

The Creation of a Dementia-Friendly Community in Aged Residential Care: A Critical Realist Case Study

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Abstract

The practice of segregating people who require specialist dementia services from residents requiring other levels of care is beginning to be questioned. The ageing of the population, along with the accumulation of long-term health conditions such as dementia in older people indicate there will be an increasing demand for Aged Residential Care facilities. There is a growing awareness of the need to transform Aged Residential Care facilities into places where people can continue to live in ways that matter to them and engage in activities they value, with support. This thesis explains the transition of residents from a traditional Aged Residential Care facility to an innovative dementia-friendly village where they are supported to live life as normally as possible. Additionally, residents who require specialist dementia services are not segregated from the rest of the community within the secure perimeter.

The case study, guided by a critical realist theoretical perspective, explains the process and outcomes of the transition of residents from Whare Aroha CARE to The CARE Village. Data for the study comprised transcripts of semi-structured interviews, records of observation of resident daily life, documents and photographs. Forty-two facility staff, residents, their family members and key informants participated in the study. Analysis of study data using a process of retroduction enabled three underlying mechanisms generating the events contributing to the process of the transition to be identified. These are 'they changed the culture of the workplace to enable person-centred care,' 'they created a physical environment that supports the vision of people living normal lives,' and 'they formed a governance network to support the transition to an innovative model of care.' Themes in the data explain the outcomes of the transition for the staff, residents and their family members.

Data analysis began with the development of codes derived from the beginning theoretical propositions for the study and the data, themes were developed from those codes. Generative mechanisms, causing significant events, were identified by a process of retroduction, using the study themes and relevant theoretical and empirical literature. Three generative mechanisms, acting beneath the surface of events, enabled the transition of residents from Whare Aroha CARE to The CARE Village. Each of the generative mechanisms was an essential part of the process of the transition,

accomplished at the intersection of workplace culture change, the development of a supportive physical environment and the support of a network of government officials. The development of an innovative dementia-friendly village was experienced differently by each of the three embedded units of analysis in the case study, the residents of the village, their family members and facility staff.

The CARE Village residents transitioned to live in small houses, decorated in familiar styles, providing them with cues for daily living. Their participation in activities they value is supported by staff who know them well and understand how to help them to do as much as they can for themselves. Family members feel welcome in the normalised environment and confident their relatives are receiving appropriate care. Technology enables those people who require a secure environment to be free within the perimeter of the village.

The thesis represents an explanation of the process and outcomes of developing a dementia-friendly village inspired by De Hogeweyk in the Netherlands, adapted to the New Zealand context. Specifically, the thesis makes a novel contribution to knowledge by explaining the complex intersection of workplace culture change, change in the physical environment and support from government officials that enabled the development of The CARE Village. The findings regarding the outcomes of the transition are novel in that they relate to the first village of its kind in New Zealand and explain how staff work together to support residents to live their lives in ways they value. Of particular significance is the finding that the development of a dementia-friendly village in ARC has enabled desegregation of residents who require specialist dementia services, and their safe integration into The CARE Village. The most significant original contribution to knowledge that the thesis makes is the contribution to theory on governance networks in public policy, in the context of person-centred care delivery in Aged Residential Care, and the national contract between aged care providers and District Health Boards.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

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Chapter 1 Introduction

1.1 What this thesis is about

It is 11 am on a weekday morning. In a large room in a modern well-run Aged Residential Care (ARC) facility, there is simultaneously an air of bustling efficiency surrounding the uniformed staff and an air of boredom surrounding most of the residents. The residents are sitting on one side of the room in recliner chairs, facing a large TV set. Because it is a weekday, the residents have activities organised for them.

The current activity for residents is to watch a DVD recording of the violinist André Rieu playing popular classical music. The TV screen is large, and the volume is loud. A row of residents is sitting in large recliner chairs, directly facing the TV set, about four metres away from it. One of them is an immaculately groomed 65-year-old woman named Brigitte.

Each morning the staff, who are very fond of Brigitte, take care when helping her to dress, apply her makeup and do her hair because her appearance is significant to her. As Brigitte sits in her chair, trapped in front of the television, she yells over and over again, "I hate Mozart." Nobody takes any notice; she does this almost every day. The place I have just described is real, Brigitte is also real, although I have changed her name.

