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| Hidden                               |            |            |
| East end                             |            |            |
| More space                           |            |            |
| Excessive                            |            |            |
| Simplify                             |            |            |
| Central                              |            |            |
| Total exos.                          |            |            |
| Broken up                            |            |            |
| Impersonal                           |            |            |
| On-street                            |            |            |
| central                              |            |            |
| Use as buffer                        |            |            |
| To rec. areas                        |            |            |
| Convenient                           |            |            |
| More open space                      |            |            |
| Central                              |            |            |</p>
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Entry to a building such as this could happen in one of two ways depending on the concept, or intent, of the design. The first is through a main entry into a commons area resembling the lobby of a hotel. Since this would be a rather major entry, the inclusion of a patient drop-off area could take the form of a porte cochere, for temporary parking, to get the patients close and oriented to the building. A problem with an entry of this type is the size in which it could become in relation to the scale of the neighborhood.

The second approach is a more decentralized plan in which there are separate entries to smaller "houses." This fits in much better with the scale and context of this particular neighborhood. Patient drop-off areas could take two forms here: temporary on-street access, or a small driveway, also temporary, to allow, as in the previous example, a drop-off area for patient, luggage, and belongings, to allow preliminary orientation before parking.

The parking requirements necessary to serve the building may be hard to accommodate, as most parking in the neighborhood is on-street. Idealistically, spaces for patient/family parking should be next to their own living areas, while staff areas can be slightly farther away, as they will be more mobile and familiar with the surroundings. According to city zoning ordinances, nursing home and hospital parking needs are one car per two beds. In this application, that will not be enough parking (only 12 cars). Since this is to be a facility for I.U. hospitals with a transient
population from all over the state, at least one space per patient will be needed (25), along with a ratio of cars for staff members and visitors. To get an idea of the minimum, I approximated one car per four staff members based on a daily employee census of 40, which indicates 10 spaces. In addition, one space per each five patients is approximated for visitors (5). This brings the total number of approximated spaces to 40. Some of the ways the problem can be addressed are as follows: 1) more on-street parking surrounding the site, 2) garages which are half underground and half above-ground, like other examples in the existing fabric of the neighborhood (possibly for long-term patient/family parking or staff parking, 3) a small parking area on the site carefully thought out so that valuable outdoor space to be used for a more positive, hospice-related uses would not be violated, 4) the use of parking lots not used on a daily basis, 5) filling up the neighborhood surrounding the site with on-street parking, and 6) carpooling for employees to conserve the number of directly accessible parking spaces for patients.
Interior Flexibility

Interior flexibility, is seen as being at the user's discretion to change, use or manipulate the space best suiting the user needs of the current time. Commons areas are designed to have the capability of being changed in a variety of arrangements. There are quiet and loud zones so there is a degree of limitation and unwritten social acceptance in some areas. For example, patient areas are quiet and they can be manipulated to do some quiet activity such as reading and conversing.

Interior Circulation:

Medical areas such as nursing stations are centrally located to patient rooms for accessibility and the patient's feeling of security. The relative closeness of the medical staff may be enough knowledge for the patients to feel secure without the necessity for direct visual contact which restricts the plan and contributes to an institutional feeling. Special care has been taken so that when rooms are open, they do not look into one another which creates a double-loaded corridor. Rather, rooms occur along quiet transitional activity links that look out to larger community commons areas, and to the outdoors to give the patient options of visual and physical activity. These areas are designed with a living room flavor, hence, patient rooms look into the family living room. By virtue of their location, and furniture placement, opportunities for interaction between hospice families are encouraged.
Security:

