Health and Place

Beyond homeliness: A photo-elicitation study of the 'homely' design paradigm in care settings

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Corresponding Author:	Kieran Richards, Ph.D. The University of Sydney School of Architecture Design and Planning Darlington, NSW AUSTRALIA
First Author:	Kieran Richards, Ph.D.
Order of Authors:	Kieran Richards, Ph.D.
	Rebecca McLaughlan, Ph.D
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Abstract

This paper examines perceptions of homeliness in palliative care environments through a photo-elicitation study involving 89 palliative care staff. The study finds that what is perceived as homely tends to exhibit a mutually exclusive relationship with a clinical antithesis. It also finds that antonymous or antithetical understandings of homeliness are as common as those based on actual attributes of homeliness. It is argued that a more nuanced understanding of the spatial and material constituents of homeliness is needed to make it a more realistic objective within the design and procurement of healthcare environments. It is also argued that the inverse relationship of homely and clinical environmental qualities could be translated into a design approach that aims to *negotiate* rather than negate their apparent mutual incompatibility.

Keywords

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Introduction

There has been a shift of focus in the conceptualisation and design of care environments in recent decades: from one of assisting patient recovery to one of optimising quality of life (Verderber and Refuerzo, 2006; Steenwinkel et al., 2012; Worpole, 2020). Current research also addresses the psychological and material nuances implicit in different types of healthcare environments, as well as more sociologically nuanced viewpoints on a plurality of possible experiences, as in the work of Imrie et al. (2016), or the studies of the Maggie's Centres by Martin et al. (2019) and Sumartojo et al. (2020). Naturally, different illnesses necessitate different forms of treatment, and this in turn begets different experiences for patients, their families and carers, and the staff who attend to them. Palliative care is an important example of this because it implicates its own unique ethos. To palliate is not to prevent or cure, but to reduce the severity of symptoms and suffering associated with a particular condition. It is to improve the quality of life of patients suffering serious illnesses, as well as that of their families (Cohen, 2002; Adams, 2016). Palliative care might be received in hospitals, hospices, aged care facilities, but it always entails a very different set of spatial and material needs than for healthcare environments more generally. Thus, to approach it in the same way as any other in-patient environment is to ignore the experiential differences that end-of-life care entails (Adams, 2016; see also, Bergenholtz et al., 2019; Author 2 et al., 2022).

Comments relating to "homely" spatial and material qualities permeate basically every encounter researchers have with patients, family, and members of staff of palliative care facilities as for other healthcare environments. Across 50 interviews with hospital in-patients "one of the most important aspects," Douglas and Douglas (2004, p. 65) suggested, "was being able to feel at home…." In 81 interviews with aged care residents, Burton and Sheehan (2010, p. 240) found that after cleanliness, feeling "home-like" was the most cited reason for resident satisfaction with their environment. Subsequent review studies concerning residential aged care and acute end-of-life care similarly concluded that homeliness was a prominent factor in environmental satisfaction and thus contributed to maximising quality of life (Brereton et al., 2012; Bradshaw et al., 2012; Zadeh et al., 2018; Wong et al., 2021; Miller et al., 2022). The converse is also true: environments that *feel clinical* have been shown to trigger negative emotions, including anxiety and discomfort, and to exacerbate the uncertainties related to the illness itself (Brereton et al., 2012; Fleming et al., 2015; Rasmussen and Edvardsson, 2007; Rowlands and Noble, 2008; Timmermann et al., 2015; Zadeh et al., 2018). The persistence of homeliness as a theme within qualitative studies of healthcare environments over the past two decades is a testament to its perceived importance to the wellbeing of all who inhabit care environments (Lundgren, 2000; Steenwinkel et al., 2012; Ewart and Luck, 2013; Fleming et al.,

2017; Duque et al., 2020).