The ARC facility Brigitte lives in has an excellent reputation, and it achieves consistently high results on accreditation audits. Also, the management and staff try to make life as good as it can be for the people who live there. I am intimately acquainted with the scene I have just described because I worked in the facility where Brigitte lived. My experiences there and in other ARC facilities and hospitals providing long-term care for older people have led me to question the rationale for the enactment of care in such institutions. The need for ARC facilities has arisen and continues to grow due to the ageing of the population.

In this chapter I explain that along with the ageing of the population, many older people have complex long-term health conditions, including dementia. ARC facilities have evolved to provide accommodation and support with activities of daily living and health for older people who can no longer live independently. Services are regulated

to comply with acceptable standards of accommodation and care. However, one consequence of regulation has been the increasing medicalisation of ARC facilities, which have become institutional and are organised according to hospital routines. International and New Zealand (NZ) policy focus has evolved, and there is a movement to the provision of person-centred care, focusing on the resident as a person, with individual preferences. Despite the regulation of ARC facilities, there are some ongoing problems.

A series of NZ reports over the past decade reveals underfunding, with consequent inadequate staffing and care rationing. The situation is a barrier to the provision of person-centred care. However, there is beginning to be a shift to models of care that support person-centred care. Additionally, there is a growing appreciation of the benefits of smaller, domestic-scale environments for ARC residents.

In chapter one I provide some background information about ARC services, explaining the constraints to person-centred care delivery in ARC. I briefly describe an innovative model of care in ARC, with an international example that has inspired the development of a facility in NZ. I then outline the research aim and questions that will enable me to explain the process and outcomes of the transition to a new facility based on an innovative model of care. I begin by explaining why I am interested in ARC and why I have chosen to conduct the research that is the topic of the thesis.

1.2 My interest in Aged Residential Care and why I have chosen to conduct this research

I am a Registered Nurse (RN), trained in the apprenticeship system in Australia in the 1980s. After completing my initial training to become an RN, I undertook midwifery training, also in the apprenticeship system. I then moved to rural New South Wales and began working in a small local hospital.

The needs of my family dictated my working life for the next 20 years; therefore, I was able to gain experience in a range of healthcare settings. When I worked in ARC facilities, I was always questioning the way care was enacted. I could not understand why it was that people had to live in an institutional environment when they were no longer independent in their daily lives. It seemed unreasonable for people to have to live in an institutional setting to gain access to support for healthcare, housekeeping,

meals and activities of daily living. Additionally, the local hospital I worked in provided care for older people waiting for admission into ARC facilities, often for lengthy periods.

The challenges of assisting those people and their families prompted the beginning of postgraduate research for me, and I undertook a Master of Nursing (Research) degree, investigating a gerontology-related topic. Regarding the current study, the management team at Whare Aroha CARE approached the study's supervisors quite early on in its journey toward the development of The CARE Village. The management team members were looking for somebody to undertake some research on the transition from a facility based on a traditional model of care to one based on an innovative model of care. At the time, I was looking for a project for my Doctor of Philosophy degree. I was offered the project as one that would match my interests and be suitable for doctoral study.

When faced with the need to move to new premises, the managers at Whare Aroha CARE ARC facility in Rotorua, NZ, saw the opportunity to provide residential care differently from the traditional, institutional model. In this thesis, I will explain their transition from providing care in a traditional ARC facility to a different model of care. In the new model of care, residents live in domestic scale environments within a purpose-built village (The CARE Village) and participate, as much as they desire and can in normal daily life. Additionally, I will explain the impact of the new model of care on the lives of the people who live in The CARE Village.

Most ARC facilities are well run, and most of the people who work in them genuinely care about the people who live there. However, it is not a normal life for residents. Life for residents in ARC facilities is routine, and they are typically passive recipients of care in settings that are governed by the priorities of the staff and the organisation. Many ARC residents have complex care needs, and this means that the most efficient way to care for them is to run the facilities the way we run hospitals. This thesis is about a different way of providing care for older people who need to live in ARC.

1.3 The need for Aged Residential Care services

Globally the population is ageing, meaning the proportion of people in society who are 65 years of age or older is increasing. In the developing world, this is due to smaller

numbers of people dying when they are young, either as children, during childbirth or of infectious diseases. In the developed world, the reasons are declining fertility and also decreasing mortality among older people (World Health Organization, 2015).