Separate entries are provided for each patient/family cluster. This could cause security problems if not monitored properly since there is not an attendant or nurse's station at each entry. Too many entries and exits may have people coming into the facility that should not be there, possibly, disturbing the patients. The nurse's station in both patient clusters are to be this active monitoring device. The way this is to be accomplished is by the use of security locks with buzzers for visitors who wish to enter the facility. The buzzer will ring at the nurse's stations in which case, the nurse on duty will go to the door to let in the guest. Families will be provided with keys which work exterior locks to their "own house" and to their apartment. After the normal staff work day from 8:00am to 5:00pm, the entries to the recreation area will be locked and guests will have to enter in the patient clusters.
Landscaping will be an important component of this scheme. The hospice philosophy stresses the importance of nature as a stimulus for reflection and contentment for terminally ill patients. Strong connections between indoor and outdoor areas are desired to facilitate this, as well as some interior green space for winter-time enjoyment. A larger patio-garden area should be provided for community functions such as cookouts in which patients, families, and staff can participate in the festivities. Patients will be using this area in various forms ranging from on-foot, to wheelchairs, walkers, and possibly hospital beds. Smaller areas within the garden for quieter moments alone, counselling or family time alone is also desired. Patients and family may help take care of these areas for therapies sake, while being economically feasible for the hospice.

On the street side of the building, it may be important to realize that over-landscaping would be very easy to do, as in actuality, not much more than street trees and scattered shrubs and flowers populate these areas.
Temporary Parking Area with Water-permeable pavers

Brick Walk

Indiana Avenue
There are two approaches to the service entry in this particular neighborhood situation. The first is to put service areas to the rear of the building, hidden from view, accessed by the existing service alley. The other option is to move the service area to the front of the building, being careful in its detailing, so as to fit contextually, yet remain functional, into the neighborhood. The size and supply requirements of the building may not call for a major loading area, making it easy and desirable to use residential symbols and scale such as a residential garage door as the service loading area. It may be possible to partially submerge this area as other garages in the neighborhood as a way to use context to its greatest advantage.
Submerged Garage Entries used conveniently in context with neighborhood precedence

Supply Receiving

Ambulance Entry

Recreation/Service Core
Cottage Grove Avenue
The spaces created are generous in area and hopefully provide enough opportunity for the user to adapt the space to their needs. Since each space was designed with furniture layouts and with the flexibility of these layouts in mind, adaptability provides the opportunity for personalization and a more home-like setting because of each user's different use and needs of that space. Promoting this breaks down a layer of institutionalism in that the freedom to move furniture around in the home environment maximizes dynamism and minimizes static, rigid layouts. A variety of quiet and loud areas with various spacial qualities allow the users to choose the area they would like to inhabit. This occurs by providing a variety of spaces such as quiet areas for reading and relaxation, and loud areas such as a recreation room, with teen room, children's room, an exercise room, t.v. area and etc. Zoning is important in the arrangement of these areas so they do not interfere with each other and with patient/family living areas.

Patient and family areas are major design concerns, as these areas will be inhabited for short and long-term stays (several days to several weeks). The length of time spent in the facility will make a difference on the amount of personalization the inhabitants are willing to do. Also important is the "territory" which a person claims and occupies. According to Debra Allen Carey in her book, Hospice Inpatient Architecture, a larger room is needed for patients in order for these things to occur, in order that patients do not feel like they are stuck away in a remote corner, but rather have a territory which is significant.
Other considerations included the space's location in the building, its connection visually and physically to community areas, and the space's individual character and spacial quality which provide the vehicle for patients and families to make their space "home." Although patients will not have their choice of room, each room is, as previously mentioned, slightly different in order to give the patient that sense of individuality which should promote personalization and identity. Attention is also paid here to the ceiling plane, which is subtly manipulated so as not to be a cubicle as most patient rooms end up being.

The individuality of each unique space occurs with the inclusion of adjustable shelves, tack surfaces, and picture rails which provide a way to display personal, treasured material possessions.

What began as a repetitive configuration in the preliminary plan, became an evolution to more individual space as location in regard to the nurse's station, views to the outdoors and community commons areas, and exterior massing problems occurred. Continual analysis of the previous repetitive plan concluded that the plan enhanced the institutionality that was trying to be negated.

**Furniture and Equipment Standards:**

In patient areas it will be necessary, for functional reasons, to have a few pieces of hospital furniture such as hospital beds and over the bed tables. Most other furniture can be residential. It should be warm in character (wood, fabric), to carry through the warm colors of nature, while
being easy to maintain as it will be used heavily by so many users. Community areas will benefit greatly from this, as the comfortable, inviting and home-like appearance should enhance its use. Furniture may be donated in order to cut down capital cost and to invigorate the atmosphere by continual change. In fact, "decorator perfect" interiors may do nothing more than create an institutional feeling of rigidity by the continuity and sameness throughout the entire facility creating apprehension so that its users are not able to be fully comfortable. In some instances, families may want to bring a favorite chair or other favorite piece of furniture in order to make the patient's stay more comfortable.

