

# **Dementia: An Investigation into Whether the Current Process of Identifying Reasonable Adjustment to Buildings By Access Audit is Consistent for all Disabilities.**

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## **ABSTRACT**

This is part of an investigation by the author, which looks at disabled access to goods and services, to assess whether current legislation, policing of that legislation and the processes adopted to facilitate the terms of the legislation are delivering as intended. Signs of dementia are often hidden, but they meet Equality Act definitions for being a disability. Dementia creates conditions which can make the use of buildings difficult. Having established the statutory position for providing equal access to goods and services, the paper looks at the building block of any access strategy, the access audit. Access audit templates are often used to undertake the survey part of an access strategy. These often refer directly to guide documents and standards. The paper investigates whether these templates, guides and standards contain the specific checklist items required to specifically provide equal access for those living with dementia. The paper looks at some of the most commonly used guide documents and templates, against a specific checklist for dementia, to see how the required adjustments are included. The research concludes by access auditing buildings against the dementia checklist. The buildings have been significantly adjusted to offer enhanced disability access. The audit will establish if core adjustments for dementia are included amongst those measures. Unfortunately the paper concludes by noting that in these case studies, they mostly have not.

## **KEY WORDS**

Dementia, Access Audit, Reasonable Adjustment, Audit Template

## **INTRODUCTION**

Legislation to enforce the equal treatment of disabled persons in the procurement of goods and services within buildings has been on the statute book since 1995, albeit that the statutory obligation to adjust buildings to improve accessibility only took total effect in 2004, (LABC, 2012). The Disability Discrimination Act 1995 (DDA), and its subsequent updates was repealed and its terms absorbed with other anti-discrimination statutes within the Equality Act 2010. Disability became a protected characteristic under the Equality Act. DDA legislation made *“it unlawful to discriminate against disabled persons in connection with employment, the provision of goods, facilities and services or the disposal or management of premises”*, (UKGov, 1995). In simple terms those who offer goods and services are prohibited by law from unreasonably offering those goods and services to disabled persons at lesser terms than they are offered to non-disabled persons, or to prevent equal access to those

goods and services by disabled persons. A disabled person is defined by DDA 1995 as being one with a condition which has a long term impact of their daily life, (UKGov, 1995). The four characteristics of disability are listed as being Physical, Visual, Auditory and Mental. It is believed that any condition which adversely impacts upon daily life can be categorised under one of these characteristics. No differentiation is made as to different characteristics requiring lesser or greater levels of adjustment planning, hence service providers are required to make adjustment as required, equally for every disability characteristic.

The potential penalties for failing to make the reasonable adjustments to a property required to facilitate equal access could be prosecution and a fine of up to £50,000, or litigation from a wronged disabled persons with no limits to the potential damages awarded. Another penalty might be withholding building control approval for planned development of the building citing a breach of the requirements of approved document M (Access and Use of Buildings), of the Building Regulations 2010, (UKGov, 2010). In order for this to be prevented statute dictates that premises should be subjected to reasonable adjustment to remove, modify or manage barriers to access, providing such action is reasonable. Identification of these barriers to equal access and an essential part of the process of deciding what is and what is not reasonable adjustment is the access audit. In simple terms this is mostly a stock building survey, often employing a template of access issues for the surveyor to investigate, culminating in a client report identifying barriers to access by reference to the standards set down in BS8300:2009. If a surveyor measures the opening to an external door and finds it to be 770mm that is reported as a barrier, whereas 780mm is not. That is because the BS8300:2009 standard for external door widths, albeit advised as being a minimum of 1000mm, is in fact for existing buildings set at 775mm, (Lacey, 2004). From a surveying perspective that encapsulates much of the process of access auditing, using a template approach.

## **RATIONALE**

The author was involved in access auditing two venues, one retail, commercial and catering and the other a tourist venue, to establish if the requirements for facilitating equal access are apparent on the ground, (Mclean 2015). Amongst the discovery that many adjustments had not been made, was a realisation that of the few that had, these were mostly to accommodate wheel chair users, a small proportion of just one of the four categories of disabled person, (Mclean, 2015). This fact would indicate one of the following scenarios. Access auditing and provision for disabled customers is being ignored. Adjustments are being made without recourse to a full access audit. Finally the access audit using a template methodology might be flawed in that it does not include full provision for all disability as described by statute.

