University of Sunderland

Policy Brief

Affiliations

The research for this evaluation report was created through collaboration and was conducted through liaison between, Universities of Sunderland, and Durham, and with participation of patients, hospital staff, families, and a health trust in the Northeast of UK.

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Summary:

This evaluation explored the impact of bringing humanizing influences into Critical Care in hospitals through the power of the natural environment. It was focussed on one garden in one hospital in the Northeast UK. The designer and artist Dr Laura Johnston created a healing garden at this hospital. Dr Sheila Quaid at University of Sunderland was the Principal Investigator. She conducted semi structured interviews with clinicians, staff, and families to elicit how people feel the garden has impacted their sense of wellbeing. This policy briefing presents interim findings, which will be updated when further evaluation with current occupancy patient takes place in 2024. This will then be continued with further qualitative study findings and ongoing evaluation of the garden.

Background

Opened in August 2022, the critical care garden at the hospital aimed to provide patients some respite from the clinical environment, offering a place to reconnect with loved ones and the outside world. Designer and artist Dr Laura Johnston designed the space, with her expertise in sculpture and the study of light at the heart of its design. In the time since the installation of the garden it has been used for an 18th birthday party, a wedding, a party to celebrate the one-year anniversary of the garden, and a Christmas gathering and celebration with staff and colleagues. It was profoundly moving and impactful in the lives of ICU patients and their friends, partners, and families to mark these significant events in this beautiful and tranquil space.

This initial evaluation reveals the background and experiences of all those who made this garden possible and elicited from former patients their feelings/ wellbeing and general health benefits of the garden. The sample was made up of patients, staff, visitors, and families at the hospital. This qualitative study will form the major foundation for the evaluation of this garden project. This was an interdisciplinary project which will produce important insights for patient benefit, specifically for patients in critical care. Findings also reveal the experiences of their hospital staff, their families, and their mental and physical wellbeing whilst undergoing hospital treatment. This project will further knowledge exchange with relevant stakeholders. It will also enable greater understanding of the health and wellbeing benefits to patients of an evidence-based approach to design.

Primary Objectives:

Provide a space that significantly contrasts with the artificial environment of ICU and reconnect patients with a more organic and natural setting.

Improve some of the physiological impacts of being on the ICU, including sensory deprivation, sleep issues, delirium etc.

Secondary objectives

Provide staff with a space to feel calm, to recharge, take a moment to recuperate during their shift and socialise with other staff.

Method

The evaluation employed a qualitative methodology, specifically, in-depth interviews with three distinct groups, namely stakeholders, practitioners, and former patients. This methodology allowed both detailed exploration of key themes, along with a flexible approach allowing participants to lead the discussion and uncover insight not initially anticipated by the research team. Most fundamental to the evaluation was the adoption of an iterative approach, in which each distinct research phase informed the subsequent phase, building an informed evidence base across the whole sample. A range of occupations were involved in this research and to protect participant confidentiality, quotes will not be attributed to specific people or note their occupation. The artist/designer responsible for the development and design of the garden was interviewed and will be referred to as part of the wider stakeholder group, apart from in the section titled: designer and artist Dr Laura Johnston reflection on the garden.

Findings

1. The ICU environment is wholly distinct from other wards, this is acknowledged in a clinical sense because of the treatment required, an emotional sense for patients, staff, and families alike. But also, the experience of ICU for patients is one completely incomparable with other wards - it is for this reason that it must be treated differently in terms of facilitating recovery. It's not a 'one size fits all approach'.

2. Upon waking up on ICU, it's common for patients to not know where they are or how they got there. Therefore, the experience starts in an extremely distressing way. Following this, patients experience severe symptoms unrelated to the main cause of their presence in ICU, but related to the fact they are being treated there: sensory deprivation, delirium, trouble with sleep etc.

3. Time spent in the garden prompted memory of normality and served to 'remind' patients that life exists outside of the hospital.

4. Hospital staff and patients alike, agreed that the garden gently reintroduces patients back into socialising, having agency over themselves, provides a space where they do not 'need' nurses to do everything for them, where they get to experience privacy for the first time in weeks or months.

5. Participants reported an increased sense of motivation to recover following visits to the garden. Nurses and hospital staff reported clear increases in emotional wellbeing and ability to care for/build rapport with patients.

6. In addition to a design-led approach, the collaborative effort between those responsible for the garden's design and those working in the hospital with experience of critical care was significant in ensuring the space was fit for purpose.