Many studies have explored the environmental differences palliative care necessitates, and the theme of homeliness is one of the most prominent within all of them (e.g., Rowlands and Noble, 2008; Gardiner et al., 2011; Brereton et al., 2012; Zadeh et al., 2018; Hajradinovic et al., 2018; Wong et al., 2021). Although current research points to the necessity of design objectives like homeliness, ways of attaining homeliness are not well understood on a detailed level. As Burton and Sheehan (2010) have argued, understanding the importance of an atmosphere for wellbeing is different from explicating detailed material and spatial strategies that endow care spaces with that atmosphere. Furthermore, within the procurement of healthcare facilities, many of the spatial and material qualities that imbue spaces with homeliness are easily sacrificed in the name of operational efficiency, concerns for infection control, or the needs of adjacent medical specialities (Fleming et al., 2017; Duque et al., 2020; Author 2 et al., 2022; Ulrich et al., 2008). For example, the use of timber, a heightened emphasis on craftspersonship, atypical spatial arrangements are likely to be the first things sacrificed in more standardised builds, where budgetary concerns or the need to follow hospital-wide design protocols take precedence (Author 2 et al., 2022). Certain economisations and clinical concessions are always going to be necessary for facilities hosting multiple forms of care, but more can be done to develop an evidence base that empowers decision-making that acknowledges the specific needs of different care environments, particularly where homeliness is concerned. In this paper we explore perceptions of homeliness in palliative care environments through a photo-elicitation study involving 89 palliative care professionals and an interdisciplinary review of secondary literature. The data presented below was gathered as part of a broader, 3-year study that seeks to enrich current knowledge of patient, family, and staff perceptions of palliative care environments, and contribute to a broad-based improvement in the design of palliative care facilities.

Background

One of the main barriers to implementing homeliness in care environments is its conceptual ambiguity. Over the past 50 years, conceptualising home and homeliness has been the concern of disciplines as diverse as anthropology, architecture, ethology, psychology, philosophy, planning, and sociology. Consequentially, there are almost as many ways of understanding homeliness as there are disciplines that engage it (Després, 1991; Somerville, 1997; Moore, 2000; Mallet, 2004; Gieseking et al., 2014). This wealth of disciplinary approaches is typically

organised into one of two groups. On one hand, phenomenological, psychological, and psychoanalytic interpretations tend to focus on emotional attachments to home from the viewpoint of the individual. They usually invoke themes of security and control, reflections of the self, and connections to and refuges from the outside world, as well as the material structure of those relationships (Desprès, 1991; Moore 2000, p. 209; Hidalgo et al., 2001; Manzo, 2003; Mallett, 2004). On the other hand, sociological and historical approaches tend to focus on how different social groups define and experience home, through relational factors such as class, social status, gender, age, kinship, politics, and rights to property (tenure or title) (Somerville, 1997; Saunders, 1988). Historically orientated studies also focus on how meanings of home are socially constructed but develop their analyses through material, spatial, and cultural artefacts (e.g., Lukacs, 1970; Rybczynski, 1987).

Several authors also observe an acritical positivity that characterises much of the scholarly literature on homeliness (Moore, 2000; Manzo, 2003; Douglas, 1991). There is a bias, Manzo (2003, p. 50–51) suggests, toward perpetuating "a myth of domestic life as blissful, which belies the fact that the residence has, and continues to be, a space for strife as well as joy" (see also, Mallett, 2004; Moore, 2000). Although qualities of actual physical homes do not always inform approaches to homeliness in care environments, at times deferring back to the physical home as a source of homely qualities is unavoidable. When this occurs, there is a risk of ignoring the fact that not all experiences of home are positive. Giuliani and Feldman (1993) challenged the positive bias toward the Western nucleic family home by examining negative forms of attachment. Home, for some, is "not a refuge, but a place of violence" (Ahrentzen, 1992, p. 113), or for others a place of work (Decker et al., 1993); it may be a place where the authority and control of others prevail (Douglas, 1991; Saunders, 1988); it may be a source of frustration and danger when it is not fitted to its inhabitants' needs (Imrie, 2014); it may bear painful reminders of loved ones that have passed away, or left (Marcus, 1995); without tenure, it may reinforce the stigmatisation of not owning a home, or the lack of control over one's abode (Somerville, 1992; Saunders, 1988). Ewart and Luck (2013, p. 26) also suggest that "the boundaries of the home are usually defined by the physical structure, despite [it being] widely accepted that the meaning of home has a psychological and emotional component, which is not spatially limited." In other words, the identification of homeliness with an actual home ignores the possibility of feeling at-home beyond those spatial boundaries––in a certain neighbourhood, for example, or upon one's land or country, with kin, or whilst engaged in a particular task (see also, Manzo 2003; Peace et al., 2011; Pink et al., 2020).