Increasing life expectancy is positive because it enables families and societies to benefit from the contributions made to them by older people. However, there are also some negative impacts; for example, the increased prevalence of non-communicable diseases such as dementia (Alzheimer's Disease International, 2015). Dementia is an umbrella term for a syndrome caused by several disorders, the most common being Alzheimer's disease. Dementia is "defined as global cognitive impairment that is irreversible and occurs in a clear sensorium" (Blass, 2003, p. 1391).

The term "global cognitive impairment" refers to "impairment in memory and at least two other cognitive domains" (Blass, 2003, p. 1391). Worldwide, the number of people who are living with dementia is increasing rapidly. In 2009, Alzheimer's Disease International estimated that there were 46.8 million people with dementia worldwide and that this number would double every 20 years. The highest increases are predicted to occur in low to middle-income countries. However, the number of people living with dementia in high-income countries is also predicted to rise (Alzheimer's Disease International, 2015). Alzheimer's New Zealand (2017) estimates that by 2050 there will be over 170,000 New Zealanders with dementia. For the individual who is living with dementia, there is a reduction in life expectancy and quality of life. The eventual consequence is that the person who has dementia is no longer able to manage daily living independently (Alzheimer's New Zealand, 2017). For people who are 65 years of age or older and no longer able to live at home alone, family and friends may provide informal support.

Additionally, government-funded formal support is available for people who have undergone an assessment of their support needs (Ministry of Health, 2011).

Alternatively, people may need to move into an ARC facility. There is evidence that older New Zealanders would prefer to remain living in their own homes rather than entering ARC (Grant Thornton Limited, 2010; New Zealand Labour, Green Party of Aotearoa New Zealand, & Grey Power, 2010).

In comparison with people in other countries, a high proportion of New Zealanders live in ARC at the end of their lives (Broad et al., 2013). In NZ, the most recent data available indicate that 31,899 people lived in ARC in 2013 (Statistics New Zealand, 2013). Globally people with dementia make up a high proportion of older people requiring care in the community or admission into ARC (Alzheimer's Disease International, 2015).

1.4 Aged Residential Care facilities

Historically the organisation and delivery of formal institutional care for vulnerable older people in developed nations evolved from the eighteenth-century poor houses and asylums to current ARC facilities (Hunter, 2005). Such places initially provided custodial care for people who had no family members to care for them (Jurkowski, 2013). Since that time, increasing regulation of the industry has led to improvements in measurable care outcomes. However, there is still work to do to improve the lives of residents (Human Rights Commission, 2012; New Zealand Labour, Green Party of Aotearoa New Zealand, & Grey Power, 2017). The medicalisation of ARC has been an “unintended consequence” of regulation, enacted initially to protect vulnerable residents (White-Chu, Graves, Godfrey, Bonner, & Sloane, 2009, p. 370).

The reframing of problems in medical terms is known as medicalisation. Reframing in medical terms can occur when conceptualising problems, during interactions between healthcare providers and consumers or at the level of institutions (Conrad, 1992). Medicalisation originated with the medical profession seeking power and lobby groups seeking solutions to their concerns and has evolved to include increasing consumerism of medical and related services (Conrad, 2005). The medicalisation of ARC is an example of medicalisation at an institutional level. Thereby, the problem of needing accommodation and support for activities of daily living for older people, many of whom have complex medical conditions, is addressed by providing care environments that resemble hospitals in appearance and routine.

The medicalisation of ARC does not fully align with the focus of international policy guidance on the provision of long-term care for older people, that has a person-centred, rights and strengths-based focus. The World Health Organization has developed a global strategy and action plan to guide member states towards to goal of

healthy lives for older adults (World Health Organization, 2017). In recognition of the impact of population ageing on the growing need for long-term care in the community and ARC for older people, one of the aims of the strategy and action plan relates to the provision of long-term care. The strategy calls for long-term care services for older people that are person-centred, respectful of consumer dignity and human rights and support the maximisation of remaining abilities.

