Dementia & The Environment

How Design Shapes The Experience Of Dementia Care

A practical guide for residential aged care teams

FACILITATED BY

Daniel Jameson,
Dementia Design Specialist
The Dementia Centre - part of Hammond Innovations and HammondCare

DELIVERED BY

E4 People
Aged Care Staffing Specialists
Committed to upskilling the aged care sector to deliver confident, dignified dementia care.

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DEMENTIA TRAINING WORKSHOP SERIES

Welcome

FROM THE E4 PEOPLE TEAM

Across the Dementia Training webinar series, we are bringing together aged care professionals from across Australia to build the skills, language, and confidence needed for dignified, person-centred dementia care.

This webinar, Dementia and the Environment, was facilitated by Daniel Jameson, Dementia Design Specialist with The Dementia Centre, part of Hammond Innovations and HammondCare. Daniel is an occupational therapist whose role is to translate what living with dementia feels like to the architects, designers and care providers shaping built environments.

This guide captures the ideas, evidence, and stories Daniel shared, so you can apply them to your own facility right away. It is written for care staff, lifestyle teams, clinical leaders, hospitality and domestic teams, facility managers, and executives. As Daniel made clear, design is everyone's business: small changes can have profound impact, and you can begin without any budget at all.

KEY TAKEAWAYS

- The built environment shapes what people living with dementia can do, feel, and engage with every day.
- Good design for dementia is good design for everyone.
- Small, low cost changes can have profound impact: you do not need to wait for a refurbishment.
- Lighting, acoustics, contrast, wayfinding and homely cues are the most powerful levers in your current building.

Acknowledgement of Country

E4 People and The Dementia Centre acknowledge the Traditional Custodians of the lands on which we live, work, learn, and provide care. We pay our respects to Elders past and present, and extend that respect to all Aboriginal and Torres Strait Islander people.

We acknowledge that connection to land, sea, and community is essential to wellbeing and identity. This principle of connection and belonging sits at the heart of any environment built for dementia care.

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CHAPTER 01

Why design matters in dementia care

Dementia, in its simplest framing, is a progressive reduction in a person's ability to comprehend, understand, and interact with the world around them.

That changing relationship with the world is not only cognitive. It is sensory, emotional, and physical. And it plays out, minute by minute, inside whatever environment the person happens to be in.

> *"Dementia is an acute sensitivity to the built and social environment."*
>
> *— Mary Marshall, occupational therapist*

Powell Lawton, an environmental gerontologist, took this further. The more impairment a person is living with, the more we should look to the environment to compensate. In other words, the harder the world becomes to interpret, the more responsibility the environment carries to communicate clearly.

For residential aged care, that has a powerful implication. We cannot ask the person living with dementia to change. We can change the building, the room, the lighting, the layout, and the everyday cues that shape what they do next.

KEY TAKEAWAYS

- Dementia changes how people interpret and interact with their environment.
- Good environments compensate for impairment; poor environments compound it.
- Adapting the building is almost always more effective than asking the resident to adapt.
- Even small environmental changes can support function, calm, and dignity.

CHAPTER 02

How familiar spaces shape behaviour

FROM THE WEBINAR

The cinema

When you walk into a cinema, you know what to do. You know roughly where to sit. You know to silence your phone when the lights go down. You can probably even imagine the smell of the popcorn and the stickiness of the carpet.

None of this is taught in the moment. The environment communicates the activity: the dark tones, the acoustically treated walls, the rows of forward-facing seats, the curtain at the front. The room is intuitive because it is consistent and familiar.

Good aged care design borrows this principle. A dining room should look like a dining room. A lounge should look like a lounge. The space itself should tell residents what they can do there.

FROM THE WEBINAR

The MRI machine

Daniel then showed an MRI suite. Workshop participants described it instantly: fear, claustrophobia, scary, narrow, cold.

The MRI is the inverse of the cinema. We do not know how to approach it. We do not know where to stand. We can already imagine the chill of the room and the smell of the cleaning products. The environment communicates anxiety.