7. Practitioners felt the garden had clearly been designed with clear thoughtfulness and consideration to the critical care experience, drawing on examples of distinct areas of the garden, areas of light and shade, along with the overall flow of the space.

8. The decision to take patients to the garden was firstly dependent on staff availability, and secondly whether the patient will be able to spend enough time in the garden to positively outweigh the organisation needed to get them there. An hour was generally considered the upper limit for a garden visit. This represents a new clinical decision in the Intensive care setting.

9. Highly significant biological benefit, was the observed impact of being outside to experience the cyclical nature of night and day i.e., assisting the circadian rhythm so it can be normalised, going some way to counter the artificial environment of the ward.

10. Practitioners especially, consistently reflected on the garden as a therapeutic space, a space of healing both emotionally and physically. They expected this to have a long-term benefit for patients, via the garden mitigating some of the psychological effects of the ward and reframing the experience even in only a small way, from unfamiliar, overwhelming, and chaotic.

11. Evidence collated suggests that primary objectives were met but secondary objectives were only partially met.

What the patients said

1. *"I was so absorbed in my environment, looking across from my bed at people on ventilators, that's what I was doing all day, I wasn't thinking about anything normal. You were very clinically involved on the ward because there were people who were very very poorly that you were looking at, the nurses were very busy. The garden was a touch of normality."*

2. *"When I was looking at other people on ventilators, I had to ask my family 'had I been like that?' and they said yes. It wasn't just about me it was about my family too. We've all been on a very long, hard, emotional journey and the garden benefitted all of us really."*

3. *"I was in intensive care for about five days I think, and then the consultant came and said she felt I would benefit from going into the garden. It was a beautiful warm sunny day, my family were visiting, my husband and daughter were there, and my son was outside waiting to swap over to see me. The nurses said they would go down with me because I was still on a drip and oxygen therapy. They wheeled me down in my bed with all the equipment, and I would say from that moment, going into the garden, it was a turning point of my improvement. It was nice to feel the fresh air, feel normality and see the beautiful plants that were in the garden."*

4. *"It brought a bit of colour back to my face as well [being outside] and made me think, there is life still going on."*

5. *"I class that [going to the garden] as the turning point in my improvement, and my moving on. It was the next day the moved me from intensive care down onto one of the other wards, to start getting rehabilitated."*

6. *"It gave me hope and determination that I can do this, I can move on, get better."*

7. *"My family were in full agreement [of the impact] and that's why I have agreed to talk to you today, because it was beneficial to my family as well. They also feel the same way, that I picked up after my time in the garden – it was lovely."*

8. *"I thought it was so peaceful and beautiful, away from the clinical environment, it was so lovely."*

9. *"My family laughed and smiled in the garden."*

Recommendations for future Success

Moving away from positioning the garden as a 'nice to have' and towards something that has clear and significant implications on recovery and subsequently meaning a small short-term investment can have long-term financial impacts for the NHS.

Buy-in from all levels within the ICU environment: Better communication of the benefits to move reorientation and rehabilitation using the garden into something considered priority.

Ultimately, while practical barriers to usage will always be present (such as practitioner time/capacity to facilitate usage), having those within the ICU environment at all levels be committed to this idea will help mitigate some of those barriers and provide justification for usage/expansion.

At the time of interviews staff were overstretched and it's sometimes easier to simply provide care on the ward, with a universal understanding of the benefits this should bring to a culture of using the garden being preference and priority.

Addressing systemic issues:

This garden only came to fruition because of a select group of very determined individuals. For the garden to be created formal channels (such as applying for distinct space or funding) were deliberately avoided. Instead, a disused hospital space was used (which thankfully turned out to meet the needs) and the garden relied on donations.

While the approach was both admirable and ultimately successful, this approach is unlikely to be sustainable in the event gardens are rolled out elsewhere. There won't always be an empty space waiting to be salvaged. Nor will there always be people around to donate, meaning the quality of these gardens will vary greatly and thus, have varying degrees of success.

For expansion to be successful, there needs to be openness from senior NHS stakeholders to allow those involved with the creation of such gardens to state their case and follow formal channels.

The ability to apply for funding through formal channels will also ensure any gardens are as effective as possible. While the designer was ultimately happy with the garden and saw the success of it, control over certain elements was removed due to financial constraints, and certain elements were ultimately not included because of such constraints.

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