NZ is a signatory to the WHO Global Strategy on Ageing and Health, along with many other nations, including countries with similar histories to NZ such as Canada and Australia. The strategies of those nations relevant to the health and care of older people flow from the Global Strategy on Ageing and Health (World Health Organization, 2017). In Canada, the National Seniors Strategy guides policy about the health, wellbeing and care of older people, including those who live in ARC facilities (National Seniors Strategy, 2019; Sinha et al., 2016). The aspect of the Canadian National Seniors Strategy relevant to ARC advocates the provision of quality care that is person-centred (National Seniors Strategy, 2019).

In Australia, a series of policy developments have guided the evolution of ARC provision. In 2013 the Australian Aged Care Act 1997 was amended, encouraging provision of person-centred care and focused on enabling older people to age in place at home, with care and support services. Additionally, a consumer website called “My Aged Care” was established to provide information and access to ARC services (Bernoth, Neville, & Foster, 2017).

However, severe deficiencies in the quality and safety of care for residents of some ARC facilities in Australia prompted the establishment of a Royal Commission into aged care quality and safety. The Royal Commission’s interim report indicates the sector requires significant reforms to enable it to provide appropriate services for ARC residents. Additionally, the commissioners identified a lack of action by previous governments despite successive recommendations for improvement of the industry (Royal Commission into Aged Care Quality and Safety, 2019).

In NZ, ‘Better later life: He oranga kaumatua’ (health, welfare of older people) is

the overarching policy guiding service delivery for older people, refreshed in 2019. The policy is driven by a vision of an inclusive nation where older people are respected, connected in community and safe from harm. Specific to health, the Healthy Ageing Strategy provides policy guidance around the health and wellbeing of older people, including advice about the provision of ARC services. The NZ Health Strategy underpins the Healthy Ageing Strategy, which promotes the delivery of ARC services that are person-centred including those using innovation to meet the needs of people with long-term conditions (Associate Minister of Health, 2016). NZ ARC service providers are contractually obliged to provide person-centred and culturally appropriate care that encourages residents to maximise their remaining abilities and maintain connections with their families and communities (Ministry of Health, 2013a).

The NZ government department responsible for the health needs of the population is the Ministry of Health (MOH). The MOH devolves local health service provision to 20 District Health Boards (DHBs), who contract with providers for ARC services under one of two national agreements, the Age-Related Residential Care Agreement and the Aged Residential Hospital Specialised Services Agreement (TAS, 2019b). The agreements cover residential care for people who have had their care needs formally assessed and require private hospital (high-level care), rest home (low-level care), psychogeriatric care and specialist dementia services (Ministry of Health, 2014b).

Providers are contracted and funded to provide care for those residents who are eligible for subsidised care, based on the levels of care they require. The Age-Related Residential Care Agreement covers the provision of private hospital, rest home and specialist dementia services, the standards of care needed by ARC residents who are participants in this study. Under the terms of the Age-Related Residential Care Agreement, residents who require specialist dementia services must have separate accommodation, including separate spaces outdoors, from residents requiring other levels of care (Ministry of Health, 2013a).

Certification and auditing of contracted services against the standards in the Health and Disability Services (Safety) Act 2001 should ensure the provision of appropriate and safe person-centred care for residents (Ministry of Health, 2013b). However, like concerns about the quality of care for ARC residents in Australia, media stories, reports

and academic literature indicate ongoing problems in the NZ ARC sector. The industry has been described as “in crisis” due to factors including under-resourcing, leading to inability to attract and retain appropriately skilled staff, and market forces contributing to the dominance of for-profit providers (Woods, Phibbs, & Severinsen, 2017, p. 365).

Within the last decade, in NZ, there have been several published reports about ARC, prompted by public concern about the standard of care in the sector. A 2010 inquiry identified widespread deficits in the care provided for residents, related to institutional environments and routines, underfunding, inadequate staffing and skill mix, improper management of medical conditions, and in some cases abuse or neglect (New Zealand Labour et al., 2010). Consequently, the authors made recommendations including improvements in funding, staff training and remuneration, mandated staffing levels and greater provider accountability. They also recommended the adoption of innovative, culturally appropriate and person-centred models of care.