The nurse's station is another area where special care has been taken in the design for its image. The intent is for it to be looked upon as a library; shelves and counters lining its walls, with large windows allowing views and natural sunlight from and into the space. It is planned so that a large wood desk is at the center of this area, complete with a nurse call system. The area is mainly a base and charting center, as the supplies are kept on each patient level in close proximity to the patient rooms where they are needed. Its character, hopefully, appears non-institutional to patients and families, yet remains functional for its intended purpose. This area should become a kind of "house center," as a place in which congregation and social interaction are promoted.
Acoustic privacy is a must at certain times and should easily be accomplished by pulling a door or acoustic curtain shut. There are several ways this has happened: 1) zoning-louder areas are grouped at the center of the facility, separate from the patient clusters so that these quieter areas are not disturbed, but remain accessible to both patient clusters; 2) convenience areas as transitions—kitchen, dining and laundry areas used as a buffer zone between the quiet and loud areas; 3) sliding partitions to potentially separate patient and family zones of the apartment unit so that, for example, the patient is resting, the partitions can be closed to allow family members to remain in their portion of the apartment if they wish. The spaces provided are intended to be ambiguous in order for them to remain open, flexible, and conducive to social interaction, yet have the ability to be closed off for other activities which require varying degrees of loudness or quiet. The need for acoustic privacy in a facility such as this is especially evident for grieving, family tension, and isolation.
As previously stated, spaces are controlled individually for the warmth or coolness desired. Other factors affect this thermal sense as well. The relative coolness or warmth of a room is effected by the colors and materials used in that space. It may be that while designing these spaces, the activity going on in the space dictates the materials. For example, patient rooms and small private satellite areas may be done in wood for warmth and intimacy, while the recreation area may be a pastel color on a smooth surface since the activity in that space would be more intense, making that area feel cooler. Another way to accomplish this (or perhaps in addition to this) is the addition of ceiling fans in certain spaces such as the exercise room in which a slight breeze may do well to cool off the inhabitants. These concerns suggest a constant temperature in the community areas of the facility which will be changed depending on space function, which will seem cooler or warmer psychologically depending on materials, color, and air movement.

Time prevented the total design integration of this aspect which would be the next step in prescribing, subconsciously, to the facilities users, where quiet and loud areas, and calm and active areas occur.
A special emphasis is put on natural light in order for sunlight to permeate the building, creating a warmer, lighter, and airy atmosphere, as well as a visual connection to nature and a dynamic, moving world. It is important in that it maintains the natural time clock in the patient mind, which sometimes is lost because of inadequate sunlight or view to the outdoors. Care does have to be taken so that direct sunlight does not bother the patient, such as sun in their eyes. With this in mind, such simple devices as adjustable blinds can be facilitated in patient rooms, while certain public areas may be allowed to have uncontrolled sunlight permeation, and others will have very little sun; this enhances spacial variety and user choice.

Active lighting will consist mostly of incandescent lamps or adjustable or track lamps on dimmer switches to be as flexible as possible to allow changes in room arrangement or activity to occur. Incandescent fixtures are much more appropriate because they emit a warm glow which is far more desirable for comfort reasons. Although fluorescent lights are economical, they will not be used, as they emit a cold, nauseating glow which probably does more to institutionalize and depersonalize an interior than many other more subtle cues such as hospital furniture.
The accompanying list is only a partial list of the regulations which govern medical facilities; the ones listed are the ones considered in this project. Interpreting and complying with these codes, as I discovered, is difficult, time-consuming, and aggravating. It is easy to see how most of these buildings end up as they do since everything has to be reviewed and approved by the State Board of Health. The problem here lies in that since the in-patient hospice unit is not an acute-care facility, they should not be governed as one. It may become necessary for the State Board of Health and the Uniform Building Code to relax code requirements in order to promote a more positive environment for medical facilities users. It should be pointed out that sole blame cannot go on the code requirements, as it becomes a matter of manipulation on the part of the designer. Imagination and cleverness are necessary to comply with the safety requirements in a less institutional way.

