SUPPORTING NURSE AND CONSUMER INTERACTION VIA VISUAL DESIGN: A WAYFINDING PROJECT FOR NEPEAN MENTAL HEALTH UNIT

Social Design
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I acknowledge the Gadigal People of the Eora nation as the traditional custodians of the land on which I work, study and live. I pay my respects to their elders, past, present and emerging, and extend that respect to all first nations people, as I recognise that ownership was never ceded, and it has and will always be Indigenous land.

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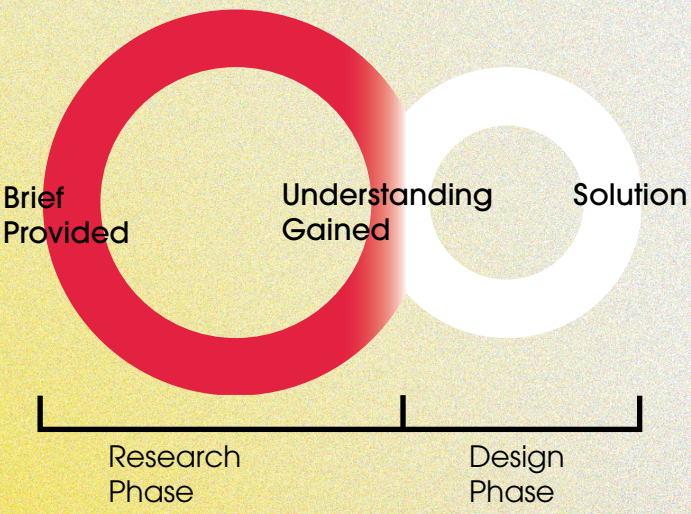
METHODOLOGY

In undertaking this project, as I have begun to do increasingly, I spent most of my time understanding the problem space, contextualising the brief, to allow myself the best opportunity at conceptualising a grounded solution that reaches beyond the surface level issues. This manifested itself in extensive desk research, in combination with the opportunities afforded to us for codesign, including the site visit to Nepean Hospital and the later prototyping workshop. The goal was develop a strong set of guiding principles that would support a variety of potential outcomes, with my final design one, reasonably polished, possibility.

I think, while possibly over used, an adapted 'double diamond' works well to visualise this process.



BRIEF

The brief was as follows: Co-design signage and wayfinding for Nepean Mental Health Unit.

At initial viewing, the brief is a simple one, the evident outcome being signage of some form or another. However, with a more open mind, 'wayfinding' offers a myriad of literal and more abstract possibilities that would only be revealed from a thorough research process.

PROBLEM CONTEXT

As noted, I believe one, if not the, most critical aspects of design is understanding the context of the brief in order to address it. My research process was lengthy, and the rest of my research, as per my research report, can be found in the appendix, here I will showcase the three key pieces of research that expanded the problem space for me and helped to formulate my guiding principles.

RESEARCH 01: THE NEPEAN HOSPITAL AND THE CHALLENGES THEY FACE

The following is the most relevant of my findings from this area of desk research. Understanding the hospitals vision and approach to care was key in understanding their ethos, and important for framing a design approach for them as the client. The Nepean Hospital model of care is built around an intentional set of values and goals. Their vision is described as: "Together, Achieving Better Health." Which they expand upon in their Vision, Values and Goals web page: "Nepean Blue Mountains Local Health District will drive innovation and excellence in health service delivery that provides safe, equitable, high quality, accessible, timely and efficient services that are responsive to the needs of patients and the community." Of note is also their CORE and SAFER values as are the goals outlined in their 2018-2023 Strategic Plan which includes both:

- "Better patient and consumer experience"
- "More talented, happy, and engaged staff"

More significantly however, was developing knowledge around the challenges that they and Australia face in respect to the medical landscape so that I could further contextualise the issues and tailor a solution. As highlighted in the Strategic Plan, these included:

- Population growth, with a predicted population of 464,000 in 2036
- An ageing population, including a predicted 166% increase in people aged 70-84 and a 250% increase in people aged 85+ by 2036
- High smoking, obesity and stress levels
- A large urban Aboriginal community with poorer health outcomes than non-Aboriginal people
- Socio-economic inequalities and poorer health outcomes

Beyond that, Australia itself faces a shortage of nursing staff of over 100,000 by 2030 according to the Australian Industrial Relations Commission (2002), which was further expanded upon by peer workers during our site visit.

Tension: It is obviously important to maintain and gain nursing staff, but nursing shortages were put down as a result of the high turnover rate associated with the profession due to the challenging and confronting nature of the job.

The significance of this is coincidently mirrored the Strategic Plan's goal of "more talented and engaged staff", and as such, nurse wellbeing formed the basis of my first guiding principle.

RESEARCH 02: THE RECOVERY MODEL

In understanding the hospital, it was then key to acknowledge their approach to care, and what mental health care can look like; although I did not know it at the time, this was the most important set of findings.

The recovery model of care is a human-centred approach to mental health care which asserts that it is indeed possible to recover from mental ill-health via a patient-directed method. While many consider this to contrast traditional bio-medical and psychiatric models of care, which focus on medication for treatment. In considering that the medical model is based upon evidence-informed practice, Deborah Mountain and Premal Shah's article Recovery and the Medical Model (2008) proposes that the two may complement one another, and at times be one and the same.

This is mirrored by Mary E. Barber's 2012 article Recovery as the New Medical Model for Psychiatry, which outlines three conceptions of recovery in line with other illnesses:

- Cure or remission of illness, in which the individual experiences no symptoms.
- Illness management, in which the individuals long-term monitoring and ongoing treatment of the illness minimise symptoms.
- Personal recovery, in which the individual functions at their best despite symptoms persisting.