Low pay and high staff dissatisfaction and turnover in ARC facilities contribute to problems with providing quality care for residents. In 2012 the NZ Human Rights Commission identified ageist attitudes concerning the ARC industry and female gender of the majority of ARC staff as contributing factors to low rates of pay for nurses and Health Care Assistants (HCAs) in the sector (Human Rights Commission, 2012). In 2016, a workforce survey identified widespread dissatisfaction with pay among ARC staff, together with a high proportion of staff signalling their intention to leave their current employment within 12 months (Ravenswood & Douglas, 2017).

The 2012 report by the Human Rights Commission inspired a gender-based pay claim by HCAs employed in ARC and home-based care for older and disabled people. In 2017 the application, based on the claim that their low wages were due to female-dominance of the industry, was successful. The legislation that enshrined the settlement encompassed wage increases and provision for funded vocational education for care staff (Douglas & Ravenswood, 2019).

In a follow-up to their 2010 report, improvements in ARC and some remaining deficits were noted by New Zealand Labour et al. (2017). Improvements included pay increases for HCAs as described in the previous paragraph, while deficiencies ongoing included lack of pay parity for RNs with their peers working in public hospitals, continued

underfunding, ongoing complaints of poor care and lack of consistency in applying standards of care. The authors made further recommendations, including the need for more inclusive and appropriate person-centred care in ARC (New Zealand Labour et al., 2017).

ARC providers in NZ are a mix of for-profit and not-for-profit, usually charities, providers. In recent years there has been a rise in the proportion of private, for-profit providers as cost pressures force small private providers out of the industry (Bernoth et al., 2017; Grant Thornton Limited, 2010). The rise in the proportion of for-profit providers in the industry may have negative implications for the provision of person-centred care for residents.

Although large for-profit providers can achieve economies of scale, they are in business to provide profits for shareholders. Staffing is a significant cost in ARC service provision; therefore, if costs need to be contained, safe staffing levels may be vulnerable (Grant Thornton Limited, 2010). A 2017 report indicated that staff to resident ratios in ARC facilities in NZ were inadequate by international standards (New Zealand Nurses Organisation, 2017).

As noted in a recent report, inadequate staffing in ARC may lead to care rationing, a barrier to the provision of person-centred care (New Zealand Nurses Organisation & E tū, 2019). A 2019 review examined the current funding model in ARC and recommended the introduction of a model that better captured the care needs of residents (EY, 2019). However, there are tensions between the views of providers, unions and central government about the most effective way to fund ARC and debate remains ongoing (Health Central New Zealand, 2019).

Therefore, there are some ongoing problems in the NZ ARC sector. While at the same time, there are calls for care in ARC to be more person-centred and environments to be more home-like. In an industry beset with problems, and seemingly unable at times to provide care that meets the standards for ongoing certification, it may not be realistic to expect care is person-centred and environments are home-like. However, ARC is where people live their lives, in what is usually their last home. Therefore, it is reasonable to expect that they will live in environments that meet accreditation standards, are comfortable and where care is person-centred.

Services for older New Zealanders, including ARC facilities, should provide holistic care that is person-centred and culturally appropriate. However, as noted previously, on page 20, the ability of an ARC facility to meet certification standards does not ensure that the service provides meaningful or enjoyable lives for residents. Consequently, there are local and international endeavours to change the focus of delivery of ARC from a biomedical and organisational one to a focus on residents and the way they can live their lives in ARC.

1.5 Changing Aged Residential Care Services

One model of care that may improve daily life for people living in ARC facilities is the clustered domestic model. The clustered domestic model of care aims to improve the lives of Aged Residential Care residents by accommodating them in a more home-like environment than the traditional hospital-like ARC facility (Dyer et al., 2018; Verbeek, Van Rossum, Zwakhalen, Kempen, & Hamers, 2009). Such initiatives align with the aims of Alzheimer's Disease International (2015), and the NZ government to improve care for people who have dementia (Ministry of Health, 2014a). Internationally there are several examples of facilities using a clustered domestic model of care including De Hogeweyk village in the Netherlands, where people reside in small communal houses in a purpose-built secure dementia-friendly village (Schumacher-Jones, 2014).

1.5.1 De Hogeweyk village

De Hogeweyk is an ARC facility near Amsterdam in the Netherlands. In De Hogeweyk, residents, all of whom have advanced dementia, live in small households decorated in styles that are familiar to them, and the focus is on encouraging them to use their remaining abilities (Godwin, 2015). The design of the physical environment is a therapeutic intervention in that it decreases the stress experienced by residents who are living with dementia while supporting them to engage in normal daily activities as much as possible (Chrysikou, Tziraki, & Buhalis, 2018).