1 in 4 UK shoppers either has a disability or is close to someone who has, (Waterman & Bell 2013). Government figures support this, citing 1 in 5 of the working population and 1 in 2 retirees as being disabled, (EFDS, 2015). This is a large number of people, however wheel chair users amount to a small proportion of these. The Papworth Trust cite a figure of only 8% of registered disabled persons using a wheel chair, (Papworth Trust, 2013). Interestingly Papworth also cite that more disabled persons have

disabilities which are not immediately visible, than those that are. 770,000 people in the UK were disabled by means of the often hidden disability of dementia in 2013, a figure estimated to rise to 1,400,000 by 2030, (Papworth Trust, 2013). The methodology for this study is to investigate the adjustments which research has deemed to make the lives of those living with dementia, who are using buildings, easier. The study will then investigate whether some commonly used access audit guides and templates would if followed faithfully establish reasonable adjustments for those with dementia, whether currently used standards reflect adjustments for dementia and whether the surveyors who employ the template methodology for access audits are in fact doing the full set of tasks required for a thorough compliance with current statute.

## **WHAT IS DEMENTIA**

*“Dementia is not a disease in itself. Dementia is a word used to describe a group of symptoms that occur when brain cells stop working properly”, (ARUK, 2016).* The term dementia describes a set of debilitating conditions. These might include memory loss and/or difficulties with problem-solving or coping with language. Common conditions might include anxiety and confusion. Dementia can be caused by brain damage. This might be caused by a stroke or by a disease such as Alzheimers, (ARUK, 2016). This means that the damage can be caused suddenly, or can be degenerative as disease causes brain cells to die more rapidly than a normal aging process would expect. The catalyst is often a buildup of abnormal proteins in the brain, (NHS, 2015). Sometimes dementia can be triggered by damage caused by a brain tumor, suffering a head injury, HIV infection, Vitamin B deficiency or substance or alcohol abuse, (NHS 2015). The actual cause in terms of the disease, or physical trauma is not really important in terms of disability legislation, as anyone living with dementia has a mental condition which impacts upon their ability to live their daily lives, such as accessing goods and services. Under the terms of the Equality Act 2010, reasonable adjustment should be made to those commercial premises to accommodate customers and clients living with any manifestation of dementia.

## **SPECIFIC ADJUSTMENTS FOR DEMENTIA**

It has been identified that for those living with dementia it is often beneficial for them to take part in activities such as sports and shopping: *“Yet – enabling people with dementia to take part in ‘everyday activities’ – to meet up with friends, take part in sporting activities, enjoy green space, go shopping – is key not only to enabling them to live healthier and more fulfilling lives, but to reducing and delaying their dependence on expensive health and social care services”, (LGA2, 2015).* There have been a number of studies undertaken into making the built environment easier for those living with dementia. The larger focus is upon dwellings and care places for dementia. It would not be reasonable for a service provider to include that level of detail as a reasonable adjustment, (Department of Health 2015). The Local Government Association in association with Bradford Alzheimers Society have produced a checklist

for commercial building owners, to make their building more suitable for users with dementia, (LGA1, 2015). This focuses on a few measures which allow those living with dementia to use buildings in pursuit of goods and services. It cites the need for bold, clear, well-lit signage that can be easily understood, and does not require memory to retrace the steps that the signage led to, i.e. directions to a toilet and also out of it again. Lighting is cited as being both beneficial and confusing. Natural light and consistent light sources aid wayfinding, whereas pools of light and shadows can cause confusion. Flooring should be non-reflective, avoid bold patterns and be texturally consistent as continuous changes in colour and texture can cause confusion. Traditional dedicated disabled toilets where someone can be aided by a carer of the opposite sex are recommended, however the typical all white colouring of a toilet space and its fittings could confuse and contrasting coloured toilets and sanitary fitting are considered to be more beneficial. The use of clearly identified seating is beneficial to allow people to gather themselves, however modern designs of seating may not be perceived as being such. Having dementia can impact upon wayfinding. It was felt that having interesting landmarks in a building like an attractive painting allows people to break a building down into smaller areas and navigate better. Finally dementia often causes anxiety and confusion. Having an area where someone can be served in a quiet environment can be beneficial, (LGA1, 2015). This is vitally important as this state can lead to combative behavior, which needs to be managed by people trained to understand dementia, (About Health, 2015). This is a summary of a specialist access audit for dementia. Whether these points are contained within a typical all-purpose access audit form, must be investigated, because if not they might not be taken into consideration as reasonable adjustments in an access strategy, and would therefore not be implemented.