The problem of a lack of special designation is the same in licensure of such a facility. The purpose of licensure is to keep track of a facility to make sure they are complying with health regulations, and are providing quality care for patients. As Dr. Margaret Pike of St. Vincent Stress Center has related, a special hospice classification is needed in order for the in-patient unit to run more flexibly. The National Hospice Organization, of which Dr. Pike is associated, sets guidelines for management of a hospice which could take the place of some of the stringent guidelines
enforced by the State Board of Health which may not be applicable. Some states have passed this special designation, the latest being North Carolina.

To be sure, the proposed design of this facility violates some codes and regulations which were either overlooked (which is very easy to do with so many to comply with), or ignored as a result of my belief that variances will need to be obtained or codes changed slightly to allow more psychologically positive facilities to be built.
Code Requirements

UBC (Uniform Building Code)

*Rating I-1, Type II F.R. Construction
*super-structure restricted to reinforced concrete, masonry or steel (chose steel for manipulation, flexibility, and not having the cold, damp feeling, and mass associated with concrete or masonry)
*3-story maximum
*11,300 sq.ft. maximum without fire separation
*automatic fire-extinguishing system
*area separation walls not less than 4 hour F.R. Construction
*area separation walls may terminate at roof soffit if 2 hour roof, must extend 30" above roof if not 2 hour
*partitions (perm. non-bearing) 1 hr.
*structural frame 2 hr.
*shafts 2 hr.
(elevator shafts vented)
*exterior/interior non-bearing 2 hr.
(with 45 min. window except.)
(allows use of clapboard siding in cross-section if treated)
*windows/doors 45 min.
*floors 2 hr.
fire-resistive floors shall be continuous and all openings for systems enclosed
(use chase for systems)
*ceiling openings not more than 100 sq. in./100 sq.ft. of area
*8' corridor for transportation of non-ambulatory patients

*no glazing in fire doors
*no exit less than 44" wide
*glazing not to exceed 84 sq.ft. with neither height nor width exceeding 12' (not observed in design)

Bloomington City Ordinances

*rehabilitative facilities allowed in any zone
*projections such as eaves may extend over property lines 3'
*projections such as non-enclosed porches may extend over property lines 6'
*setbacks depend on context of neighborhood
*must maintain a diagonal line of site at least 25' from corner
*no specific parking requirements for application
hospital/nursing home 1 car/2 beds
hotels/motels 1 car/unit
dwellings 2 cars/unit
assume 1 car/bed, 1 visitor car/5 patients, 1 staff car/4 staff based on daily employee count of 40
total spaces required: 40
*fire zone designation depends upon structure's use, generally Bloomington is fire zone 3, for this application, fire zone would be 1

Indiana State Board of Health

*minimum patient room area 100 sq.ft.
nurse's call system
*visual privacy in multi-bed rooms
*clean holding room
*soiled holding room
*clean storage
*nourishment station (for snacks)
*equipment storage room
*parking for stretchers and wheel chairs out of normal traffic path
*site survey and recommendations obtained from board prior to site acquisition
*ceiling height minimums
8'-0" in patient rooms, etc.
9'-0" in boiler rooms
*piping, conduit, and ductwork shall be run in concealed areas
*boiler rooms should not be located underneath patient service areas
*the number and arrangement of boilers shall be such that when one boiler becomes inoperable, or when routine maintenance requires that one boiler be taken temporarily out of service, the capacity of the remaining boiler shall be sufficient to run all systems
*outdoor intakes located no closer than 25'-0" from exhaust
*the following requires a separate mechanical exhaust system:
  toilets
  baths
  soiled holding rooms
  janitor's closets
  food preparation, and dishwashing area
  garbage storage
  laundry rooms
*reading lights shall be provided for each patient switched at bed and at
door
*each room served by at least one call station
*call signal shall actuate a visible signal at patient's door, clean workroom, soiled workroom, and nourishment station
*call emergency button located in patient bath
*emergency electric services provided
Typical Wall Section

- asphalt shingles
- felt
- plywood sheathing
- light-gauge steel trusses
- insulation
- 2-layers gyp. for fire protection
- I-beam super-structure
- mechanical space
- 2 layers gypboard susp. ceiling on alum. track
- I-beam super-structure