The theoretical diversity and contentiousness associated with homeliness pose a substantial challenge for researchers and designers of healthcare environments. From both viewpoints, it is

a matter of translating a complex multiplicity of ideas about homeliness into discrete material and spatial propositions, as well as design regulations and guidelines (Steenwinkel et al., 2012; Ewart and Luck, 2013; Imrie, 2014; Fleming et al., 2017; Duque et al., 2020; Worpole, 2020; Wong et al., 2021). Steenwinkel et al. (2012, p. 197) have suggested that despite the recurrence of themes and ideas within studies of home and homeliness––such as the reciprocal determination of people and place, and the inherent sociocultural relativity of what home means to different people––"there seems to be no complete consensus about which aspects are important for a home environment." Ultimately, the vagueness of homeliness as a theoretical concept diminishes the possibility of recognising it in guidelines, regulations, and policy on the level of government and non-government organisations. Somerville (1992, p. 536) brought this problem to light in relation to policymaking and homelessness, with the observation that "official government perceptions and constructions" of home and homelessness do not (perhaps cannot) recognise the multidimensional complexity of either term. This problem also seems to translate more broadly to design guidelines and standards for care environments in many parts of the world, such as the UK, Australia, and across Europe (Fleming et al., 2017).

The ambiguity of homeliness also diminishes its perceived importance within healthcare procurement ecosystems. Implications for cost-effectiveness or operational efficiencies, for example, are much easier to quantify and understand, and therefore commonly take precedence in decisions that impact the homeliness of environments (Ulrich et al., 2008; Duque et al., 2020; Author 2 et al., 2022). Numerous studies have explored ways that design research might become more "outward-facing" when it comes to homeliness. Steenwinkel et al. (2012) have constructed a framework for achieving homeliness based on two characteristics of autonomy and security. Robertson (2010) proposed strategies to recognise individual and collective histories within facilities. Drawing on the work of Case (1996), which argues for the importance of *leaving* home in creating homeliness, Worpole (2020, p. 136) proposed "the programming of activities within residential boundaries and well beyond." Duque et al. (2020) advocate for everyday designing through a renewed attention to supporting the attitudes and behavioural patterns of staff to affect homeliness within care facilities. The underlying strategy of these approaches might be summarised as shifting the focus away from spatial and material aspects of care environments, and onto more behavioural, dynamic aspects. While these are undoubtedly important directions for future research, we also believe that an ever-deeper engagement with the spatial and material constituents of homely environments is just as important for achieving it in care settings, particularly for the creation of guidelines, regulations, and specific design briefs, and to advocating for these qualities throughout procurement processes.

Method

This paper presents the responses of 89 Australian-based healthcare professionals to two photo-elicitation questions. The questions were part of a larger survey, which sought staff perceptions about how the built environment impacts their work and how it aligns with their values and aspirations for patient care (see Appendix 1). The effectiveness of photo-elicitation methods for understanding perceptions, preferences, and responses to physical environments is well-documented (Clark-Ibáñez, 2004; Collier, 1957; Harper, 2002). Images shown to participants provide visual cues that can connect them with their own lived experiences in ways that words can't, and assist them in articulating those experiences (e.g., Radley, 2003; Hajradinovic, 2018; Author 2, 2019; Alvariza, 2020). Photo-elicitation is commonly used in interview settings rather than surveys. The decision to use it within this survey was informed by the difficulty of articulating experiences involving concepts like homeliness. The approach drew inspiration from the recent work on "materialities of care" and its related concepts by Buse et al. (2018) and Nettleton et al. (2020), among others (e.g., Gieryn, 2002; Bellacasa, 2011; Vannini, 2015; Fox, 2016; Bates et al., 2017).

Harper (2002, p. 13) identifies three main functions of photographs in the context of photo-elicitation methods: "visual inventories of objects, people, and artefacts," illustrations of institutional or collective events, and those that illustrate more "intimate dimensions of the social." The 5 images used in this study were of the first function: they were representative inventories of a variety of real hospice or general hospital environments in which palliative care is delivered (see Fig. 1). The selection was based on maximum variation sampling from a larger pool of potential images, with the intention of maximising a diversity of spatial and material qualities (Colorafi and Evans, 2016). The proposed selections were shown to four clinicians and two Professors of Nursing, all of whom had experience consulting on the design or refurbishment of healthcare facilities. Two changes were made to focus image content on the patient room, as this was deemed to be the most frequented type of palliative care space and the most representative of the overall atmosphere of a palliative care facility as a whole. The survey was then tested with five palliative care professionals and no further changes were made.

