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Realising Person-Centredness: Transitioning to a Clustered Domestic Model of Aged Residential Care for People With and Without Dementia

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ABSTRACT

Introduction: Many older people who cannot live independently live in aged residential care facilities to obtain support with social and healthcare needs. Despite old age being a precious time for people to live well, many facility residents have limited access to activities that promote their well-being and connectedness. In New Zealand, one provider of aged residential care developed a village inspired by de Hogeweyk in the Netherlands, where resident engagement in valued activities supports continuing lifelong identities.

Methods: The study aimed to explain the transition from a traditional Aged Residential Care facility to a clustered domestic model of care. A critical realist theoretical perspective underpinned case study research. Data comprised transcripts of interviews with key informants, facility staff, residents and their families, records of observation of residents' daily lives, organisational documents, photographs and the first author's study journal.

Results: The intersection of philosophical workplace change to support delivery of person-centred care and a change in the physical environment enabled realisation of the organisational vision of residents living normal lives.

Conclusion: Policy makers and practitioners must be aware that while a domestic-scale environment provides cues to normal living, staff who know residents and what is important to them enable participation in community and valued activities.

Implications for Practice: Innovative living arrangements are a synthesis of philosophical aspirations, architectural and design vision, dedicated leadership and committed teamwork.

1 | Introduction

Aged Residential Care (ARC) is a supported living environment for people, mostly over the age of 65, who cannot live independently. The demand for ARC services is increasing due to population ageing internationally and in New Zealand (NZ). Older people in NZ are at higher risk of entering ARC facilities than their international peers (Broad et al. 2015). A recent NZ survey found that 40,941 people live in ARC facilities. Of these facilities, 49% are part of a major group, 50% are either part of minor groups or individually owned and 1% are government-owned via local health districts (New Zealand Aged Care Association and Business and Economic Research Limited 2022). In 2019, it was estimated that over half of the people residing in NZ ARC facilities had cognitive impairments, including dementia (Ernst and Young 2019). There are four levels of care in ARC in NZ, assessed for and organised around people's physical and cognitive capabilities, rather than other considerations such as social needs. This article focuses on three levels of care: rest home care for people who need assistance with activities of daily living;

Summary

What Does This Research Add to Existing Knowledge in Gerontology?

- Workplace culture change is an essential part of transitioning from a traditional to a clustered domestic model of care in aged residential care.
- Normalised living in Aged Residential care occurs at the intersection of person-centred care and recognisable domestic environments.

What Are the Implications of This New Knowledge for Nursing Care for and With Older Adults?

- Holistic care encompasses all aspects of the person, including their valued lifelong identities.
- Staff must be consistently assigned to residents to enable them to develop the understandings required to support residents to remain connected with people and activities that are important to them.

How Could the Findings Be Used to Influence Practice, Education, Research, and Policy?

- The criteria for clustering people together in aged residential care requires rethinking by policymakers to enable residents to live well.
- To support holistic well-being dedicated staff members are required to organise resident activities that are purely for pleasure.
- Further research using a large national dataset to describe resident quality of care and quality of life outcomes in facilities utilising the clustered domestic model of care is needed.

hospital-level care, for people with complex healthcare needs; and specialist dementia care for people who require a secure environment. Not all people with dementia who live in ARC require a secure environment.

There are two predominant models of care: the traditional model, with a biomedical focus and the biopsychosocial social model, with a humanistic focus on care (Ostaszkiewicz, Dunning, and Streat 2018). The clustered domestic model of care is an example of a biopsychosocial approach (Dyer et al. 2018). In that model, residents live in small groups in domestic-scale environments and can engage in familiar household activities, supported by familiar staff.

The end of a lease on an existing facility, Whare Aroha CARE, prompted the care model transition of the aged residential care provider at the centre of this study, providing the opportunity to shift from a traditional model of care to a clustered domestic model. The managers were open to innovative living arrangements because they were relatively new to the facility and ARC services. They began the transition to a new care model by purposefully leading organisational culture change, shifting from institutional and staff priorities to implementing person-centred care (Shannon 2021).