This approach seeks to empower the individual, and provide optimism, a quality that is critiqued by medically focused academics; however, Barber notes Helen Keller and Franklin D. Roosevelt as examples of successful recovery despite persisting symptoms.

Sarah Lyon's article (2020) on the same subject, underscores key aspects of recovery-centric care:

- Health: Physical and mental wellbeing
- Home: As a stable location
- Purpose: Meaningful daily life
- Community: Supportive social environment

The importance of the recovery model was underscored by the peers workers during our site visit, as they, as people with experience in the mental health system, understanding the significance of power and autonomy in recovery.

Tension: While there is an increased push, especially politically, towards an increased use of recovery model strategies in mental health care, the traditional bio-medical model of care pervades every corner of the medical system. This is most evident in the physical manifestations, where, for example, nurses' uniforms and hospital buildings themselves, are cold, apathetic, and intimidating, reinforcing a power dynamic in which consumers are lead through their recovery, powerless, by a much more powerful body of nurses and doctors.

As such, power, autonomy and equality in power became a large focus of my thinking, and form the second guiding principle.

RESEARCH 03: NURSE-CONSUMER INTERACTIONS

At a later stage, in understanding these two principles, one being user empowerment, and secondly, nurse wellbeing, I identified a potential conflict, however also an opportunity; there existed the option to leverage the success of one group for the others benefit as well. Nurse-consumer relationships and interactions are key for both parties experiences of the mental health landscape, and research was required to understand these dynamics, especially within the context of power and the recovery model.

Nurse-Patient Interaction in Acute Adult Inpatient Mental Health Units: a Review and Synthesis of Qualitative Studies (2012) by Michelle Cleary, Glenn E. Hunt, Jan Horsfall and Maureen Deacon provides a very convenient analysis of existing papers, and note that nurses are often critiqued for a failure to develop therapeutic relationships, but "perhaps the criticism of psychiatric nurses not spending enough time with patients is because so much of their work is behind the scenes, which render daily nursing accomplishments invisible and creates a perception that nursing work is not

satisfactory." They identify six categories and twenty-eight different forms of interaction between the two parties, with the most notable including:

- Relating through the ordinary
- Negotiation
- Rules Management
- Managing Diversity
- Being with, and Being there for
- Exchanging Patient Information
- Having a Sense of Humour
- Respecting Patients' intrinsic humanity

The most significant of all of those is 'negotiation' within the context of a recovery-based approach because it implies a two-way dialogue in which the service user has autonomy, respect, and power; an equalling of the playing field in conversational setting.

In light of this, an understanding of negotiation was important, so I turned to Say Anything to Anyone, Anywhere: 5 Keys to Successful Cross-Cultural Communication (2013) by Gayle Cotton to explore what interaction and negotiation between two very separate, at times conflicting parties can look like. In his writing on rapport, he highlights the importance of finding another's need and servicing that need while remaining flexible in respect to an ability to adapt your communications style. He underscores prior understanding and awareness as key to that ability.

Tension: Nurse and user interaction is evidently key in developing a rapport, and thus enabling negotiation to occur, but the two groups are often adversaries due to the, often involuntary, nature of the user's admittance.

As such, negotiation became my third guiding principle, with an ability for both nurses and consumer to be informed and aware of the others communication style key.

GUIDING PRINCIPLES

With research taking me down a clear path, it was easy to develop clear guidelines for values that could direct future work. They were:

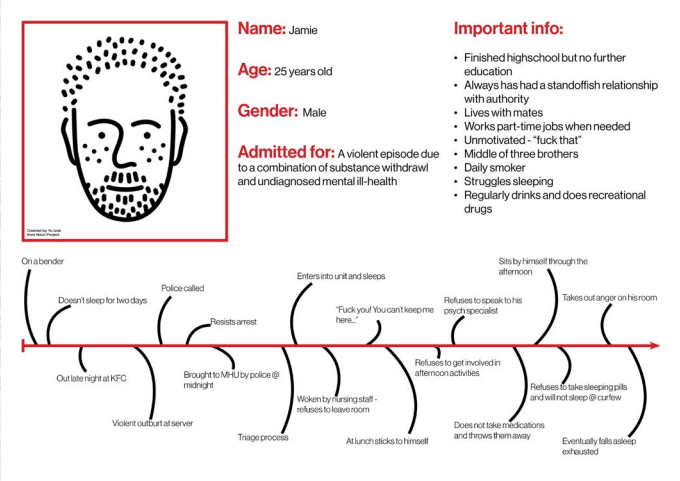
Nurses' wellbeing: With nurse turn-over so significant, keeping them safe, comfortable, and confident is key.

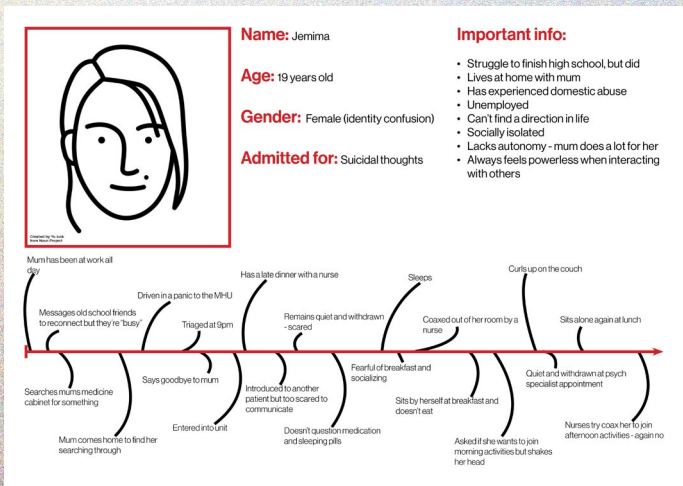
The recovery model: The increasing adoption of recovery-based forms of care, as well as the humanising ability of those forms indicates the importance of providing autonomy and power to users.