The online survey was conducted between July 2020–March 2021 (see Appendix 1). In addition to the two photo-elicitation questions reported here, it included eight open-ended questions and seven demographic questions. The results of the eight open-ended questions have been reported in another paper (refer, Author 2 et al., 2022). Of the 89 participants who completed the survey, 50% were nurses ($n = 45$), 39% doctors ($n = 35$), and 11% allied health professionals ($n = 10$). Forty-three percent of participants either worked or had worked in a

palliative care unit situated in an acute hospital setting ($n = 38$), 18% within a sub-acute hospital setting ($n = 16$), 23% within a free-standing palliative care unit situated on a hospital campus ($n = 21$), and 10% within a standalone palliative care facility ($n = 9$).

The photo-elicitation questions asked participants to identify the image they *most* (Q4a) and *least* (Q5a) preferred and explain their reasoning for those preferences (Q4b & Q5b). Those responses were analysed using an interpretative description approach (Thorne, 2016). In the context of palliative care, staff perceptions have been examined less than those of patients and family members (Author 2 et al., 2022). Staff naturally have an intimate awareness of the practical and functional needs of palliative care environments and based on this it would be reasonable to expect that their perceptions might gravitate towards more practical matters of care. This tends not to be the case, however, in previous studies––staff perceptions typically tend to express more concern for the needs of patients and family members than their own (Gardiner et al., 2011; Brereton et al., 2012; Miller et al., 2022). Although most staff members won't have lived experience of being a palliative care patient, they will all have had innumerable encounters with patients and families. Most are acutely aware of the importance of balancing functional requirements with the needs of patients and family members. In this study, the vast majority of staff highlighted issues relating to the experiences of patients and family members rather than their own working conditions.

Figure 1: The five images as they appeared within the online survey. Images are numbered as per the identification key at the bottom right. The survey was administered using SurveyMonkey and the order in which the images appeared was randomised (see Appendix 1). Credits for each image are as follows: Image 1 ©Daryl Kessler; Image 2 ©Keith Hunter; Image 3 ©Jim Roof; Image 4 ©Peter Clarke; Image 5 ©Randy Larcombe.

Findings

There was an unexpected uniformity in the way palliative care staff responded positively and negatively to the five photographs. No respondents selected Image 1 as their most preferred; and 82% (n = 73) selected it as their least preferred. Together, Images 2 and 3 were the most preferred of 78% (n = 36, n = 42 respectively) of respondents. No respondents selected Image 2 as their least preferred and four selected Image 3 as their least preferred. Eight respondents most preferred and four respondents least preferred Image 4. Four respondents most preferred and nine respondents least preferred Image 5 (see Table 1).

Table 1. Participant responses to Q4a and Q5a.

Image No.	*Most Preferred (No.)*	*Least Preferred (No.)*
1	0	73
2	36	0
3	42	4
4	8	4
5	4	9

<u>The reciprocity of homeliness and clinicality.</u>

Homeliness was by far the most prevalent quality invoked by participants for the three most preferred images, Images 2, 3, and 4. Each of the rooms depicted in those images has solid timber cladding on different parts of the room, carpeted flooring, hidden or minimal medical service panels, non-standard beds, warm-toned ambient lighting, and each frames a view to the outdoors. Many comments related directly to these elemental components of homeliness, as well as other features typically associated with a homely atmosphere, such as colour palettes and furnishings. The strongest emphasis was perhaps on the use of timber for the furnishings and interior surfaces. Respondents suggested that "the wood makes it look more homely," that it has "comforting tones," its "warmth" gives the room a "more homelike decor," and a "not-too-

hospitalish" naturalness. The bed, it was suggested, "looks like an ordinary bed… [because it's] not so clinical." Some explanations of the perceived homeliness of the rooms depicted in Images 2 and 3, as well as Image 4 simply alluded in a general way to the home-like resemblance of the room. Some explanations were based on a negation of clinical qualities or hospital environments. For example, that a room "appears to look *least* like a hospital room," that it had "no clinical features," or that "it doesn't seem like you are in a hospital." In relation to Image 3, as another example, one participant wrote that "the colours make it feel like a living room rather than a hospital room."