The rhetoric of person-centred care is evident in government strategy and policies in NZ and internationally (Ministry of Health 2019; World Health Organisation 2017), but due to multiple constraints is typically only partially realised in practice. Person-centred care is a humanistic concept that, at its core, involves respect for the innate value of all human beings (Brooker and Latham 2015). In social relationships, recognition of personhood by others is implicit in person-centredness, highlighting the need to support staff caring for people with physical and/or cognitive disabilities (McCance and McCormack 2017). When an ARC facility shifts from a biomedical model of care to person-centred care, a culture change process is inherent.

Shifting to person-centred care delivery is an international trend in ARC facilities that began in the United States in the 1990s. The culture change movement, aiming to improve resident quality of life, continues to influence policy and practice internationally (Fazio et al. 2018; Standards New Zealand 2021). In the current study, the facility's change to person-centred care led to the development of a facility driven by the vision of residents living normal lives. In the new facility, The CARE Village, inspired by de Hogeweyk in the Netherlands, residents would live with like-minded peers, not those requiring the same care level. In de Hogeweyk, an ARC facility built to resemble a small town, residents, all of whom have severe dementia, live in small groups with like-minded peers, with similar earlier life experiences and interests, they contribute to the running of their households and engage in hobbies, maintaining lifelong identities (Van Amerongen- Heijer 2015). Not all residents in the NZ facility would have dementia, and those with dementia would be integrated within the village, distinct from De Hogeweyk. The study aimed to explain the process and outcomes of transitioning from a traditional ARC facility to an innovative model. This article explains the changes in workplace culture and the physical environment and how they intersect to influence residents' daily life. As explained elsewhere (Shannon and Neville 2023), the transition was accomplished with a collaborative governance network.

2 | Materials and Methods

2.1 | Study Context

The Care Village is on a 1.3-ha (3.2 acres) site, adjacent to a reserve on the lakeshore; residents can walk to the lakefront and enjoy the view from park benches. The perimeter is secure, with one point of access, via double doors in the administration block. Residents who require secure care wear an electronic device signalling the doors to lock when they are nearby. All residents are integrated within the facility, enabled by that feature. The physical environment at The CARE Village enables staff to support residents to maximise their abilities and live according to what matters to them. Following the transition from the traditional facility, residents now live in small households with recognisable domestic spaces enabling continued engagement in activities that support identity. Residents are housed according to characteristics of their earlier lives, meaning they are likely to live with people with shared interests and values. Consistently assigned staff,

known as Home Leads, run each house, assisted by other staff according to residents' needs.

2.2 | Study Design

We used case study research methodology underpinned by a critical realist theoretical perspective, enabling the identification of generative mechanisms that act beneath the surface of observable reality to cause events. Identifying generative mechanisms enables the researcher to explain social phenomena (Bhaskar 2013). Yin's explanatory case study (Yin 2014) aligns with critical realism, enabling the collection of a range of types of study data and begins with theoretical propositions.

2.3 | Ethics Statement

We obtained ethical approvals, detailed in the institutional review board statement. We signed a locality agreement with the ARC provider. Ethical considerations about inclusion of facility residents with dementia as research participants concerned balancing the risk of coercion with the right of people to be consulted about matters that concern them. Participants who were not legally able to make their own decisions were supported in decision-making by their legal proxy decision maker (Shannon, Montayre, and Neville 2021).

2.4 | Recruitment and Data Collection

The facility receptionist provided potential participants with an information sheet and collected the names of those interested in participating, whom the first author then contacted. Data collection with residents and facility staff occurred at the ARC facilities before and after the transition, and with key informants and family members in their offices or homes. The study participants were selected because they had differing perspectives and together enabled an understanding of the transition. Yin (2014) recommends including documents as part of case study data. Data comprised interview transcripts, organisational documents, photographs of each facility, the first author's project journal and observational records of resident daily life, using an observation tool drawing from Dementia Care Mapping, a validated observational tool (Surr et al. 2016) repeatedly utilised to observe quality of life and care for people with dementia (Brooker 2005). We interviewed key informants once and most other participants twice; before transitioning to the new facility and at least 4 months after moving.

The beginning theoretical propositions for the study guided questions in the in-depth, semi-structured interviews. We amended the questions during data collection as data analysis identified areas where more information was needed to refine the theoretical propositions (Danermark, Ekström, and Karlsson 2019). We offered the choice of a standard or go-along interview to participants who were facility residents. During a go-along interview, the researcher accompanies the participant on their daily activities with the questions woven into the conversation about what they are doing (Kusenbach 2011). Participant interviews lasted from 11 min to beyond 2 h.