Negotiation: By providing both groups an understanding of one another, a dialogue can support a healthy relationship, and in doing so, provide power to the users and safety to nurses.

USERS AND JOURNEYS

Exploring how these interactions currently look was essential, and by exploring two personas and their contrasting journeys within the acute unit was useful in further breaking down those relationships. Larger versions may be found in the appendix.





Both Jamie and Jemima have unproductive relationships with nurses within the current system of care, both lacking the power and autonomy they need. Jamie on one hand has a particularly adversarial relationship, and is always at odds with staff members while Jemima struggles to be involved and take responsibility despite nurses encouraging her.

On the other hand, nurses are faced with abuse and harassment by Jamie, while they don't have the technical skills to bring Jemima into her recovery. A solution would help break down those barriers and supporting the building of those relationships.

REBRIEF

With all of the above in mind, a rebrief was significant in pulling together all that I now knew and finding a framing and focus. It reads: How might we support a 'recovery-based' approach to care by assisting nurses and patients navigate their interactions.

DESIGN OPPORTUNITY

Please note in my appendix that this final concept is an evolution of a certain line of thinking examining the artefacts that reinforce the power dynamic implied by the tradition medical model of care and ensure that service users and nurses remain separate and at odds.

CURRENT STATE

I have identified name tags as a significant artefact that does this, as both parties have them, but neither serve to introduce one to the other.

- Users have clinical, administrative wristbands, that acts to further dehumanise them, tagging them as a number as if they're a product or an animal.
- Nurses have cards that double as security cards and are found on their hip for safety reasons. These serve a practical purpose, and if anything, are another symbol of their power in contrast to users; they have the access and the power to move around and leave when they want.

IDEAL STATE

If properly designed, name tags could serve as the perfect artifact to facilitate interaction and help both groups navigate their relationship as in line with my guiding principles.

- Names could be clear and informal to ease the introductory process
- Elements of design could provide information about the person to provide that understanding and support the other adapt their communication style before the first word
- Everyone would be able to design their own providing power and agency
- Everyone could wear them to place everyone on a level playing field, nurses and users.

For patients this will:

- Enable fair and even negotiation, providing them agency.
- Provide a sense of equality.
- Assist in developing friendly and familiar relationships in an unfamiliar place.

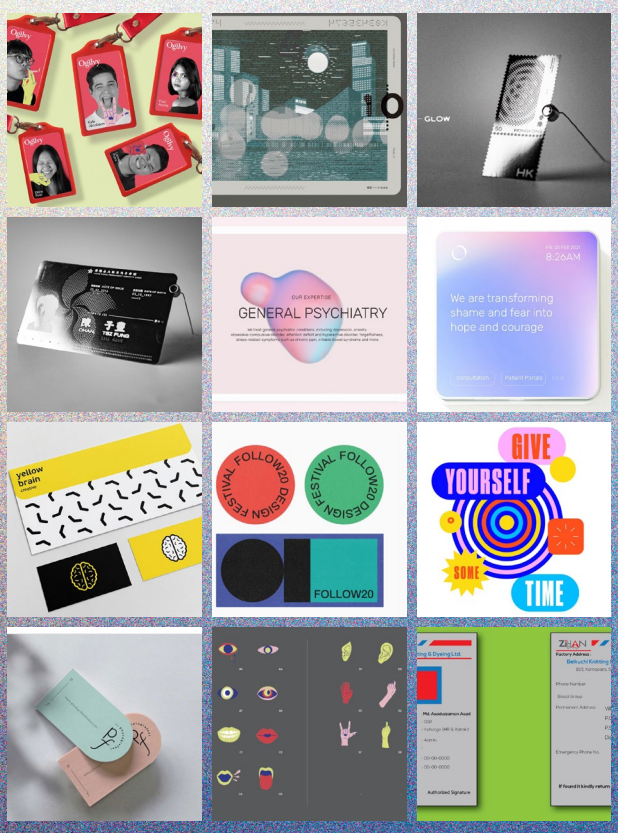
For nurses this will:

- Assist in approaching conversations with unpredictable individuals, where technical training may not prepare them, enabling them to provide care.
- Assist in developing a friendly relationship with patients, reducing the challenges and dangers of those individuals.

PROTOTYPE DEVELOPMENT

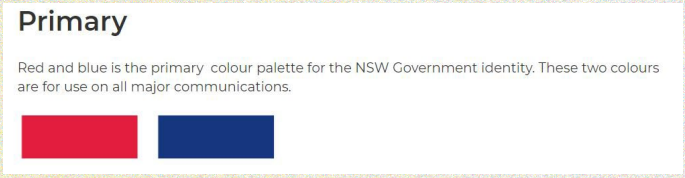
MOOD BOARD

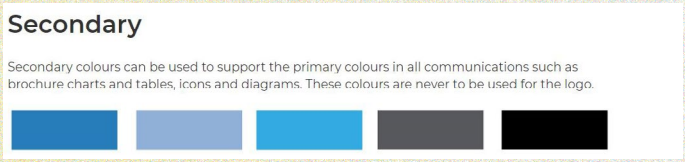
I began with look at existing examples that offered a more exciting alternative to traditional name tags.