On the contrary, a *lack* of homeliness was the most invoked quality in respondents' explanations for least preferring an image. Of the 73 respondents who selected Image 1 as their least preferred, responses highlighted features such as the drab colouring, the "classic hospital fluorescent lights," the overt presence of medical equipment, and the lack of natural light. Many others invoked the unhomeliness of the room depicted in more general ways, for example: that it's "cold and clinical, [and] feels like a hospital"; or "very sterile and hospital-ish"; or "too clinical [and] unlike home"; or that it's a "very un-homely, bland space," with "nothing reassuring in the space." Respondents also suggested it would be "difficult to bring personality into it." Similar qualities were highlighted for cases in which Image 5 was selected as the least preferred. In the few cases where the room depicted in Image 4 was the least preferred, however, the reasoning gravitated around its resemblance to an office or a "banal hotel room" that "does not look cosy" rather than a hospital room. Out of all responses to Question 5 for all of the images, the word *clinical* appeared 37 times, *hospital* appeared 31 times, *sterile* appeared 11 times, and *cold* appeared 10 times. These were the four most common adjectives used in responses.

Homeliness, safety, and operational efficiency.

What was clear within these responses, then, is that palliative care staff would like patient rooms to feel less like a hospital and more like the interior of a home. At the same time, however, the need to consider the spatial and functional necessities of clinical care was also present. Within the broader survey, the safety of patients, visitors, and members of staff was a prominent concern among respondents, and this sentiment was echoed in responses to the photo-elicitation component of the study (Author 2 et al., 2022). Of the four participants that selected Image 3 as their least preferred, for example, each highlighted issues relating to safety and the adequacy of the space for care. There was a perceived lack of working space around the bed, and that the room was "crowded." The unconventional appearance of the "not hospital style" bed gave the impression that, like an ordinary bed, it was not height adjustable. Similarly,

the non-standard, carpeted flooring (with the non-uniform pattern having the appearance of a rug) elicited concerns that there would be a trip hazard within the room. (Despite these perceptions, the bed depicted in Image 3 is fully operational and the flooring is one continuous, flat surface.) The apparent absence of medical equipment within the room was also a cause for concern.

Each of the respondents that invoked concerns for safety as the reason for *disliking* any of the images also tended to invoke safety features as a reason for *most appreciating* any image. One respondent commented on the "excellent bathroom access" in the room depicted in Image 5, for example, which would make bathing "much safer, more personal, and less time-consuming." Another also appreciated the room depicted in Image 5 because it was "well lit," contained a standard hospital bed "with appropriate wall facilities," had an "easy to clean floor," and was "easy to observe from [the] corridor." Respondents that answered in this way were few, however; most preferences recorded in this study were determined by the presence or absence of home-like aesthetic qualities.

Discussion

This study illustrates the capacity of spatial and material qualities to dramatically influence the way palliative care staff perceive their working environment; as well as the extent to which it aligns with the type of care they aspire to deliver. It also makes it clear that the way staff aspire to deliver care informs a range of tangible expectations about how a palliative care environment should look and feel. Careful negotiations of the balance of homely qualities and clinical necessities was the most apparent among them.

Negotiating the homely and the clinical.

There was an unmistakable symmetry in the way staff expressed what they perceived as homely and what they perceived as unhomely, or clinical. For homeliness, responses tended to identify the general atmosphere of a room depicted in one of the images as homely or to identify specific features that were homely. There were also identifications of homeliness based on negations of clinical qualities and hospital environments more broadly. For clinicality, furthermore, responses exhibited a similar pattern but in reverse. Antonymous or antithetical definitions were easily the most common across all responses. This polar opposition of homely and clinical qualities is also established in current literature. "One cannot define what is homelike without defining what is institutional and vice versa," as Lundgren (2000, p. 112) suggests (see also,