- 45 min. double-hung window w/alum. frame
- interior wood trim
- exterior treated wood trim

- rigid board insul.
- light-gauge steel fmg.
- insulation
- 2 layers gypboard
- 1½" steel deck w/1½" concrete
- I-beam super-structure
- treated clapboard siding
- mechanical space
- concrete block wall
- blocking
- 2 layers gypboard susp. ceiling on alum. track
- steel framing on interior w/insulation (cavity)
- 2 layers gypboard
- drip-board
- 45 min. double-hung window w/alum. frame
- interior wood trim
- exterior treated wood trim
- ashlar foundation wall (where exposed)
- stone sill

- concrete block found. wall
- 1½" steel deck w/1½" concrete
- I-beam super-structure
- light-gauge joists
- crawl-space
- expansion joint
- 4" slab on grade
- water protection
- continuous concrete footing w/rein.
- isolated footing for steel super structure
Utilities are conveniently located for easy hook-up to the facility. The alley which the proposed building spans is not vacated, but since no easements exist on this portion of the site, it should be no problem to free this piece of property. The only easement which does exist on the site is at the back of the site where there is buried phone cable. Water, sewer, gas, and electricity will be hooked up to the building in three locations along Cottage Grove Avenue, corresponding to the three separate sections of the building with independent systems. This serves as a back up in case of one systems failure, economy in that fire dampers do not have to be used at the two fire-wall locations, and the areas served by the system can be more quickly served in a smaller area.
Heating, ventilating, and air conditioning is controlled individually by room since the relative warmth of an individual is a personal preference. Other reasons for this are that patients, in general, feel colder because of their condition and inactivity, while those around them feel warmer; hence, patient rooms should be warmer. This is made possible by anyone of the three separate systems which the facility contains. They are air systems which force air at a constant temperature the whole year while each area, served by its own duct, contains a heating coil which regulates the temperature of the air being blown through it. The facilitation of such a system is desirable not only for patient comfort, but also for convenience and economics. Using such a system is economical in that fire-dampers will not be necessary at the two fire-wall locations since there are three independent systems; it is a back-up in case one system goes out, the whole facility will not be paralyzed, and the overall smaller area to be served can be done so quicker. A ventilation system integral with this will recycle and change used air from the community so that no lingering smells can permeate and invade the positive image created. The senses become very sensitive to things such as smell in a medical facility because of the varying smells of sickness and antiseptic.

There is an opportunity to use active and passive solar devices in this design for energy conservation and economics which was not explored. The extent to which passive solar can be considered in this design is in the amount of glass exposure allowed into each space. This consideration was more for the concerns for natural light penetration and ventilation.
nurse's station centrally located and on a split level between patient levels is equally as bad for the nurse going half way up or down, prominence may be overwhelming in community living area

Family "house" nice scale, but patient/family units too rigid and repetitive

exterior massing needs to be simplified

this apartment unit may become excluded from interaction because it is tucked in a corner

need more glass exposure to outdoor green area

wasted space in living area

too much corridor space

good promotion of visual access to community areas

elevator opening to wall better than onto patient room, as patient has view of elevator

view from "house" sitting area into patient room
fire stair the only way to recreation level other than elevator, need nicer stair

separate areas for receiving and ambulance; gives more respect to those who are taken out in the ambulance, than to be taken out receiving area
dynamic open space
balcony a good place to stand or sit
and people watch
child room close to community area for surveillance

open wasted space

recreation area to open to outdoor area

convenient direct access to administration
double occupancy room convenient and versatile for use with or without primary care-giver
private staff area to get away from patient atmosphere
offices without windows