2.5 | Analysis

We used several processes for data analysis, aligned with critical realist theoretical perspective and case study methodology, allowing us to develop an explanation of the process and outcomes of the transition. NVivo 11 (QSR 2016) computer-assisted qualitative data analysis system (CAQDAS) was used to manage data and assist with analysis. We developed codes and themes from the data using the procedures described by Miles, Huberman, and Saldana (2014). In the first stage of coding, similar pieces of data were grouped together with the code names being derived from the beginning theoretical propositions for the study, the participants' words or from relevant action words. Following the development of initial codes, these were grouped together to form themes. We used data display tools (Miles, Huberman, and Saldana 2014) to aid understanding of the complex series of events and the roles of and relationships between organisations. Finally, we identified the generative mechanisms responsible for the transitions' events using a retroduction process, which involves looking backwards to identify what has made events occur (Danermark, Ekström, and Karlsson 2019). Extant theory, along with themes developed from the data are used to identify generative mechanisms, for example, the generative mechanism, *the managers changed the workplace culture to enable person-centred care* was developed using the data and the person-centred practice framework, developed by McCance and McCormack (2017).

3 | Results

3.1 | Participants

Participants included 11 facility residents and seven family members, 17 staff and seven key informants from the facility management team and regulatory and funding organisations. Participant demographic characteristics are presented in Table 1, below.

3.2 | Overview of the Key Findings

We identified two generative mechanisms explaining the transition process from the old to the new facility. The first generative mechanism, *the managers changed the culture of the workplace to enable person-centred care*, explains the work undertaken to shift the workplace culture at Whare Aroha CARE from a focus on tasks and staff priorities to a focus on residents' personhood. Three themes supported the development of the generative mechanism. The first, *culture change*, explains the workplace culture. The second, *like family*, explains the relationships between people at Whare Aroha CARE. The third, *special feeling*, explains the atmosphere at Whare Aroha CARE following the change in workplace culture.

The second generative mechanism: *The managers created a physical environment to support the vision of people living normal lives* explains the transformation of the physical environment. Two themes supported the development of the generative mechanism. The first, *working with architects and builders*, explains the importance of collaborating with

TABLE 1 | Participant demographic information (Shannon 2021, 314–315).

Participant number	Ethnicity	Age range	Role
1	NZ European/Māori	50–59	Staff member
2	Indian	30–39	Staff member
3	NZ European	20–29	Staff member
4	Indian/Fijian	20–29	Staff member
5	Māori/French/Irish	50–59	Staff member
6	NZ European/Māori	40–49	Staff member
7	English	80–89	Resident
8	NZ European	60–69	Family member
9	English	80–89	Family member
10	Filipino	40–49	Staff member
11	NZ European/Māori	60–69	Staff member
12	NZ European	80–89	Resident
13	NZ European/Māori	50–59	Resident
14	English	80–89	Resident
15	NZ European	90–99	Resident
16	Māori	50–59	Staff member
17	NZ European	80–89	Resident
18	Māori	60–69	Resident
19	NZ European	40–49	Staff member
20	Māori	60–69	Family member
21	Māori	40–49	Family member
22	NZ European	80–89	Family member
23	NZ European	70–79	Resident
24	NZ European	80–89	Resident
25	NZ European	80–89	Resident
26	NZ European	40–49	Family member
27	NZ European	60–69	Staff member
28	NZ European/ Māori	50–59	Key informant
29	NZ European	90–99	Resident
30	Indian	50–59	Staff member
31	NZ European	50–59	Family member
32	NZ European	30–39	Staff member
33	Māori	40–49	Staff member
34	NZ European/Dutch/Scottish	40–49	Key informant
35	NZ European	60–69	Key informant
36	NZ European	60–69	Staff member
37	NZ European	50–59	Key informant
38	NZ European	50–59	Key informant

(Continues)

TABLE 1 | (Continued)

Participant number	Ethnicity	Age range	Role
39	Māori	50–59	Staff member
40	NZ European	50–59	Staff member
41	NZ European	60–69	Key informant
42	NZ European	50–59	Key informant

contractors who understood the purpose of the new build. The second, *the favourable surrounding*, describes the physical environments at the two facilities. Additionally, three themes explain the resident outcomes enabled by changing the workplace culture and the physical environment. The first is *life's pleasures and meaning of life*, exploring what matters to residents. The second, *compatible cohabiting*, explains resident relationships within their homes, while the third, *living a normal life* describes resident life in The CARE Village. What follows are the study results beginning with the generative mechanisms that made the transition to an innovative model of ARC possible.