De Hogeweyk contains a supermarket and retail outlets including a bar and a restaurant, which are open to the public, as well as apartments where the residents live. The perimeter is securely fenced, and entry and exit are via one secure point; within the village, residents can move about freely and are supported in their daily lives by staff and a large number of volunteers. Residents live in apartments with five

or six peers who have shared a similar lifestyle in the past (Schumacher-Jones, 2014). The Hogeweyk care concept is driven by the vision of the organisation, “living as usual in small groups with lifestyle for people with severe dementia” (van Hal, 2014, p. 2). I review the literature about De Hogeweyk village in chapter two, beginning on page 37.

1.6 Whare Aroha CARE

The Rotorua Continuing Care Trust (RCCT), which operated Whare Aroha CARE ARC facility on the corner of Whakaue and Hinemaru Streets at the edge of the Rotorua Central Business District (CBD), built a village inspired by the Hogeweyk care concept. Whare Aroha Care provided rest home, private hospital and specialist dementia services. Care for approximately 80 residents was delivered in three wings in a converted nurses’ home leased from Pukeroa Oruawhata Trust.

Pukeroa Oruawhata Trust is the company that manages the landholdings of Ngāti Whakaue, a local iwi (sub-tribe) of the Te Arawa Māori tribe. The lease on the land occupied by Whare Aroha CARE was ending and Pukeroa Oruawhata did not intend to renew it, because of plans to redevelop the site for tourism purposes. The end of its lease at the Whare Aroha CARE site in Rotorua provided an opportunity for management to consider different models of care for their residents.

The consideration of different models of care to inform the development of a new ARC facility aligns with World Health Organization recommendations for person-centred and dignified long-term care for older people. According to the World Health Organization (2015), there needs to be a shift in focus in ARC towards models of care that support the active participation of residents in aspects of life that matter to them. Support for active participation compensates for disability and is therefore reabling rather than disabling.

After exploring several options, the team agreed that the Hogeweyk care concept resonated with them as the inspiration for a possible way of life for the facility residents. The RCCT purchased a block of land at Ngongotahā, approximately eight kilometres from the Rotorua, see map, Figure 1, on page 24. It engaged an architectural firm to begin the process of developing The CARE Village. Residents moved from Whare Aroha CARE to The CARE Village in September 2017. The CARE Village is the first completed village in NZ inspired by the Hogeweyk care concept, with

the setting adapted to NZ lifestyles, including a cultural house for people accustomed to living a Māori cultural lifestyle.



Figure 1. Map of Rotorua District. Photograph taken by Bay of Plenty Regional Council. Used with permission.

The CARE Village was built to accommodate all Whare Aroha CARE residents at the time. Those residents were a mix of people who required private hospital, rest home and specialist dementia services. The provision of accommodation based on their previous lifestyle means residents requiring specialist dementia services are not segregated in a secure unit and is innovative in NZ.

1.7 Research aim and questions

The research aims to explain the resettlement of Whare Aroha CARE residents into The CARE Village, and the effects of the resettlement on the lives of the residents.

Consequently, the two research questions for the study are:

- How has the transition of Whare Aroha CARE residents to The CARE Village been accomplished?

- What is the effect of the transition of Whare Aroha CARE residents to The CARE Village on the lives of the residents?

1.8 Thesis structure

In the remaining seven chapters of the thesis, I describe the theoretical perspective, methodology and research methods utilised to answer the research questions. I then progress to the results of the study and discussion of those results. I explain the theoretical perspective of critical realism, underpinning the research. I also explain case study research methodology and the methods used to collect the study data. I present the results of the study and discuss them with the relevant existing literature; finally, strengths and limitations of the study, together with recommendations for practice, policy and further research are discussed.

In chapter two I review the recent research literature that is relevant to the thesis topic. There are six topics in the literature pertinent to the current study. These are models of care in ARC, person-centred care and the person-centred practice framework, culture change in ARC, governance networks in public administration, the capability approach and wellbeing in older adults and dementia-friendly physical environments in ARC.