For a person living with dementia, who is already finding the world harder to interpret, the equivalent environments in aged care, the clinical corridor, the bright treatment room, the unfamiliar bathroom, can trigger the same anxiety response, every single day.

FROM THE WEBINAR

The retail world

Retail spaces are engineered to do something to us. They use light, signage, layout and product placement to guide choice, to excite us, and to encourage spending. The chocolate bars at child eye-height by the checkout are not an accident.

Daniel's point: retail environments deliberately overstimulate. People living with dementia are particularly vulnerable to overstimulation, whether from clutter, signage, competing demands for attention, or too much choice presented at once.

Care environments can take the helpful lesson from retail (clear cueing toward a single action) without inheriting the harmful one (sensory overload).

FROM THE WEBINAR

The food court

Workshop participants described a food court in one word: busy, crowded, cold, overcrowded. That is the design intent. A food court is not engineered for a leisurely three-hour lunch with friends. The noise, the lighting, and the hard surfaces are designed to keep diners moving so the next group can sit down.

Daniel's observation: many residential aged care dining rooms unintentionally borrow this design. Loud acoustics, hard surfaces, large group seating, busy staff zones. The result is the opposite of what residents need at a meal.

For people living with dementia, who can already find the physical act of eating difficult, an overstimulating dining room makes meals harder, more agitating, and more frustrating, and contributes to the very behaviours staff then have to manage.

The red button

If there is smoke in the room, what do you do? You hit the big red button. The design needs no instruction. It is familiar, intuitive, and unambiguous. Aged care environments should aspire to the same clarity wherever a resident needs to act.

FROM THE WEBINAR

The fly in the urinal

An airport in Amsterdam had a problem with spillage at the men's urinals. The solution was not new fittings, more signage, or extra cleaning. It was a single small fly etched into the bottom of each urinal, giving male users a target.

Spillage dropped dramatically.

Daniel uses this example to make a critical point about aged care: you do not need to demolish a building to make it work better for people living with dementia. The smallest interventions, applied with insight, can deliver profound improvement. The whole webinar series is built on this premise.

KEY TAKEAWAYS

- Familiar, consistent spaces communicate what to do without instruction.
- Anxiety-producing spaces (cold, unfamiliar, clinical) compound dementia symptoms.
- Overstimulation, whether from retail style signage or food court acoustics, is one of the most common design failures in aged care.
- Small, targeted changes can have outsized impact.

CHAPTER 03

When the environment works against the resident

The dining room that does not look like a dining room

A residential aged care dining room with the servery roller door pulled down, plenty of staff signage, and a tabletop arranged like a nurse's station, no longer reads as a dining room. A person who already has difficulty articulating that they would like a cup of tea or a piece of fruit loses an important cue.

If you have a dining room, it needs to continue to look like a dining room and continue to act like one. The same principle applies to a kitchen, a lounge, or a garden.

The obvious locked door

There is a legitimate need for some secured spaces in dementia care. Risk is real, and security supports safety. The problem is not the lock itself but the visibility of the lock.

A glass-panelled door that lets a resident watch people coming and going on the other side is the dementia equivalent of being shown the exit you cannot use. It is confronting, frustrating, and a frequent trigger for agitation and aggression. The kinder design intervention is to obscure the view through the door: same colour for the door, the frame, and the surrounding wall.

The nurse's station

Daniel made an unapologetic point: residents are at home, not in an institution. A prominent nurse's station implies a hierarchy in which the staff side has control and the resident side does not. Where a staff workstation is required, the design intent should be to play it down, not display it.

Murals on the wall

Murals are well intentioned but often misread. A trompe l'oeil bookshelf prompts residents to try to take a book that is not there. A mural with a dog may delight some residents and frighten others. As a rule, murals are more confusing than supportive.

Reflective floors and basins in corridors

Highly polished floors can read as wet or slippery, changing a person's gait and increasing fall risk. They can also create glare that makes the space harder to see. Hand wash basins installed at corridor level can be misinterpreted as urinals by residents who are already searching for the toilet. Both are quietly degrading design choices that can be solved with simple changes.