SITTING AREA

wasted space

need more room in sitting area
Elevation Studies

Existing houses

Indiana Avenue

massing a big problem

minimize repetition of windows

SOUTH ELEVATION
cottage grove ave.
4'1"-0"

change dimensions on projections

use porches to break scale down
two-story solution in one-story neighborhood

massing in width is good, but height needs work

Proposed Hospice

lowering gable to create rooms in the eaves one positive solution inside to create a dynamic space and outside to lower scale

change in roof planes will help emphasize change in scale

make connections less apparent (more trellis-like; vine-covered walkway)

street trees will help break mass down
abstract facade study

use existing roof pitch
lower scale by addition of
roof forms closer to existing
fabric
use of porch to break down scale
overall appearance too alien
to neighborhood context
scale broken down well
still appears as a two-story
solution in a one-story
neighborhood
one-story appearance for two-story solutionaise second floor higher on a "foundation"
use of earth berm to break down the scale
use of oversized drip-board to help break down apparent size
use of longer windows
use of porch to break down scale
"foundation" surrounding entry may give appearance and feeling of entering into a basement

variation of the same theme
take here definitely given the basement feeling
raising of porch makes the facade appear too high, and not functional for its function as a porch
Living Areas

1 patient/family unit
1a double-occupancy patient unit
w/family area if needed
2 porch
3 entry vestibule
4 supply storage
5 "house" living area
6 patio
7 community living area (shared by 12 units)
8 nurse's station (serves 12 units)
9 patient drop-off area
10 sitting/sub-area

Convenience Areas

11 dining area (shared by 12 units)
12 public restrooms
13 laundry (shared by 12 units)
14 kitchen (shared by 12 units)

Mechanical Areas

15 receiving area
16 ramp
17 trash room
18 receiving office
19 food storage
20 main kitchen (serves whole fac.)
21 chapel
22 enclosed garden
23 ambulance entry
24 morgue
25 laundry
26 mechanical
27 storage

Community Recreation Areas

28 community multi-purpose space (shared by whole facility)
29 exercise room
30 physical therapy
31 child play area
32 teen area
33 active recreation

Medical Support/Staff Areas

34 staff lounge/conference
35 men's locker
36 women's locker
37 therapist
38 psychologist
39 extra
40 social worker
41 clergy (non-permanent staff)
42 doctor (non-permanent staff)
43 dietician
44 hospice volunteer coordinator
45 hospice administrator
46 secretary/receptionist

A open to below
B Fire Stair
C Fire Wall
## Living Areas

1. patient/family unit
1a. double-occupancy patient unit
   w/family area if needed
2. porch
3. entry vestibule
4. supply storage
5. "house" living area
6. patio
7. community living area (shared by 12 units)
8. nurse's station (serves 12 units)
9. patient drop-off area
10. sitting/sub-area

## Convenience Areas

11. dining area (shared by 12 units)
12. public restrooms
13. laundry (shared by 12 units)
14. kitchen (shared by 12 units)

## Mechanical Areas

15. receiving area
16. ramp
17. trash room
18. receiving office
19. food storage
20. main kitchen (serves whole fac.)
21. chapel
22. enclosed garden
23. ambulance entry
24. morgue
25. laundry
26. mechanical
27. storage

## Community Recreation Areas

28. community multi-purpose space (shared by whole facility)
29. exercise room
30. physical therapy
31. child play area
32. teen area
33. active recreation

## Medical Support/Staff Areas

34. staff lounge/conference
35. men's locker
36. women's locker
37. therapist
38. psychologist
39. extra
40. social worker
41. clergy (non-permanent staff)
42. doctor (non-permanent staff)
43. dietician
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45. hospice administrator
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A open to below
B Fire Stair
C Fire Wall
Elevations
Indiana Avenue Elevation
(looking east)

Building Section
(looking west in Indiana Avenue Wing)
Fess Avenue Elevation
(Looking West)

North Elevation
(Looking at Outdoor Area)
Mechanical Space

Perspective Section Looking South
Recreation Core
Hospice architecture, as a building type, and as a free-standing facility, is still too new to have many examples to evaluate. Because of their capital expense, more economical, less-effective solutions have been generated. Often hospitals will give up a few beds in a certain zone of the building for terminally ill patients to be isolated from everyone else. Putting patients in this type of environment is debilitating for several reasons: 1) the imagery of the facility is often not a restful, home-like atmosphere; 2) the patient can be further depressed and reclusive in knowing that surgeries and medications are being administered to people around them who will get well; and 3) a feeling of isolation and abandonment because either there may not be adequate numbers of staff to keep them busy, and/or they are separated from their loved ones. (Some Hospices have fold-out beds, etc., for family members to sleep on.)