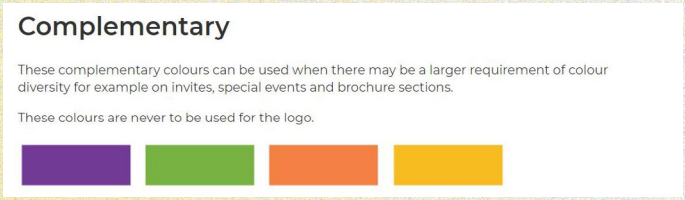


COLOURS

From there I developed a colour palette. While the NSW government does have a set colour palette, as you can see, it's pretty restrictive.



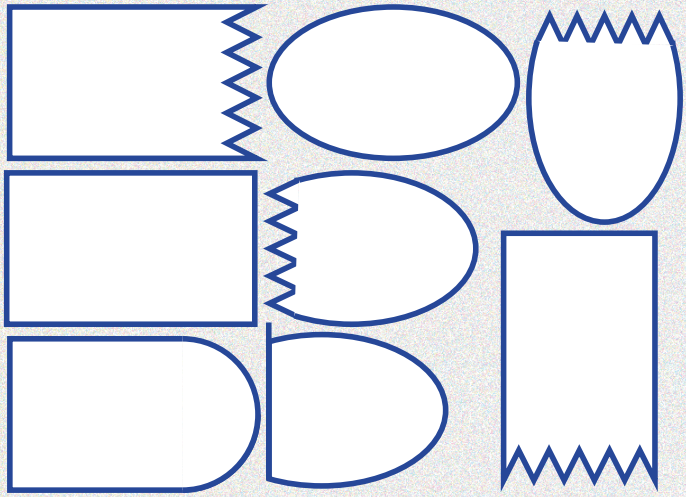


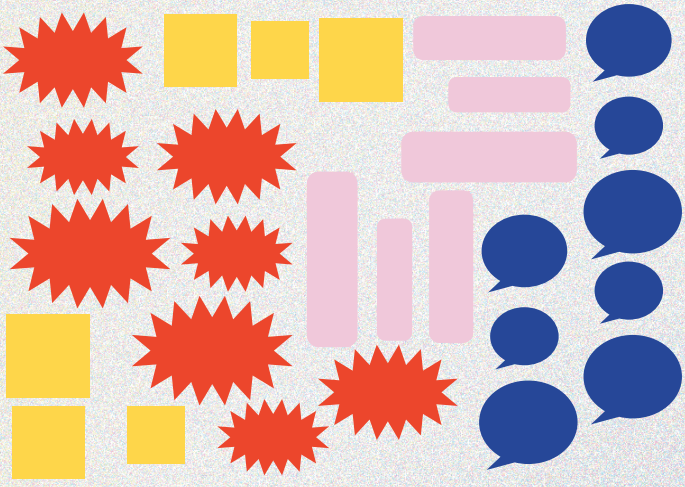


My colour palette and font test looked like this, taking inspiration from other forms of print media and branding that draw on fun and comic aesthetics:

SYMBOL SYSTEM

While I was unsure at this point, I recognised that having visual elements that function in a system would be key in communicating those aspects of personality that are important for interaction, able to be 'designed' by the individuals in an easy process, allowing abstracting yet readability to those who understand the system; a self portrait almost. The logic was not perfected at this stage, as I waited for the prototyping workshop to gauge reactions and engagment.





PROTOTYPING WORKSHOP

The process of this workshop included me printing out the above name tags and symbol options, and providing them, along with glue and markers, to fellow students, encouraging them to make their own name tags.

The feedback was insightful. Firstly, people were largely disengaged. Secondly, they suggested that having adults do this, basically arts and crafts, would be patronising and childish.

FINAL CONCEPT

Instead of cutting and pasting, I recommend that when they first enter the unit, and possibly weekly from that point forward, patients are able to use a simple word doc, or online tool, to create their own security cards with a premade set of backgrounds and foreground elements that are indicative of their place in their own recovery.

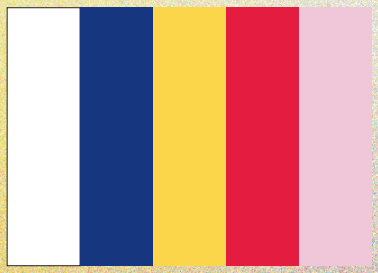
FUNCTION

Here I'm suggesting that we give patients the ability to unlock and lock their own room. No other patients can get in, but nurses obviously can in the event of an emergency. They'd be attached with a clip on the shirt so they're visible, and there's no long chord posing any danger to anyone.

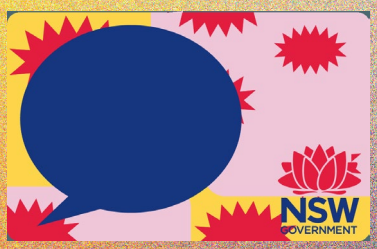
- This gives them their own private space and reinforces the significance of having that personalised space.
- It provides them a real autonomy – its something that no one else can do. It's unique.
- And it makes the card useful – power and function are tied to this artefact.

VISUAL DESIGN

I altered the colour scheme to include the red and blue of the NSW government emblem, as I think formalising the design will support power and function.