## **COMMONLY ADOPTED GUIDELINES**

There are a number of guides issued for compliance with the requirement for undertaking reasonable adjustment. Two of the premier of these would be the guide “*Accessibility By Design*”, produced by Local Authority Building Control, (LABC), and “*Designing for Accessibility*” produced by the Royal Institute of British Architects, (RIBA). From these guides which are both based upon the standards laid down in BS8300:2009 *Design of buildings and their approaches to meet the needs of disabled people*, are many access audit templates based. Investigation of LABC, however notes that provision for dual sex toilets where carers of the opposite sex can assist someone with dementia are recommended only for larger buildings. There is no mention of the need for seating, or for provision of quiet areas where anxious customers can be accommodated. Also absent from LABC is the recommendation for the inclusion of landmarks within the decorative scheme to facilitate confident wayfinding, and signage which shows the way out as well as in to sanitary facilities. Similarly RIBA whilst it does recommend obvious seating being placed in buildings it does not advocate the provision of quiet areas. It looks purely to signage for wayfinding and whilst it recommends unisex disabled toilets their design might not adequately include provision for a carer too. An observation which is inescapable in both works is that whilst there are particular recommendations for wheel chair users, people with

visual conditions and people with auditory conditions, but there are no recommendations obviously made specifically for dementia.

## **COMMONLY USED TEMPLATES**

As undertaken above the author intends to investigate two widely used access audit templates, to look for reasonable adjustment recommendations focused upon dementia. These are the *Design Guidance Note Audit Check List* produced by Sport England, (Sport England, 2012), and the Equality Commission, Accessible Business Checklist, (ECNI, 2014). Sport England written in checklist rather than guide form is more comprehensive in terms of specific issues. There are checklist items for seating, provision of quiet areas, provision of “visual clues”, to aid circulation, provision of “family” unisex changing and toilet areas areas. The only issue which is not to be checked is signage which leads out as well as in. In contrast however ECNI provides a package of measures specifically for disability in line with the guides examined above. Quiet areas, landmarking, and provision of toilets which allow different sex carers to operate are however notable by their absence. Another somewhat parochial checklist often recommended by the author when instructing students to undertake access audits is issued by the Diocese of Blackburn, (Diocese of Blackburn, 2012). This, perhaps because they are a given in church property, does advocate quiet areas, but not unisex toilets for those needing carers, however this checklist strongly advocates a management policy covering all forms of disability in the event of fire, when alarms and flashing lights designed to inform, might cause anxiety and confusion, and the presence of officers trained in dealing with all forms of disability.