Douglas and Douglas, 2004, Rigby et al., 2010; Brereton et al., 2012, Timmerman et al., 2015; Fleming et al., 2017, Martin et al., 2019; Bergenholtz et al., 2019). For palliative care facilities situated within acute settings in particular, the clinical nature of a ward tends to impose on the working patterns of palliative care staff, as Bergenholtz et al. (2019) have shown. The opposition is also embedded in the celebrated generic brief used to design individual Maggie's Centres––a charity dedicated to providing care for cancer patients in architecturally sympathetic spaces. "Maggie's scale is deliberately a domestic one," the brief reads, "the antithesis of the hospital's. … [It is] a unique place that fits perfectly into its surroundings––a home away from home that's designed to feel *nothing like a hospital*" (Maggie's, 2015 [emphasis added]). What responses to this study seem to characterise, then, is an apparently irreconcilable mutual exclusivity of that which is homely and that which is clinical.

Another aspect of the same opposition is the tension between homeliness and clinical necessity. This was expressed when components of environments deemed necessary for clinical care precluded the cultivation of a homely atmosphere. One example of this tension was the appreciation for the softer floorings used in the rooms depicted in Images 2, 3, and 4, contrasted with the appreciation for the practicality of vinyl laminate for cleaning and the apparent danger of "trip hazard rugs." Other examples include the issue of standard and non-standard beds in patient rooms and the visual prominence of medical equipment at the patient bedside. As Duque et al. (2020) suggest, this is what happens when the "need for clinical, hygiene, and safety conditions in hospital design" makes homeliness "difficult to achieve" (Duque et al., 2020, p. 214; see also, Ulrich et al., 2008; Author 2 et al., 2021). On the one hand, then, contemporary attitudes about the design of care environments emphasise the importance of endowing care environments with a sense of homeliness to best serve patient wellbeing; yet, at the same time, there are almost always going to be necessary clinical features of any care environment. As Mol et al. (2010) point out, it is too easy to separate unhomely clinical technologies and apparatuses from care practices as if they weren't intrinsic to them at all, but often those technologies and apparatuses are inseparable from care itself (see also, Kenkmann et al., 2017).

Considered as such, what this series of oppositions seems to suggest is that it may be necessary to orientate the attentions of designers, researchers, and regulatory authorities to the negotiation and reconciliation of these oppositions on a rigorous and detailed, almost bespoke, level of concern––that is, rather than making sweeping assertions that ignore either clinical or personal needs. Some of the approaches developed by the Maggie's charity to different aspects of care illustrate what this kind of negotiation might look like. Martin (2017) observes how Maggie's Centres typically aim to minimise or re-shape "institutional triggers, such as reception areas and staff badges," thus situating visitors "in different ways than a hospital appointment

might" (Martin, 2017, p. 43). Kitchens and communal areas are also emphasised in the design of Maggie's Centres as an important way to create a domestic scale and a sense of homeliness. Charles Jencks (2017, p. 68), the husband of the charity's late founder, Maggie Keswick Jencks, describes this approach as "kitchenism." Initial introductions and orientations are carried out there where possible, which deformalizes the initial assessment process for new patients. These subtle, yet potent gestures re-imagine the performance of clinically necessary tasks and procedures in ways that acknowledge and re-shape the inherent tensions between what's homely and what's clinical in a care setting.

Materials and their gestures.

The set of images also reflected distributions of preferences that weren't forthcoming in images considered individually, notably, in the way participants responded to variations in the use of timber (or timber veneer). Although responses indicated an unambiguous affection for the use of timber in the room depicted in Image 3, it must also be observed that all five rooms contained timber, albeit to varying degrees. Image 1 featured dark timber finishes on numerous pieces of furniture alongside the bathroom door. Image 2 featured lighter timbers, used more extensively on built-in cabinetry and furniture. Image 3 featured doors, windows, furniture, and a bed with different timber finishes. Image 4 featured walls, furnishings, and external louvres of timber, and Image 5 had a timber-patterned floor and feature panel behind the bed. What this seems to suggest is that it is less the material itself than the *way* that the material is used, which influences perceptions of the environment overall. The use of natural materials like timber is well-documented as having a de-institutionalising effect on the way care environments are perceived (Van Steenwinkel et al., 2020; Worpole, 2020; Author 2, 2022; Martin et al., 2019; Author 2 et al., 2022). Yet, in focusing on *what* materials affect a sense of homeliness instead of *how they are used* to affect a sense of homeliness, environmental design research overlooks a key aspect of homely environments.