My initial ideas included:



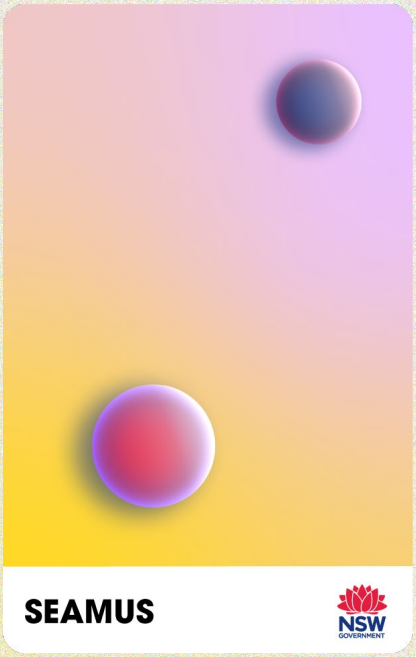
I eventually landed upon a clear visual language that takes from the colour palette. The background would indicate how the user perceives the space around them:

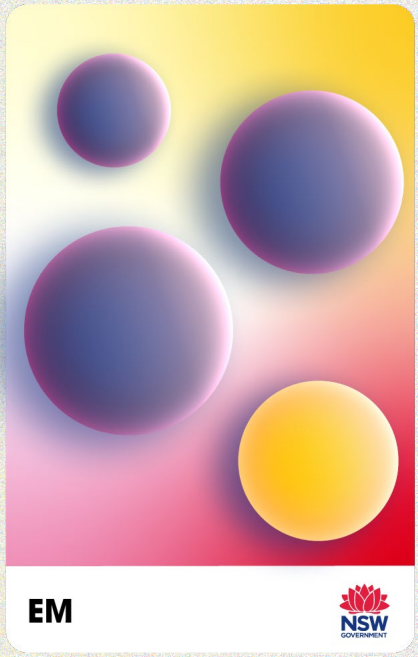
- Blue would signify unhappiness
- White would represent calmness
- Red and pink would show engagement and energy
- Yellow would show optimism

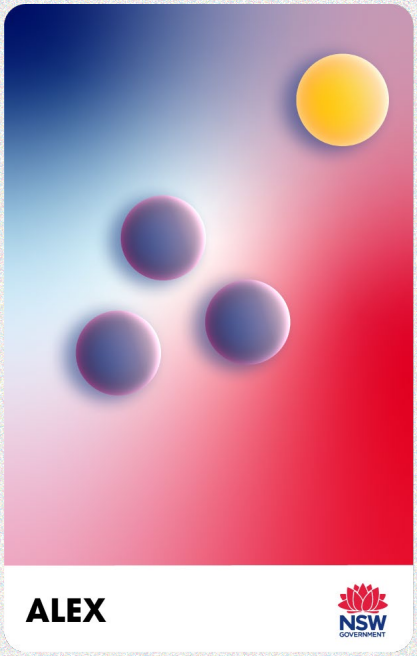
The foreground elements would show how they perceive themselves and those around them.

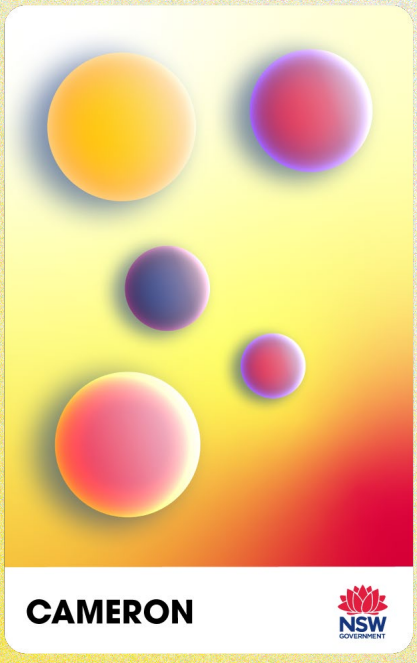
Nurses would not create an abstraction as how they view their recovery, but would look at their personality. A security card works best on the hip for safety reasons, but a name tag serves the purpose of supporting conversation.

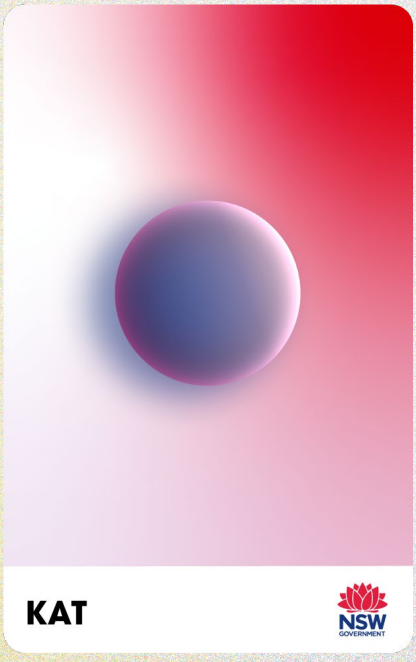
Users can go for as abstract an approach as they would like. I've also included the NSW Government logo to formalise the cards and imbue them with power, and a clear name in Avante Garde Gothic. A portrait format was selected to shift away from traditional notions of these cards and visually it offered more.

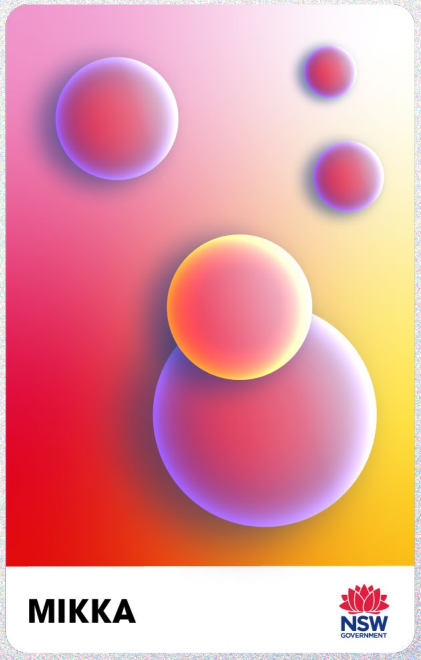












EXAMPLES

- Kat maybe feels like she is alone, but has found some peace in that experience.
- Alex possibly feels to be by themselves, with others grouped together, and while he feels energised in the space, it does have a darker capacity.
- Seamus could feel alone and separate from a significant other, but feels optimistic.