3.3 | Generative Mechanism: The Managers Changed the Culture of the Workplace to Enable Person-Centred Care

The generative mechanism: *The managers changed the culture of the workplace to enable person-centred care* was identified using McCance and McCormack's (2017) person-centred practice framework and themes developed during data analysis. The themes contributing to the development of this generative mechanism are *culture change, like family* and *special feeling*.

3.4 | Theme: Culture Change

Changing the workplace culture began when managers new to the ARC sector and the facility commenced at Whare Aroha CARE and witnessed an organisational culture where the focus of care work was staff convenience and priorities, rather than being on residents. Not all staff supported the changes. The key informant in the quote below used the notion of a waka metaphorically. A waka is an Indigenous canoe that requires masterful, synchronised teamwork to navigate with accuracy:

> Some of the staff found it difficult to accept a different way of working, that the resident was at the center, it was about what was good for them not what was good for staff. It was a little bit like you're either on the waka [boat] or you're not, if you're not on the waka you have to get off because you just create a situation where the waka is going nowhere, some people are trying to paddle forward, but you're paddling backwards, so in fact everything is staying still, so we had to make some really hard decisions and some people had to go.
>
> (Participant 28, key informant) (Shannon 2021, 142)

As part of the shift to person-centred care, staff who did not accept the need for change left the organisation and recruitment altered:

> We changed and started employing people who cared rather than people with care experience, so we changed the culture on two levels. Those people had been there a long time and were never going to change left, and we brought in people we could train.
>
> (Participant 35, key informant) (Shannon 2021, 142)

Leaders demonstrated they valued staff by gradually increasing their wages, beyond the minimum. Additionally, staff expertise began to be recognised.

3.5 | Theme: Like Family

Many participants, including staff, described each other as family members. A staff member discusses her perception in the quote below:

> Many of our residents don't have family, so we become their family. They feel comfortable with us, they know us.
>
> (Participant 6, staff member, pre-transition interview)

A family member's perception of the staff being like family influenced her decision about whether her husband should move to the new facility:

> We went to see this other place, but I didn't like it, my son was OK with it, but he doesn't see his dad as often as I do, and I thought it's like a 5-star hotel, but I didn't get that feeling that the staff were like the staff here. They are family, and he would miss that. Because everybody to me, they are like family.
>
> (Participant 9, family member, pre-transition interview) (Shannon 2021, 145)

In addition to feeling like staff and residents are like family, participants noted a special feeling at Whare Aroha CARE.

3.6 | Theme: Special Feeling

Participants described a special feeling at Whare Aroha CARE. A key informant notes the link between the culture change and the special feeling. Below, a key informant explains:

> There is a special feeling. What creates it? People create it, don't they? They create it, and all we have done is tried to value and love people. Because that is what it is, it's love.
>
> (Participant 28, key informant) (Shannon 2021, 146)

Many people in the area identify as Māori, Participant five interprets the feeling using her Māori world view:

> The minute I walked in here, I thought, it feels great. You can feel the wairua [spirit, soul], the aroha [love, concern, compassion].
>
> (Participant 4, staff member, pre-transition interview) (Shannon 2021, 146)

Workplace culture change contributed to what people describe as a special feeling. The organisation supports staff to deliver care encompassing technical competence and humanistic values.

3.7 | Generative Mechanism: The Managers Created a Physical Environment to Support the Vision of People Living Normal Lives

The new management team were aware of the impending move, and although the workplace culture was improved, residents were still living in an institutional setting. The decision to build a new facility inspired by de Hogeweyk led to the need to build a physical environment. *The managers created a physical environment to support the vision of people living normal lives*, is the second generative mechanism that enabled a change in how residents live. The themes contributing to developing the generative mechanism are *working with architects and builders* and *the favourable surrounding*.