## **UNDERSTANDING DEMENTIA**

An investigation of guides and widely used access audit check lists does suggest that particular requirements for dementia might, if the surveyor works strictly to the chosen guide, not become part of every accessibility strategy, even in buildings where their inclusion might have been considered as reasonable. A report by the National Union of Journalists in respect of hidden disability may provide some of an answer. It is written in respect of hidden disabilities, and states that hidden disabilities are often ignored or demeaned, (Brooks et al, 2008). It also makes the point that those with visual disabilities may also have hidden ones, (Brooks et al, 2008). An elderly person living with dementia may also have visible physical frailties, but the impact of dementia may not be so obvious. Badrakalimuthu and Tarbuck cite an instance of between 38% and 72% of those living with dementia as suffering from anxiety, whilst they claim that very little research has been carried out about managing this anxiety, (Badrakalimuthu & Tarbuck, 2016). This would put pressure upon people who are essentially entrepreneurs, service providers and surveyors to understand exactly what reasonable adjustments are required for dementia. Beattie et al make an important point in relation to dementia, that not all those living with the condition are elderly, and those under 65 may not be fully understood as having a disability, (Beattie et al, 2005). Disability Rights UK however are unequivocal about stating that disability whether hidden or visible is still a disability, and the Equality Act does not differentiate, (Disability Rights, 2015). Perhaps the acid test of reasonable adjustments being made for dementia, is to audit building's where reasonable adjustments have clearly been made to comply with the Equality Act.

When looking for a specific dementia access audit form there are several available. There is a comprehensive form available from Innovations in Dementia, however this covers many issues which might be considered more best practice than issues likely to inhibit access to goods and services, (Innovations in Dementia, 2015). A checklist which focuses more on issues likely to be considered barriers to access is provided by Bradford Alzheimer's Society, and a copy of this can be found below. It is upon this checklist that any access audit work will be based, (LGA1, 2015)

### **Quiet Space**

Do you have a quiet space for someone who might be feeling anxious or confused? A few minutes with a supportive person might be all that's needed to continue the transaction.

### **Signage:**

Are your signs clear, in bold face with good contrast between text and background?

Is there a contrast between the sign and the surface it is mounted on? This will allow the person to recognise it as a sign

Are the signs fixed to the doors they refer to? They should not be on adjacent surfaces if at all possible.

Are signs at eye level and well lit?

Are signs highly stylized or use abstract images or icons as representations?  
(These should be avoided)

Are signs placed at key decision points for someone who is trying to navigate your premises for the first time? People with dementia may need such signs every time they come to your building

Are signs for toilets and exits clear? These are particularly important.

Are glass doors clearly marked

### **Lighting:**

Are entrances well lit and make as much use of natural light as possible?

Are there pools of bright light or deep shadows (these should be avoided)?

**Flooring:**

Are there any highly reflective or slippery floor surfaces? Reflections can cause confusion.

Do you have bold patterned carpets? Plain or mottled surfaces are easier; patterns can cause problems to people with perceptual problems.

Are changes in floor finish flush rather than stepped changes in floor surfaces can cause some confusion due to perceptual problems. If there is a step at the same time you also introduce a trip hazard.

**Changing rooms and toilets:**

Do you have a changing room (where applicable) where an opposite sex carer or partner can help out if the person needs help with their clothes? If not are staff briefed in how to meet this need sensitively.

Do you have a unisex toilet or other facility which would allow someone to have assistance without causing them or other user's embarrassment?

Toilet seats that are of a contrasting colour to the walls and rest of the toilet are easier to see if someone has visual problems.

**Seating:**

In larger premises do you have seating area, especially in areas where people are waiting? This can be a big help.

Does any seating look like seating? People with dementia will find this easier so for example a wooden bench would be preferable to an abstract metal Z shaped bench

**Navigation:**

Research shows that people with dementia use "landmarks" to navigate their way around, both inside and outside. The more attractive and interesting the landmark (which could be a painting, or a plant) the easier it is to use it as a landmark. Have you had a good look round and thought about these landmarks?

**Other issues:**

This list is not exhaustive if possible speak to people living with dementia and ask them how they find your premises. Other unexpected things can cause problems for example reflections can be confusing.

(Fig 1 Checklist as advocated by LGA and the Alzheimer Society,  
(LGA2, 2015))

## **ACCESS AUDIT CASE STUDIES**

The first building chosen for audit is one where elderly people often meet. It is a detached purpose built community library, It is a modern construction form but built before building regulation, and DDA. It has subsequently been retro-fitted with reasonable adjustments, mostly for physically disabled users, but with some measures for other categories of disability.