These are just some of the infinite options open to users.

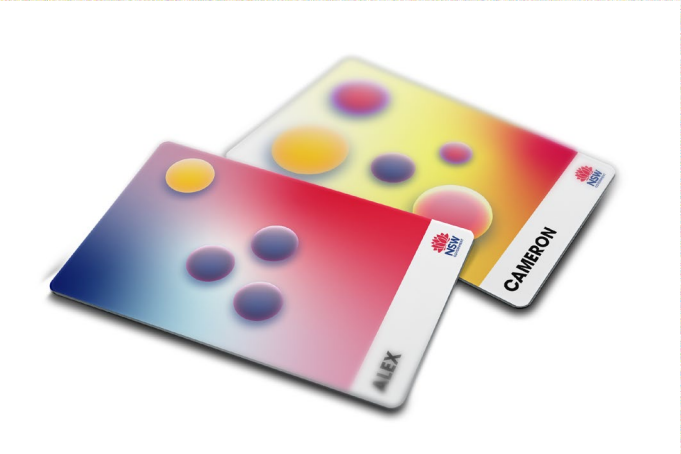
This is one solution built around what I believe are some really solid guiding principles.
The recovery-model, nurse wellbeing, and negotiation.

CONSIDERATIONS AND NEXT STEPS

As noted, this is one potential outcome because the guiding principles could be considered in framing a variety of solution. With this solution in mind however, here are some thoughts for the future:

- Ideally the system of visual elements, background and foreground, is actually developed in co-design with patients and nurses; the existing visual language should change.
- Ideally these are redesigned every week, and the user gets to observe their journey, but budget and access to a computer might be limiting.

- Ideally everyone on the ward, including doctors and visitors also have similar tags to maintain an equality across every member.



PERSONAL REFLECTION

I am starting to really enjoy social and systems design, and it is quickly becoming a focal point of my practice. Having said that, I am only used to applying these skills in the context of the Bachelors of Creative Intelligence and Innovation, and because of that, my Visual Communications skills have taken a back seat, and my engagement with this degree has dropped. It is lovely to see that the visual skills can be applied in unison with those social design skills to facilitate social change, important change.

Beyond that, I'm quite proud of this project because of the underlying principles and guidelines that directed this project. I'm confident that these guidelines could be handed to anyone else and they would produce a really interesting, but completely different solution to me. I am proud of the outcome I did come up with too, however. I believe that the name tag and security card was a great artefact to select, and the graphic work I ended up putting in was also solid, especially having not worked in this space for a while.

I'd love to have the opportunity to look at these principles from a different perspective, or to develop these further. Engaging with codesign and social design concepts is rewarding, and applying them in the betterment of this concept.

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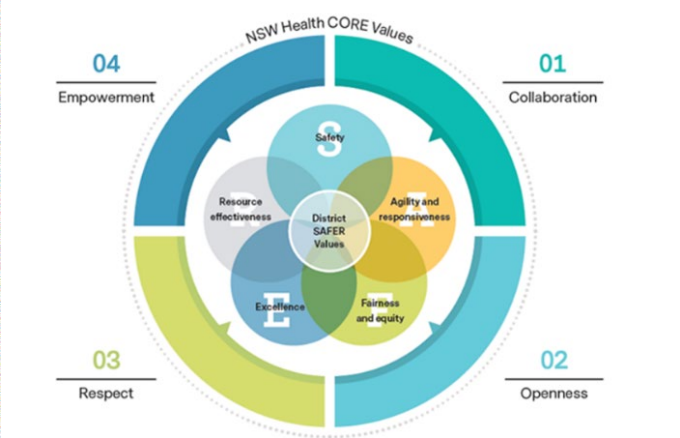
APPENDIX

01 RESEARCH

01.1 About the LHD

The Nepean Hospital, and its' Mental Health Unit, is responsible for providing primary health and hospital care for people living in the Nepean and Blue Mountains Local Health District (LHD). Comprised of both urban and rural areas, with a population of over 350,000, including over 8,000 Indigenous people, the region has notable diversity in respect to the socio-economic spectrum (NBMLHD, 2021).

01.2 From Strategic Plan



WE WILL:

- Embed patient safety, respectful culture and service excellence throughout the organisation
- Build a high performing culture that fosters proficiency and develops our talent
- Attract, recruit and retain high quality staff to achieve self-sufficiency in service capability and provide world-class clinical care
- Plan and recruit appropriate staffing that is aligned with all redevelopments and capital works
- Work with our partners in the Quarter, Penrith (Health and Education Precinct) to develop a workforce, locally grown, for all Local Health District services for now and for the future
- Employ innovative technology systems for recruitment, training, rostering and staff management
- Be a white ribbon accredited workplace.