3.8 | Theme: Working With Architects and Builders

The management team of Whare Aroha CARE attended a dementia design workshop by an organisation renowned for home-like facilities. There they were introduced to the Hogeweyk concept for people with dementia incorporating the concept of living with peers who shared common assumptions about lifestyle. The workshop convenors stressed the importance of working with architects who understood how to design dementia-friendly environments and an introduction to an architect who had previously attended a workshop was facilitated:

> When we met him, straight away there was a rapport. The Hogeweyk were running a masterclass in Sydney so the architects came so that they could hear what the ladies were talking about and get it, and then they had an opportunity to directly ask questions because everything they'd heard had come from us, apart from their research.
>
> (Participant 28, key informant)

It was important to management of Whare Aroha CARE to engage a construction firm who similarly understood the project:

> One of the reasons that we chose [the contractor] to partner with us, was when they came to present their proposal, they had sat their team down, and watched the documentary about De Hogeweyk. They had talked about what that meant.
>
> (Participant 28, key informant) (Shannon 2021, 163)

Management, architects and builders collaborated to develop a facility that supported the vision of people living normal lives.

3.9 | Theme: The Favourable Surrounding

Despite the work done to enable the delivery of person-centred care, the institutional physical environment at Whare Aroha CARE was a barrier to resident enjoyment of daily activities. The building was two-storeyed, with those with the highest care needs living upstairs, without outdoor access. Residents who required secure dementia care were segregated in a unit with a separate garden and those with low-care needs were free to enjoy the ground floor and garden. A family member described the institutional environment of the rest home wing of the building:

> It's an older style building, and all residents have a separate room. There's a lovely outdoor garden area, but it is very much like a standard rest home. The nurses do a lot, the cooks do a lot, they do a lot of outings there which give the residents a chance to go out and experience the world, because it is in an older building and they're aware of that.
>
> (Participant 26, family member, pre-transition interview)

In contrast, the new facility was designed to support normalisation of resident daily life. There are 13 houses on the site, each with six or seven bedrooms. Congruent with contemporary New Zealand architecture, the kitchen, living and dining areas are in an open-plan space with outdoor access via a sliding glass door. There are two bathrooms and a laundry where the household linen and resident clothing is washed by staff and/or residents. Meals are prepared in the kitchens of the houses by staff and/or residents. A staff member describes the environment, below, highlighting the neighbourliness and connection:

> This is a village, and the residents can walk around. It is a nice environment; you can see the residents going to the lake front and sitting there. Here you have your neighbours, it's a nice, peaceful village environment.
>
> (Participant 10, staff member, post-transition interview)

As noted by a resident, below, a kaumatua (Māori elder) blessed the site before construction began, an important cultural practice for Māori, contributing to culturally appropriate care:

> This is brand new, this whole place has all been blessed and everything, it's important to me because being a Māori that's how we were brought up, be aware of things out there, if you feel things aren't right bless yourself with the water.
>
> (Participant 13, resident, post-transition interview)

3.10 | The Effects of the Transition on the Lives of Residents of the CARE Village

Three themes in the study data are relevant to the transition's effects on residents' lives. They are *living a normal life, life's pleasures and meaning of life and compatible cohabiting* (Shannon 2021).

3.11 | Theme: Living a Normal Life

In The CARE Village, residents require support for activities of daily living. Staff are assigned to the same residents and know them well; therefore, they can support resident participation in meaningful aspects of life. The recognisably domestic environment combined with person-centred staff support enables resident participation in normal daily living. These activities include Māori cultural activities organised by Māori staff, cooking, shopping, cleaning, caring for peers, the arts, exercise and laundry, a contrast with the prior setting:

> Being in here is not that normal. We stand a lot in the hallway and talk; we can watch things on TV.
>
> (Participant 23, resident, pre-transition interview) (Shannon 2021, 208)

A daughter describes how her mother used to contribute to the running of the household when they lived together. In the quote below, she contrasts her mother's role in the household with her lack of purpose after she moved into the old facility:

> In the time when she lived with us, she was always responsible for doing the washing. She just loved doing the washing, hanging it out, folding it. Now there is a sense of her not knowing what she should be doing. You go in there sometimes and just find her kind of sitting, just not really sure where she should be.
>
> (Participant 26, family member, pre-transition interview) (Shannon 2021, 208)

The staff in The CARE Village who know the mother well, identified that she would like to be responsible for the household laundry and enabled this to happen. Her daughter illustrates the importance of the laundry to her mother's identity in the quote below:

> She definitely likes the feeling that she owns that room. She shows it to me every time I go there, and "this is the room where I do this, and I line it all up in little piles."
>
> (Participant 26, family member, post-transition interview) (Shannon 2021, 208)

Lifestyle influences what is important to people in their daily lives. In alignment with the Hogeweyk care concept, residents in The CARE Village live with peers who have had a similar lifestyle. We now discuss the impact of living with peers in lifestyle groups.