Ultimately, the question of the *way* specific materials might be used within particular designs could be boiled down to what are, conceptually speaking, relatively simple ideas: how much attention is given to the sensorial qualities of the material and to the way it is crafted into a space? Are the elements in the space, such as armchairs, flooring, beds, and bedheads complementary to the needs of its occupants? There is no shortage of research into how materiality positively impacts quality of life in end-of-life care environments, but it seems that further research is needed into the subtle yet targeted gestures that affect those impressions. So often, this is what is not carried through to architectural briefing processes, where things like the need to follow hospital-wide cleaning protocols or reduce initial costs, tend to come at the

expense of those smaller gestures. “The brief is everything,” as Worpole said in *Modern Hospice Design: The Architecture of Palliative Care* (2009, p. 26), but as far as the work done in end-of-life care research isn’t translated into architectural briefs––for whatever reason––then there can be no guarantee of the progress it is supposed to engender.

Conclusion

Homeliness is a pre-eminent especially prominent theme in contemporary research on the design of care settings, and the findings presented above reflect that pre-eminence. Even after decades of interdisciplinary research, however, there is little consensus on how homeliness should be defined conceptually or expressed in spatial or material terms. This is why, as Worpole (2020, p. 138) argues, the concept of homeliness has become “devalued,” and “either has to be renewed or abandoned altogether.” The ambiguity of homeliness also carries through to the procurement of healthcare facilities, and particularly those intended for end-of-life care, in which homeliness is frequently briefed but without enough detail to guarantee its realisation. Consequently, the environmental elements that affect homeliness are too easily sacrificed within procurement ecosystems, in which budgets, safety concerns, and operational efficiencies tend to take precedence.

In this paper, we proposed that design research needs to address this problem by seeking out new, innovative ways of understanding what homeliness means and how it might be constituted in space. There needs to be a body of evidence that can be carried into procurement processes by its advocates, such that homeliness is afforded a gravitas commensurate with the needs of patients, family members, and staff. The findings presented above highlighted a fine-grained reciprocity of that which is perceived as homely and that which is perceived as clinical. The distribution of preferences among respondents suggested that what ultimately determined the most and least appreciated rooms was the extent to which elements typically associated with clinicality were either *eliminated*, *minimised*, or *re-invented*. Thus, to achieve homeliness *within* the boundaries enclosed by the clinical necessities of care, we suggest that design thinking should be situated at the intersections of the homely and the clinical. This suggests that those involved in the design of health environments might design through the antagonisms homely and clinical elements, in an approach that attempts to both achieve homeliness and to minimise the impact of clinically necessary elements wherever possible. Rather than a negation of one or the other, this would be a negotiation between the two.

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Figure

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Appendix 1

The survey questions as they appeared on SurveyMonkey. Questions marked with an asterisk were compulsory. Respondents were given a prompt and were unable to progress to the next question if these compulsory questions were not completed.

Survey Description: Designing for Inpatient Palliative Care in Australia

We'd like to understand your views on the physical environments in which inpatient palliative care is delivered in Australia.

Anyone who works in palliative care, or has previously worked in palliative care, in Australia, is eligible to answer this survey.

This survey will take **12-18 minutes**; it consists of 6 survey questions, plus 6 demographic questions.

Your participation is voluntary. By completing this survey, you are consenting to the researchers using the information you provide within conference papers and journal articles. **No identifying information will be published.** All responses will be saved in a de-identified format, which means they will not be linked to any information that can identify you (name, email address, etc.). You will be given the option to provide your email address for further correspondence. If you chose to provide an email address, this will be stored separately from your survey responses once your responses are exported from SurveyMonkey.

If you have any questions about the project, please contact the chief investigator, Dr ****: [email removed]

This project has been approved by the University's Human Research Ethics Committee, Approval No. H-2019-0056. Contact: [details removed for peer review]

*** What is your current role in palliative care?**

If you previously worked in palliative care, please tell us your most recent role.

Nurse

Doctor

Allied health professional

Other (please specify)

*** 1. What do you think is the most important part of your job?**

Please answer in 1-2 sentences.

_____

2. The way spaces are designed can support or obstruct patient care making it easier, or harder, for staff to carry out their roles. Can you think of any way that your current physical work environment supports and/or obstructs your job and <u>how</u>?