WE WILL:

- Provide person-centred care that is integrated between hospital, community health, general practice, private specialists and our partners
- Deliver high quality, safe and culturally appropriate health services for the residents of the Local Health District and for NSW residents through a network of tertiary referral and district level hospitals and community health centres
- Provide world-leading clinical care within hospitals that are fit for purpose, consistent with the *NSW State Health Plan Towards 2021* and the Premier's Priorities
- Continue to nurture consumer engagement and participation
- Complete the important Stage 1 of the Nepean Redevelopment
- Continue to advocate for Nepean Redevelopment Stage 2 to support the provision of world-class clinical care in hospitals that are fit for purpose
- Continue to advocate for a new, single Hospital in the Blue Mountains with a clinical school to expand clinical experience options to develop the next cohort of clinical leaders
- Deliver new and expanded Community Health Centres at Penrith and at Orchard Hills and St Clair (HealthOne initiatives) to support integrated care from acute facility, through community-based care and return to primary care
- Continue to advocate for new Community Health Centres in Penrith and Blue Mountains LGAs, to meet the needs of the growing population and provide joined up services as close to the patient's home as practicable.

01.3 Therepeutic Landscapes

Ellie Bryne writes on the concept of the therapeutic landscape in her 2012 thesis Visual Data in Qualitative Research: The Contribution Of Photography To Understanding Mental Health Hospital Environments, discerning from her research, that it is one of the two key components of care – the other being activities. She quotes Christine Milligan et al. (2004) to define the term: "The concept of the 'therapeutic landscape' is … concerned with a holistic, socioecological model of health that focuses on those complex interactions that include the physical, mental, emotional, spiritual, societal and environmental." And

as such, the concept can be viewed as not only the physical structures and spaces, but also the interactions between people, their surroundings, and cultural understandings. Through this lens, Bryne offers insight into the multifaceted influence spaces have on their inhabitants.

01.4 Wayfinding

Chapter one, in Wayfinding and Navigation (2015), titled Cognition for the Navigation of Complex Indoor Environments by Stephen C. Hirtle and Cristina Robles Bahm comprehensively explores historical studies and literature on the principles of indoor navigation. Some of their key insights include:

- - Navigational information learned from maps or signs was fundamentally different from the spatial knowledge gained via a walkthrough.
- - In initial exploration, visual access to spaces facilitated navigation greatly, however after multiple tours through space, individuals do not require the same visual access.
- - In one study of 'complex' spaces, in this case, a 5-story hospital, nurses failed to develop comprehensive spatial knowledge, even after two years. This was compared to naïve participants, who, when asked to memorise the layout, were able to relay much more accurate spatial knowledge.
- - 'You are Here' maps can be effective tools, however, their placement within a space eg. at the end of a wall, is critical in their effectiveness.
- - A 2009 study found that, in the context of a subway station, that individuals responded best to photographs in a fast-moving transitional environment.
- - A study on cognitive-architectural perspectives in 2007 identified entrance ways and dead ends within a conference centre as problematic for navigation.
- - A study on spatial syntax noted that naïve participants use a common space eg. an entrance hall, to navigate in what is described as a 'central- point strategy', while experts will not.

From this review, the authors synthesised a list of factors that contribute to navigational problems:

1. Visual access
2. Individual spatial ability
3. Navigation aids
4. Mental maps constructed by the user
5. Spatial learning
6. Reasoning strategies
7. Physical environment

02 CODESIGN

02.1 Codesign and Reflection on Site Visit

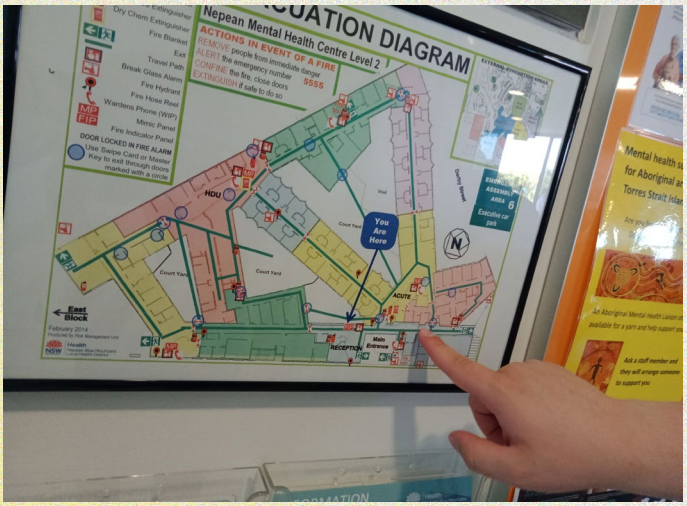
In our tour of the mental health unit at Nepean, we made several key stops, and staff on-site directed our thinking.

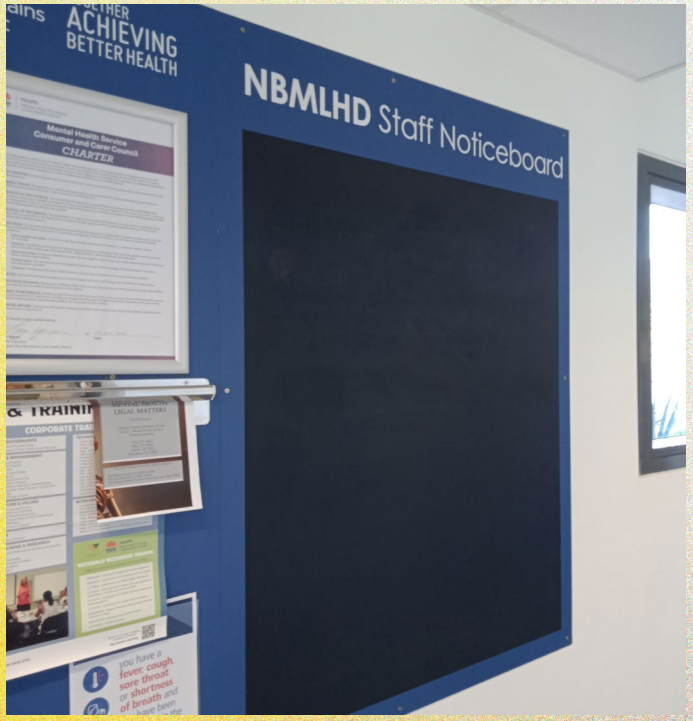
The reception space, which is heavily used by a variety of stakeholders at multiple points in time, is a critical point of engagement. It functions to direct new patients into the facility, via the new transitional space, and into the units. Signage and reception intend to direct these individuals, however their new changes concerning the transitional space, and new window in the nurses' station, illustrate that this process is not entirely successful. This is particularly important as new users have no time to familiarise themselves with the space, generating a sense of confusion that may exacerbate existing mental illness. This space is also critical for family, who similarly, may be in a state of distress, and are unfamiliar with the process and environment already. These issues are different when considering patients using the space during leave, or families and friends making return visits.