3.12 | Theme: Compatible Cohabiting

There are four lifestyles in The CARE Village; classical, cultural, simple living and 'middle' New Zealand. Residents are allocated households that are decorated and managed in alignment with their previous lifestyles. Similar interests enable friendships to be fostered, as noted by a resident below, describing her husband's friendship with another resident:

> He has also got a new male friend now, and they go, they are gone.
>
> (Participant 25, resident, post-transition interview) (Shannon 2021, 212)

While most households selected for residents are the right choice, some changes were made after the transition. Because there are 13 houses in The CARE Village staff are easily able to move residents to another house if there are incompatibilities, as noted by a key informant:

> When I took that lady out, it really changed that house, and it changed her as well. She is less anxious, she is in the right house, and she has got the right mix of ladies.
>
> (Participant 35, key informant) (Shannon 2021, 212)

If the lifestyle selected for a resident seems to not suit the resident, further discussion with the resident, family or friends is needed.

3.13 | Theme: Life's Pleasures and Meaning of Life

NZ ARC facility operators must provide activities for residents, under the terms of their contract with Te Whatu Ora Health New Zealand (TAS, 2019). Prior the transition to The CARE Village there were many organised activities, but they often did not reflect the lifelong preferences of residents.

In The CARE Village, daily life provides many opportunities for residents to be active and involved in running their households. They also have leisure time to pursue hobbies, as described below:

> I'll knit, or I'll take my walker and go for a little walk around and sit on a seat and look over the lake, the other day I had a nice chat with a lady who was walking her dog. Sometimes I come and play games on the computer. I am writing my life story on it. There

> is one grandchild in particular who is interested. Sometimes I write poems. I do cooking as well.
>
> (Participant 29, resident, post-transition interview) (Shannon 2021, 215)

Initially, no formal activities were coordinated, and Home Leads organised resident activities, as noted by Participant 16, below, regarding Māori cultural activities.

> We are singing the song Whakaaria Mai [How Great Thou Art] at the moment. Then we are learning an opening karakia [prayer] for meetings. The ones that know the reo [language, word], there are a few here, but they don't get to hear it, so we've tried to incorporate it in the weekly activities. Their eyes light up when they hear it, especially the old kuia [older women]. That's what makes this job wonderful, to see the glint in their eyes when they remember things.
>
> (Participant 16, staff member, post-transition interview) (Shannon 2021, 197)

However, it rapidly became apparent the workload was unsustainable: Participant 32 describes the situation that led to the reinstatement of dedicated activities staff:

> At the old facility we had some staff called Lifestyle Coordinators who organised activities. There is no such role in the new setting, it was initially thought that would also be the responsibility of the Home Lead. I think it's becoming obvious now that the Home Lead is busy enough running the home, so there is a role there for someone to facilitate the activities.
>
> (Participant 32, staff member, post-transition interview)

While the original plan of having daily life take the place of organised activities was unsuccessful, an adaptation has enabled residents to participate in usual household activities, aligned with their lifelong identities and enjoy fun activities. Hospitality staff coordinate various clubs catering to resident interests, including knitting, poetry, games, a men's shed, fitness and waiata (Māori songs) singing.

4 | Discussion

Consumer expectations and ethical considerations about older adults' personhood are driving innovations in service delivery. We have explained the transition from a traditional to an innovative model of care in ARC, beginning with changing to a workplace culture. Visionary leaders, naïve to the taken-for-granted assumptions about how to deliver ARC services drove the change. In alignment with previous studies (Brodtkorb, Skaar, and Slettebø 2019), the leadership style utilised to drive innovation modelled valuing all persons including staff. There was an organisational shift towards delivering person-centred care, inspired by the desire to improve daily life for facility residents, similar to motivations for ARC culture change noted by other researchers (Slettebø, Skaar, and Brodtkorb 2021). However, residents were still living in a building not purposely built. Architectural features compromised person-centred care. The lease termination allowed the development of a physical environment supporting resident participation in meaningful activities that affirmed lifelong identities.