> *"When we get design wrong, the experience can be confusing, dangerous, degrading, restraining, and downright boring. Day on day, hour on hour, that is chronically stressful. I know I would not cope with it."*

And when we get it right, it is simply good design: good for older people, good for people living with dementia, good for staff, good for visitors, good for everyone.

CHAPTER 04

The household model of best practice

What's the gold standard for residential aged care as the small household model? The principle is simple. None of us, including the staff who work in aged care, particularly want to live in care. But if we have to, we would much rather it felt like home than like a hospital, an institution, or a cruise ship.

What home means

When Daniel asked the audience to describe what home means to them, the answers came quickly: personalised, safe, family, familiar, comfortable, photos, a kitchen, a laundry, beautiful meals. These are not luxuries. They are the everyday markers of identity, belonging, purpose, choice, and control.

> *"I want to belong. I need to have purpose. I need to be able to express choice. I need to have control. And no one should be coming into my room without knocking first."*
> *— Daniel Jameson*

What the small household model looks like

- Fewer than 15 people living together in each household.
- Accessible outdoor space available to every household.
- Continuity of staff, so residents and care teams build real relationships.
- Meals cooked within the unit, not just delivered from a commercial kitchen.
- Self-service access: residents can make a cup of tea, grab a piece of fruit, take a biscuit.
- Residents can help with meal preparation if they wish.

What the evidence shows

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What the evidence shows

When this model was compared to standard Australian residential aged care, the outcomes were striking:

- 73% reduced chance of emergency department admission.
- 68% lower chance of hospital admission.
- 50% less likely to be prescribed inappropriate medication.
- Higher self-reported quality of life from residents themselves.

Daniel noted that this approach is not new. HammondCare has been delivering it for around 30 years. International examples include Belong, the Hogeweyk in the Netherlands, the Greenhouse model in the United States, and, in Australia, providers such as NewDirection Care in Caloundra.

KEY TAKEAWAYS

- Households of fewer than 15 residents are best practice.
- Familiar domestic activities (meals, laundry, gardening) are central to wellbeing.
- The model is proven to reduce hospitalisation and inappropriate medication, and to raise quality of life.
- The model is not new: there are 30 years of Australian practice to learn from.

CHAPTER 05

The National Aged Care Design Principles and Guidelines

In response to the Royal Commission, the National Aged Care Design Principles and Guidelines were released to translate evidence about good design (including the small household model) into a clear framework providers can use.

The document is currently a tool of encouragement rather than enforcement, but Daniel noted this may well change over time. He encouraged every participant to download a copy and explore it. It is written to be useful to architects, executives, boards, and care teams alike.

The four principles

1. Enable the person. Support people to live in a place that maintains their health, wellbeing, and sense of identity. This includes lighting, acoustics, colour, contrast, air quality, and every other element that helps people decipher their environment.
2. Cultivate a home. The space should read as home, not institution. Residents have privacy, control, and a sense of belonging.
3. Access to the outdoors. Every group of people living together should have their own access to outdoor space. It is fundamental to wellbeing.
4. Engage with community. The environment should help residents continue to participate in meaningful activities and feel connected to community life.

The full document contains 31 guidelines, written through resident and staff personas so they can be used as practical problem-solving prompts.

> *"That is what we do when we are supporting people living with dementia. We are problem solving every day."*
> *— Daniel Jameson*

CHAPTER 06

Acoustics: when sound becomes noise

Daniel framed acoustics around a simple distinction: a sound is something we enjoy or accept; a noise is a sound we cannot control, cannot escape, or cannot identify.

Think about the sound of a noise in your car that you cannot quite place. It is small, but it can become unbearable within minutes. Now imagine a person living with dementia experiencing that level of frustration with the everyday acoustic environment of a residential aged care facility.

Common sources of noise in care

- Loud, crowded dining rooms.
- Trolleys crashing through corridors.
- Cutlery and crockery clanging in the servery and the dishwasher.
- Staff conversations and pages echoing across hard surfaces.
- Mechanical sounds from doors, alarms, and equipment.