Access to the library is excellent for disabled persons of any category, however once inside in terms of use by those living with dementia, it did not provide a best practice example. Albeit that libraries are inherently quiet, there was no area where an anxious person could be provided for. Signage was plain black lettering, and not at eye level. It could only be read from a position in front of it with keen eyesight, and realistically a user would need to remember where the books they seek are kept. Lighting was subdued at the heart of the building, but very bright near the large floor to ceiling windows. The carpet was plain, but three colours had been used for reasons other than wayfinding. Wayfinding was difficult with no landmarks or extra signage, and a common grid arrangement of the same style of book shelf. There was no signposted public toilets which is an equality factor of sorts. The audit did not allow inspection of any facilities installed for staff use. Qualified librarians are apparently trained to deal with the elderly.

The second building takes account of a factor in elderly activity that the over 55s are the fastest growing sector of gym membership. (Guardian, 2003). Also the second building facilitates a fast rising sport of over 70s bodybuilding. It is reported that there are a significant and growing number of over 70s training and taking part in bodybuilding and physique contests, (MailOnline, 2013). Building two is a health club run by a large national sports and leisure company. It is part of a mostly retail complex. It too is of modern construction form, and was also built pre- building regulations, and pre-disability discrimination statute. It too has been significantly retro-fitted with reasonable adjustment features.

First thing to notice about approaching the gym, is that it is located on the building's second floor. Both the staircase and the lift enter a plain lobby which has three doors. None are signposted, and finding the correct one to enter the gym, requires looking through the central glazing panel to see what is on the other side. Entrance beyond reception into the gym area is a complicated card operated turnstile, requiring a number of automotive function operations to navigate it. There is seating on both sides of the turnstile but no dedicated quiet area. The private office area is outside the club area through one of the other doors off the lobby. The receptionist had not been formally trained about dementia. Way finding to the changing room was poorly signed, and finding the toilets and the way out is difficult for anyone, as doors are hidden until the seeker is right upon them. Wayfinding around the gym is very difficult and memory of where to find equipment in the three gym areas is essential. There are no real landmarks to aid wayfinding. Signage to the rooms where classes are held and the sauna are not clear or numerous. Whilst lighting is good, albeit with no natural light, the presence of reflected images on mirrored walls makes it appear that there are a number of staircases present and equipment shows in areas where it is not located. Given this fact it is probably good that there are few landmark features to



reflect. Flooring often changes material, texture, level and colour. There are no dual-sex toilets at all, or facilities for carers of the opposite sex to operate.

## **DISCUSSION**

The buildings audited were both of late twentieth century construction and owned by local government and a multi-national company. Both had been access audited and reasonable adjustments had obviously been made. To find that so many of the adjustments which would help people with even mild symptoms of dementia use the facilities better to be absent was quite shocking. Research leading to the case study audits did highlight that provision for reasonable adjustment as presented in good practice guides and audit templates can be loaded towards visible disabilities, in particular wheel chair use. The case study properties were chosen as the author was sure that these were not owned by organisations who would take their responsibilities under disabled access lightly, or who were ill-funded when it comes to making adjustments. Both buildings were in use for activities which attract a higher proportion of elderly users. This suggests a potential issue in the current process of access auditing which might lead to provision of reasonable adjustment for some often hidden disabilities to not become considered.

## **CONCLUSIONS**

For whatever the reason, it seems that the built environment still offers unreasonable challenges for disabled persons seeking to access goods and services. Evidence is readily observable that every facet of provision and policing of reasonable adjustment could be improved. Evidence is also available that the one guide or audit template fits all approach could fail to provide a comprehensive survey. Whether it would be reasonable in terms of cost, time and expertise of the surveyor to conduct four separate audits for each category of disability could be debated. It is probable that a mental disabilities only audit would pick up adjustments required for dementia, whilst an all disabilities audit does not appear to always do so. Perhaps if more people living with dementia exercised their rights under the Equality Act as wheel chair users are currently doing, then main provisions for dementia might become as prominent in buildings as ramps and powered doors. With an estimated increase in numbers of people living with dementia to 1,400,000 by 2030, and medical advice advocating sports activity, shopping and meeting people as stimulation to assist people living with dementia, the issues introduced by this work are only likely to become much more significant.

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