We demonstrate that residents can live life in ways that matter to them when staff enact a philosophy of person-centred care in a home-like environment, consistent with valuing the individual, and element of person-centredness described by Brooker and Latham (2015). The need for recognisably domestic environments to support ARC residents with dementia is well-documented (Calkins 2018). In alignment with previous authors (Hermer et al. 2017), our findings demonstrate the benefits of person-centred care for ARC residents delivered in a supportive physical environment. We have explained how residents have been supported by staff who know them well to participate in usual daily life in The CARE Village. Because the houses are all single storey and have easy access to a pleasant and inviting outdoor environment, residents can access the outdoors independently or with the support of staff. An Australian study found residents in facilities utilising a clustered domestic model of care had greater frequency of going outdoors than those living in traditional facilities; however, many needed staff support. Residents who participated in the Australian study valued the ability to access outdoor spaces and those who went outdoors daily experienced better quality of life than those who did not (Dyer et al. 2019).

For many people enjoyable activities connect them to their true selves, including culture and ancestors. Consistent with recommendations from a recent review about culturally appropriate care for older indigenous people (Brooks et al. 2022), we note Māori staff organise cultural activities to connect Māori residents with their cultural identities. Connection to the true self, including the quality of relationships, and engagement in pursuits supports eudemonic well-being for people living in ARC facilities (Dewitte et al. 2021). The concept of eudemonic well-being is related to meaning in life, and to people having the opportunity to reach their human potential (Vittersø 2016). Like the work of Pöllänen and Weissmann-Hanski (2020), we demonstrated that being supported to engage in handcrafts contributed to the well-being of study participants.

The experience of pleasure contributes to hedonic well-being or life satisfaction. Contributors to hedonic well-being include relationships, health, standard of living and leisure (Dewitte et al. 2021). It is particularly important for older people, conscious of their mortality, to engage in pursuits purely for pleasure. The enjoyment of pleasurable activities has health and intrinsic benefits for the individual (Stephens and Breheny 2018). Without staff to specifically organise leisure activities for residents this important aspect of life can be forgotten in the busyness of practical day-to-day activities.

5 | Conclusion

Continuation of lifelong identities via engagement with like-minded peers in valued activities occurs at the intersection of a supportive physical environment and person-centred care. Living

a normal life in a domestic environment affords opportunities to participate in activities that contribute to well-being. To support holistic well-being dedicated staff members are required to organise activities that are purely for pleasure. This study highlights that it is not enough for staff to aspire to the provision of person-centred care; a revolution in architectural design and the rethinking of the criteria for clustering people together are matters of urgency. A shift away from quasi-clinical spaces to domestic living arrangements appeared to fundamentally shift relational behaviours between staff, residents and family members.

5.1 | Study Limitations

Study participants were volunteers, and their perspectives may not be representative of those who were not involved, potentially limiting the transferability of the findings to other settings. The case study explains the transition of one ARC facility to an innovative model of care, the results may not be generalisable to other facilities. The process of data analysis in critical realist studies is complex, with no English language examples available at the time the study was conducted, potentially affecting the quality of the analysis process. While facility staff were confident residents were settled into their new environment, the timing of the second phase of data collection, 4 months after the transition, may have affected the results of the study.

6 | Implications for Practice

We argue that leaders must envisage care beyond prioritisation centred around physical and cognitive capabilities for people to live well. Leaders must also be prepared for change processes to be disruptive throughout the organisation as not all staff will have the desire or capacity to shift from task-orientated to person-centred care, nor to shift away from a more clinical environment. Innovative living arrangements are a synthesis of philosophical aspirations, architectural and design vision, dedicated leadership and committed teamwork. The integration of Māori cultural activities developed by Māori staff is essential for provision of culturally appropriate care for Māori residents.

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Ethics Statement

Health and Disability Ethics Committee approval was obtained for the study. The approval number is 16/NTA/133. Following the Health and Disability Ethics Committee approval, further ethical approval for the study was obtained from the Auckland University of Technology Ethics Committee. The Auckland University of Technology Ethics Committee approval number is (16/424).

Consent

Participants provided informed consent for the study. Next of kin, who also provided consent, supported those with cognitive impairment to consent to their participation. For those who were unable to provide informed consent, next of kin consented on their behalf.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Study data may be available upon reasonable request to the first author.

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