areas.</p>
1	Washing room	12	As described under the ward section
1	Resting room	10–12	Quiet / resting room for patients feeling unwell. Space for a couch and a small chair.
<b>Sum: 142 - 144 m<sup>2</sup></b>			

<sup>41</sup> The size is based on experiences from three English day hospice centres and is not absolutely certain.

<b>Support services</b>			
Number	Type of room	Estimated net area per room (m <sup>2</sup> )	Description and functional demands
1	Kitchen	120	<p>Cold/warm kitchen for ward section, day hospice centre and all staff. Including space for scullery, baking section, cold section, freezing, cooling, storage, rubbish, washing-up, depot, facilities for kitchen staff etc.</p> <p>The proportions of the kitchen should be able to accommodate individual food preferences from the patients and possibly relatives and staff.</p>
1	Caretaker room	10	<p>Office and workshop for handy man. Contains office workspace and space for smaller repairs/tools.</p> <p>Need for archive: 8 lbm.</p> <p>The room should preferably be close to distant depot.</p>
1	Changing room and showers – men	Approx. 20	Changing facilities for staff and volunteers. Include toilet , showers and lockers.
1	Changing room and showers – women	Approx. 30 -40	Changing facilities for staff and volunteers. Include toilet, showers and lockers.
2 or more	Toilets for staff and visitors in the communal areas of the hospice	7	The design of the toilets is to be handicap friendly.
1	Entrance to the hospice		<p>Personal welcome.</p> <p>Entrance signalling openness and possible access to information</p> <p>Possible lift should be on the same architectural level as the main entrance.</p> <p>Easy exit with coffin/stretchers through main entrance.</p>
1	Parking area for cars and bicycles.		<p>Parking bays for staff, relatives and patients, in accordance with regulations in district plan. Experience shows that 20–25 parking bays are the absolute minimum.</p> <p>Plus more parking bays for a possible day hospice centre.</p>
<b>Sum: 194 - 204 m<sup>2</sup></b>			

All rooms are net areas. It should be noticed, however, that the staff area includes print/copy, meeting, visitation rooms and therefore also walls. Experience shows that the above should be multiplied by a factor number of 1.3 –1.5 in order to show a final gross area.

## **Notes:**

### **Consequences of building on two levels**

When building wards on two levels it is important that lounges exist on both levels to ensure that these are easily accessible for all patients. In addition, washing rooms etc. should be established on each floor. Depending on the shape of the building it may become necessary to establish extra rooms for medicine, storage and bathrooms with bathtubs.

With more than one level the lifts should have space for beds.

### **Hoist**

In all the places used by the patients (wards, bathrooms, therapy rooms, toilets etc.) a hoist from the ceiling should be installed or it must be possible to have access with a mobile hoist. Choice of hoist type should be integrated in a practical and aesthetic way into the physical framework of the building either via rails, which are hidden/well integrated in the building, or via the possibility of easy and discreet placement of a mobile lift, when this is not in use.

### **Wireless network**

A wireless network connection should be established at the hospice to accommodate future electronic journal handling, the use of laptops and relatives wishing to work during their stay.

### **The experienced environment**

Generally, a pleasant indoor climate should be ensured, including the possibility of ventilation and the opening of windows. Soundproofing should be installed between the wards, and also in connection with the ventilation system and generally, good acoustic regulation should be in place. External views should be possible including for bedridden patients, and it should also be possible to screen off the office workplaces against uncomfortable and direct sunlight. Besides, distinctions should be made between work light and 'cosy' light.

### **Aesthetics**

It is important to think holistically in relation to architecture, supporting constructions and installations to prevent one area being given preference over another. Various surfaces, detailing, joints and connections, visible fittings etc. should be worked out in the most aesthetically pleasing way. It should be possible for users of the hospice to move through various activity zones, which each promotes and furthers different types of atmosphere and relations – that space, surface, colours and lighting support this in unison.

### **Floors**

It is preferable to use flooring from wood, linoleum or tiles to minimise the institutionalised appearance of the hospice.

### **Information and signposting**

Signposts are to be done discretely to prevent an institutionalised feel – the hospice is a home.