The Hospice philosophy includes in it the necessity of nature in the death process. Views and access to nature allow the patient time and impetus for reflection; to look back and sort out their lives. The ability to look out to nature creates a much healthier imagery than merely a window which allows light, but affords no particular view. This one aspect should be a controlling factor in new facilities; which have to look toward imagery and its effect on the user's perception of their environment.

The following progression in the design of such a facility was conceptualized to accomplish a positive environment. First, to design a building to which the users can relate. By the nature of the program's needs, a home environment, residential in character
seems to be suggested in order to "get patients and families in the door." What is behind this door should be a restful, peaceful, anxiety-free environment; one in which social interaction is promoted. This suggested the possibility of locating in a residential neighborhood. In a neighborhood there would be more of a chance for social interaction ranging from other patients to a neighborhood child. This, of course, depends on the nature of the patient, and the stage of disease, which would determine if the patient would want to actively interact with passersby. Second, provide a well-trained, understanding staff which can help put fears and anxieties aside. Since the staff can literally "make or break" the effects of a delicate program such as this, their needs are very important. Working in this type of atmosphere is very depressing, so compensatory allowances have to made; monetary, (time off, higher wages, insurance plans), in the physical surroundings (private areas, inter-staff counselling), or time away from the hospice environment. Private areas "for staff only" with views and or physical connection to greenspaces, should provide the opportunity to relax and reflect for the staff as well as the patients; "a happy worker is a good worker." And finally, provide an environment conducive to these activities occurring. If we are to provide a backdrop for activities to occur and be enhanced, then a variety of spaces will be needed to account for small as well as large group activities. In this proposed facility, a community recreation area for louder and more "active" activities, while smaller sitting or sub-areas are for more intimate interaction is provided. In order to
tackle this problem, a set of programmatic ranges were identified: 1) private living areas (patient and family); 2) community recreation areas; 3) medical support areas (for serving users and related areas), 4) convenience areas (family), and 5) mechanical support spaces (for behind the scenes maintenance/upkeep). This range provided a starting point from which to generate ideas on needed spaces. This set of ranges gives a broad enough overview, and provides a basis from which to start.

Since the whole concept of my thesis was to take the "home-approach," I took the extreme and designed a series of residences in an older residential neighborhood to emphasize what I considered to be a strong, easily read, symbolism. It was difficult while doing facade studies, to decide whether I was going to take the physical form of the neighborhood in its exact form, or abstract it to give the building its own identity. I decided early on, that a more literal interpretation was the better of the two choices. It seemed to me that maybe the abstract would be an interesting exercise in architectural fantasy, but for the delicate psychological state of the users of the facility, the abstract architecture may have the same institutional effect that I was trying to avoid.

There are many other unexplored avenues that could have been taken in this problem. For example, a site could have been chosen in the country which would have had its own implications, unlike those I found in the neighborhood context; the program is similar, but is manipulated depending on the site context. It would be interesting to do this project over again in that atmosphere. A
rural, rustic, respite approach may have also created the positive atmosphere I tried to create. To design such a place would have been much harder to accomplish, with much more time necessary in research as to whether the isolation of the facility would indeed be peaceful, or a negative feeling of detachment from the world which is constantly moving; of which the patient would become further detached.

My design is not the "perfect" solution, as there is no such thing. There are always other solutions, which, dependent on the factors which influence the design make it a better facility. There is no prototype for this facility, but this is the way it should be. The influences surrounding the site, building, etc. should dictate somewhat to the design of the building, because this is what makes it appropriate for its location. For this reason, I feel the image of my solution, if nothing else, is "right" for the neighborhood, although far from perfect.

Evaluation of such a facility, designed with the user specifically in mind, is difficult when there is no tangible, measureable criteria; only guess work. Architectural interpretation of existing can be a dangerous thing because of the subjectivity involved; what works for one person may not work for another. This leaves us with very little other than an educated guess judging other similar facilities' weaknesses and strengths; also subjective because of the change in user situations and regional differences.