You can leave this question blank if you can't think of anything.

(2a) Supports _____

(2b) Obstructs _____

*** 3a. If you could make one change to the physical environment you currently work in, to improve it for patients, family members and/or staff, what would you change?**
Changes could include alterations to existing spaces or adding new spaces / architectural features.

_____

*** 3b. Who would this change most benefit?**

Patients

Family members

Staff

*** 3c. How would it benefit this group?**

_____

3d. Would this change provide benefits for any other group? Please tell us which group and how.

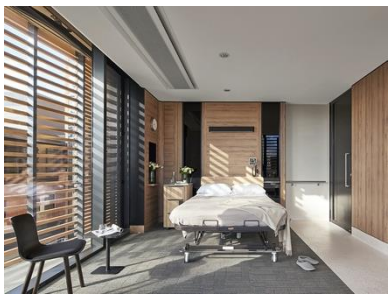
_____

3e. Are there any additional changes to the physical environment you would like to make?

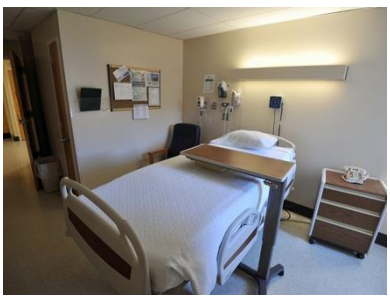
Please list changes or leave this question blank if you have no further changes to add.

_____

*** 4a. The photographs below depict different palliative care settings. Which do you find the most appealing?**
Click on the image to select.





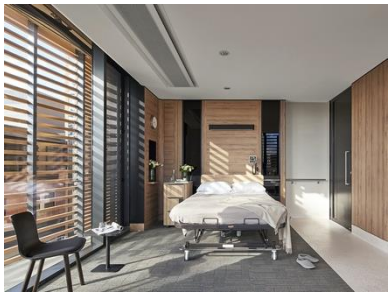


*** 4b. What did you find appealing about this image?**

_____

*** 5a. Which do you find the least appealing?**




*** 5b. What did you find unappealing about this image?**

_____

*** 6. Do patients bring personal belongings into the hospital to make it feel more like home?**

Yes

No

If yes, please provide examples of the types of personal belongings that patients bring in:

_____

*** How many years have you worked in palliative care?**

Less than 1 year

1 to 2 years

3 to 5 years

5 to 10 years

10+ years

*** Please select the answer that most closely describes the location of the palliative care facility you work in, or worked in:**

Inside an acute hospital

Inside a sub-acute hospital

Beside an acute hospital (i.e., it is a free-standing building on a hospital site)

Beside a sub-acute hospital (i.e., it is a free-standing building on a hospital site)

Driving distance from the nearest hospital (i.e., it is a stand-alone hospice or palliative care facility)

If you answered 'none of the above' - please briefly describe your work environment:

_____

*** Please select the answer that most closely describes the relationship to landscape of the palliative care facility you work in, or worked in:**

My facility sits within a garden setting (e.g., gardens are all around and easy for patients to access)

It has a garden space adjacent to the building and on the same floor

It has a garden, but patients must travel by elevator to access it

My facility has no garden space but there is a public park within walking distance

There is no garden space available for patients to access

None of the above

If you answered 'none of the above' - please provide a brief description:

_____

*** In which Australian state or territory is your workplace located?**

ACT / NSW / NT / QLD / TAS / VIC / WA

Which gender do you most identify with?

Female / Male / Non-binary / Prefer not to say

What is your age?

18-24 / 25-34 / 35-44 / 45-54 / 55-64 / 65 and over

Thank you for completing this survey.

Photographs were generously contributed by the following architects/photographers:
Bates Smart / Peter Clarke; Ryder Architecture / Keith Hunter; Perkins + Will / Jim Roof.
For further information about this project please visit: **[website address removed for peer review]**

Would you like a summary of the results once the project is completed? Yes/No

Are you interested in being contacted to participate in future research about palliative care design? Yes/No

Your email address

If you answered 'yes' to either of the questions above, please provide your email address

so that we can contact you (this will be stored separately from your survey responses). *If you would prefer not to provide your email address in this survey, but you would like a summary of the results and/or would like to be contacted for future research, please email ***: [email removed for peer review]*

_____