From our conversation with a peer worker, it became clear that the existing bio-medical model of care manifests itself in the environment, creating a harmful dynamic between patients and the spaces they inhabit, especially in considering naïve individuals. She described her role as one that balances power between carers and patients within the space, noting that "medicalisation" contributes to a sense of intimidation and disorientation for people unfamiliar with the unit, which as a result may feel "unsafe". She emphasised her belief in the recovery model of mental health care and recognised that the mindset of the hospital, and the building itself, was in the slow process of making that transition from a traditionally bio-medical perspective to one that sought collaboration between patients and staff.

Finally, as noted before, Australia faces a concerning shortage of nursing staff in the future, and as outlined in the hospital's goals,

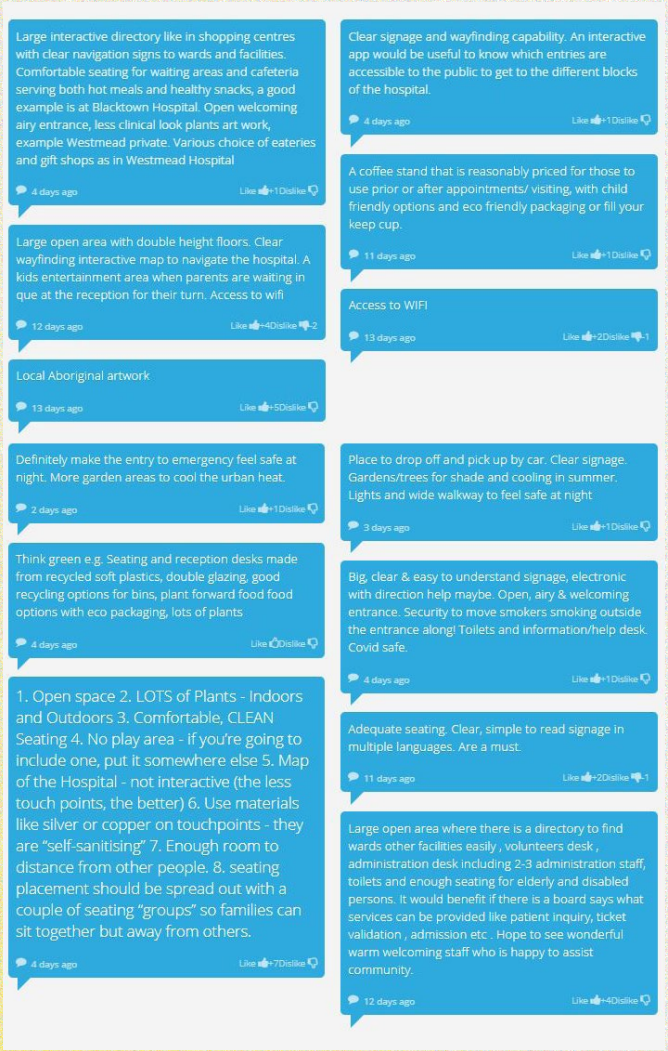
retaining talented and happy staff is a key task. While training in trauma is critical to the wellbeing of nurses according to a peer worker, the hospital spaces themselves should seek to support those individuals who deal with complex and difficult tasks daily. There are individuals on site, with bright red shirts saying, "ask me if you need help," for the specific task of assisting new nurses to find their feet.

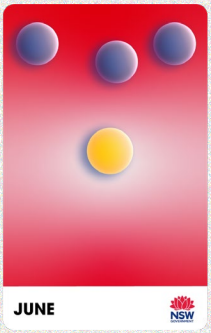


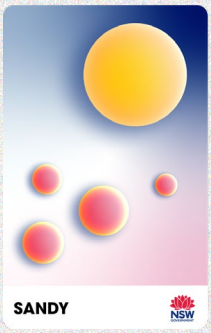


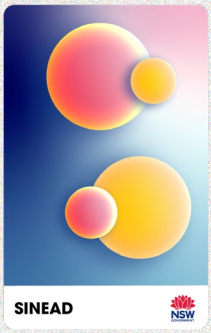
02.2 Existing Codesign

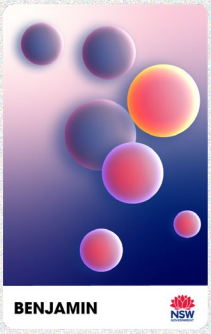
Our codesigning capability is limited in its current form, so any additional sources of information through a codesign lens is certainly useful. Discussion with peer workers was certainly interesting in understanding their role across care design. The other example of this is an online forum by NSW Health that encourages public participation concerning the Nepean development. Here online visitors are asked "How can we make the new Front of House (reception area and main entrance) at Nepean Hospital more welcoming and convenient for you?" It offers invaluable insight.











03 FINAL DESIGN EVOLUTION