How to soften the soundscape

- Add soft furnishings: curtains, tablecloths, upholstered chairs.
- Use carpet where you can. Daniel was clear: nothing improves the acoustic quality of a residential aged care home more than carpet.
- Close doors when providing personal care, both for privacy and for acoustic comfort.
- Manage the source where you cannot remove it. Where is the noise coming from, and can you do that task differently, more quietly, or somewhere else?

> *"If you are providing care to someone in their bed, have you closed the door? You are protecting their privacy and improving the acoustics of the whole space at the same time."*

CHAPTER 07

Wayfinding: helping people know where they are

If you have ever returned to a multi-storey car park and could not find your car, you know how quickly disorientation tips into anxiety. For people living with dementia, that experience can be a daily one inside the building they live in.

Wayfinding can be defines as four linked abilities: knowing your destination, knowing where you are, knowing and following the best route, and recognising the destination when you arrive. Each of these can be difficult for a person living with dementia.

Layout

A simple layout (a kitchen visible from the corridor, a single sightline to the lounge) is easier to understand than a complex one. Many of us have got lost inside an aged care facility ourselves. If we get lost, residents living with dementia almost certainly will.

Line of sight

People can only navigate to what they can see. Daniel referenced 30 years of HammondCare practice where bedrooms are designed so the resident can see the toilet from their bed head. This single design choice helps people remain continent for as long as possible.

Landmarks, not signs

In everyday life, we navigate by landmarks: the fountain we turn left at, the shop we pass before the escalator. The same principle works in aged care. Landmarks at decision points help people find their way. To be effective, landmarks should be:

- Informative: they signal that a decision needs to be made.
- Persistent: they stay in place over time.
- Meaningful: residents recognise and remember them.
- Distinctive: a vase of flowers at every junction is not a landmark.

Signage

People living with moderate to advanced dementia are unlikely to see, read, or recognise signage in the way design teams imagine. Daniel's rule: less is more. Where signs are used, place them at resident eye height or slightly below. Aged residents, and many people living with dementia, gaze downward rather than up. A sign above a door is, for many residents, invisible.

KEY TAKEAWAYS

- Wayfinding is about more than signs. It starts with layout and line of sight.
- Plan landmarks at every decision point, and make them informative, persistent, meaningful, and distinctive.
- Use signage sparingly. Place it at resident eye height or below.
- If you have ever got lost inside a facility, your residents will too. Redesign the path before you add another sign.

CHAPTER 08

Lighting: the most underused lever

Lighting is one of the most powerful and underused levers for improving environments that were not originally well designed.

> *"On average, people living with dementia need double the amount of light that you and I need. If it feels a bit dull to you, it is way too dark for them."*
>
> *— Daniel Jameson*

Two rules of thumb

1. Provide approximately double the illumination most adults are comfortable with. The aging eye and changing visual perception both reduce the amount of light that reaches the brain.
2. Aim for evenness. Walking from a bright spot to a shadow and back again is disrupting. A corridor with downlights that create alternating pools of light and shadow can be deeply disorientating for a person living with dementia.

Both rules apply across the whole facility, including bedrooms, bathrooms, dining rooms, corridors, and the transitions between indoors and out.

CHAPTER 09

Colour and contrast

We do not see objects in isolation. We see objects against their backgrounds. A camouflaged tree frog disappears because its colour matches the bark. A bright pink frog stands out for the opposite reason.

People living with dementia rely heavily on contrast to make sense of what they are looking at. Where contrast is poor, important features of the environment can vanish.

Where contrast matters most

- Floor to wall: without contrast, residents may lose the boundary between the two and become unsteady.
- Toilet to floor and toilet to wall: a white toilet on a white floor against a white wall is genuinely hard to find.
- Grab rails to wall: a chrome grab rail on a pale tiled wall offers little visual cue.
- Plate to table: a white plate on a white tablecloth makes meals harder for someone whose perception is already compromised. Contrasting place settings, tablecloths and crockery help.