The psychological, medical, physical and spiritual concerns of the terminally ill should have a large say in what is to be generated in the architecture of medical
facilities. It has been proven that most solutions in medical facilities design has not served the user. This negligence is detrimental to the health and well-being of patients, families, staff, and visitors. By designing a structure which provides a "stage" for their special needs, the terminally ill, their families, staff and visitors can inhabit a space which is thoughtful in respecting their needs. In creating such a facility, it should be possible to design better health facilities with this positive approach to design for those who will get well; maybe quicker, and with less anxiety.
NHO Standards of a Hospice Program of Care

Standard
1. Appropriate therapy is the goal of hospice care.
2. Palliative care is the most appropriate form of care when cure is no longer possible.
3. The goal of palliative care is the prevention of distress from chronic signs and symptoms.
4. Admission to a hospice program of care is dependent on patient and family needs and their expressed request for care.
5. Hospice care consists of a blending of professional and nonprofessional services.
6. Hospice care considers all aspects of the lives of patients and their families as valid areas of therapeutic concern.
7. Hospice care is respectful of all patient and family belief systems, and will employ resources to meet the personal philosophic, moral, and religious needs of patients and their families.
8. Hospice care provides continuity of care.
9. A hospice care program considers the patient and the family together as the unit of care.
10. The patient’s family is considered to be a central part of the hospice care team.
11. Hospice care programs seek to identify, coordinate, and supervise persons who can give care to patients who do not have a family member available to take on the responsibility of giving care.
12. Hospice care for the family continues into the bereavement period.
13. Hospice care is available 24 hours a day, 7 days a week.
14. Hospice care is provided by an interdisciplinary team.
15. Hospice programs will have structured and informal means of providing support to staff.
16. Hospice programs will be in compliance with the Standards of the National Hospice Organization and the applicable laws and regulations governing the organization and delivery of care to patients and families.
17. The services of the hospice program are coordinated under a central administration.
18. The optimal control of distressful symptoms is an essential part of a hospice care program requiring medical, nursing, and other services of the interdisciplinary team.
19. The hospice care team will have:
   a. a medical director on staff
   b. physicians on staff
   c. a working relationship with the patient’s physician.
20. Based on patient’s needs and preferences as determining factors in the setting and location for care, a hospice program provides in-patient care and care in the home setting.
21. Education, training, and evaluation of hospice services is an ongoing activity of a hospice care program.
22. Accurate and current records are kept on all patients.

A copy of the NHO Standards Document is available from National Hospice Organization, 301 Tower Suite 506, 301 Maple Avenue West, Vienna, VA 22180.
Setting Up an In-Hospital Hospice

1) Provided public health hospice forums, a regional conference, and a speakers bureau that is ongoing.

2) Provided consultation to the state General Assembly's subcommittee on hospice.

3) Prepared and received approval for the first Certificate of Need in the State of Virginia.

4) Increased donations to the unit.

5) Held seminars on death and dying.

6) Formalized a cooperative relationship between Riverside Hospital, a nonprofit organization, and the Peninsula Health District, a government organization, to provide comprehensive hospice care to the terminally ill.

7) Integrated services of the clergy, volunteers, social workers, and pharmacists with the services of physicians, nurses, physical therapists, occupational therapists, and nurse's aides to deliver hospice care.

8) Provided a 24-hour "hot line" for patients and families.

9) Provided home-care emergency visits on a 24-hour basis.

10) Provided access to an inpatient facility on a recurring basis.

11) Achieved an active inpatient and home-care volunteer program.

12) Provided specialized and coordinated inpatient and home-care services for palliative and supportive care.

13) Educated hospice team members to increase their skills in the care of terminally ill patients and their families.

14) Provided a mechanism for sharing the committee's experiences with others interested in developing a hospice.

15) Developed a mechanism to collect data to evaluate the quality and the efficiency of hospice care.

16) Developed a booklet entitled, "Family Centered Care of the Dying — The Hospice Way," which outlines in detail the hospice program at Riverside Hospital, including forms and job descriptions.

The hospice opened within five months from the establishment of the committee—a month earlier than its target deadline.

Because of the enthusiastic support from the community, hospital and public health department staffs, and the medical staff, the hospice has encountered no roadblocks. Community awareness, which began with the workshop on death and dying and the community meetings on the same subject, has continued to grow, as evidenced by the number of agencies and individuals involved in providing services or education regarding the terminally ill.

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