KEY TAKEAWAYS

- We see objects against backgrounds: contrast is what makes an object visible.
- Audit floors, walls, bathroom fittings, grab rails, and table settings for sufficient contrast.
- Lighting, acoustics, and contrast are the three highest-impact levers in an existing building.

CHAPTER 10

Questions from the field

Participants raised several practical questions in the live Q&A. Daniel's answers form a useful set of operating principles.

"Residents find their way to the door, then we redirect them."

Daniel acknowledged that providers often manage risk by restricting outdoor access. His view is that residents have a dignity of risk. If a resident makes the choice to step outside in the rain, and the environment is set up to support that choice safely, the answer is not refusal. It is enabling.

> *"If they want to go outside, they want to go outside. Have a hat rack and a coat rack alongside the outdoor door. If it is cold, there is a coat. If it is hot, a hat and sunscreen. Do not discourage the choice."*

"Are stop signs useful for discouraging entry to other residents' rooms?"

Daniel was sceptical. If a resident wants to leave and the answer is a taller fence, you have not solved the problem. The same logic applies inside the building. The better response is to understand what is happening for that person. Do they feel they belong? Do they have purpose? Are they bored?

Where wandering into a particular bedroom is genuinely a problem, the response should be individual to the resident and the room, not a blanket rule.

"When should we suspect delirium rather than dementia?"

Daniel noted that this question sits outside his design specialty, but offered the practical distinction. Delirium is an acute onset change in cognition, typically caused by an underlying pathogen or other treatable cause. The first step is treating the underlying cause and waiting for the delirium to subside. Any consideration of dementia diagnosis should occur after that, under the treating GP and, where relevant, a specialist.

"Home-like cues can clash with infection control. How do we balance them?"

Daniel's answer was about clever practice rather than abandoning standards. We can have residents help with cooking, cleaning, and washing up in ways that respect food safety and infection control. The bowl of batter residents mix may not be the one served. Small homely cues such as a kettle, a dishcloth, and a fruit bowl reinforce that this is a domestic environment, not an institution.

CHAPTER 11

One bite at a time

Daniel closed by acknowledging the scale of the challenge. Improving the environments in which most Australians living with dementia receive their care is, in his words, a colossal job. But:

> *"How do you eat an elephant? One bite at a time. We make a little bit of progress every day, and we get closer to better, and we improve the lives of people living with dementia."*
> *— Daniel Jameson*

You do not need a refurbishment budget to start. You can change the way you arrange the space. You can change how you use a room. You can change fixtures, furniture, and signage. Routine maintenance is itself an opportunity. So is the way you and your team work inside the space every day.

Resources to keep going

- National Aged Care Design Principles and Guidelines. Available free from the Department of Health and Aged Care.
- Environmental Assessment Tool (Dementia Training Australia). A practical, tick-box style assessment tool.
- DesignSmart Tool. A more detailed audit resource for built environments.

KEY TAKEAWAYS

- You can begin with no budget, today.
- Practice, room arrangement, fixtures, and signage are all within your control.
- Use the National Aged Care Design Principles and Guidelines to anchor decisions.
- Small improvements, repeated, add up to a transformed environment.

About the facilitator and the series

THE FACILITATOR

Daniel Jameson

Daniel is the Dementia Design Specialist at Hammond Innovations (previously The Dementia Centre), part of HammondCare. An occupational therapist by background, his role is to translate the lived experience of dementia into the language of architects, designers, executives, and care teams, so that the buildings and rooms residents spend their lives in genuinely work for them.

THE TRAINING PARTNER

The Dementia Centre

Part of Hammond Innovations and HammondCare, The Dementia Centre is one of Australia's most respected providers of evidence-based dementia education and consultancy. Their work supports residential aged care providers, home care services, and individual practitioners to deliver care that respects identity, dignity, and the lived experience of people living with dementia.

THE DELIVERY PARTNER

E4 People

E4 People is an Australian healthcare staffing brand committed to upskilling the aged care sector. Our Dementia Training Workshop Series brings sector-leading expertise to residential aged care facilities across the country, equipping teams to provide confident, dignified dementia care every day.