In chapter three I introduce and explain critical realism, the theoretical perspective informing the study, together with a justification for its use for the project. As discussed briefly previously, critical realism is a perspective in social science that is useful for guiding research seeking to explain phenomena in society. Critical realism recognises a stratified ontology, enabling the underlying mechanisms generating surface events to be identified (Bhaskar, 1975). Additionally, I explain case study research methodology, used to inform the study.

In chapter four the methods used to collect the study data are described and explained. As discussed previously, case study research methodology is flexible and useful with a variety of theoretical perspectives (Luck, Jackson, & Usher, 2006). There are several principal authors on the topic of case study research methodology and methods. I have used the methodology and methods described by Yin (2017) for the current study.

I present the results of the study in chapters five, six and seven. In chapter five the transition from Whare Aroha CARE to The CARE Village is presented as a narrative. Following the narrative, I explain the first generative mechanism for the transition, 'they changed the culture of the workplace to enable person-centred care.' In chapter six I will explain the second and third generative mechanisms for the transition. These are 'they created a physical environment that supports the vision of people living normal lives' and 'they formed a governance network to support the transition to an innovative model of care.' In chapter seven the outcome of the transition, the effects on the residents, their families and the staff of The CARE Village is explained.

In chapter eight I discuss the results of the study concerning other research about the topics relevant to the study. The original contribution the study has made to the research literature will be reiterated. Additionally, I make recommendations for practice, policy and further research.

1.9 Summary of chapter one

In chapter one I have introduced the thesis topic and the context and background of the current study. First, I give an example from my previous practice as a Registered Nurse in ARC that illustrates the reality of daily life for many people who live in ARC facilities and explains my interest in the study topic. I have briefly described the historical and policy context relevant to ARC.

Additionally, I have explained the regulatory and policy contexts that govern the provision of ARC in NZ. I have described factors backgrounding the current trend towards making ARC facilities more liveable for residents. Additionally, I have provided the background surrounding the need for Whare Aroha CARE to move to new premises. I have stated the study aim and research questions and described the methodological considerations underpinning the study and the methods used to undertake the study. In chapter two I will review the previous recent research literature that is relevant to the study.

Chapter 2 Literature review

In chapter two I review the literature about the topics that inform the study. The study focuses on the transition of Whare Aroha CARE residents from a traditional ARC facility to The CARE Village. The CARE Village is a purpose-built ARC community using an innovative model of care, where the physical environment and person-centred care intersect to enable residents to maintain their identities. Additionally, there is desegregation of people requiring specialist dementia services within the facility. The CARE Village is primarily but not exclusively, for people who have dementia and is inspired by the Hogeweyk care concept.

De Hogeweyk is an innovative ARC facility in the Netherlands, where residents, whom all have advanced dementia, live in domestic-type environments. Three generative mechanisms enabled the process of transitioning from Whare Aroha CARE to The CARE Village. They were: Changing the culture of the workplace to enable person-centred care, the formation a governance network to support the transition and the creation of a physical environment that supports the vision of people living normal lives.

Therefore, there are several aspects of the theoretical and empirical literature that are included in this narrative review because they are relevant to this project. They are models of care in ARC, person-centred care and the person-centred practice framework, culture change in ARC, governance networks in public policy, the capability approach and wellbeing in older adults and dementia-friendly physical environments in ARC. Additionally, when I was writing the study proposal, I reviewed the literature about dementia-friendly community initiatives. Subsequently, I decided that the topic was not directly relevant to the study; therefore, it is not part of this chapter.

However, I have published a review of the literature pertinent to dementia-friendly community initiatives in the *Journal of Clinical Nursing* (Shannon, Bail, & Neville, 2019). The published manuscript is included in the thesis as Appendix A, and a list of conference contributions drawn from the study is included as Appendix B.

2.1 Structure of the literature review chapter

There are eight sections in the literature review chapter. In the first section, I describe the process I used to identify the literature. In the second and subsequent sections, I

review the literature about the topics relevant to the current study; finally, I identify a logical next step in research, the present research explaining the transition of residents of Whare Aroha CARE to The CARE Village. I continue the chapter with a description of the procedures used to identify the literature in this review.

2.2 Identification of the literature

I utilised electronic databases accessed through my institution's library for the literature search. The databases searched were CINAHL complete via EBSCO, Australia New Zealand reference centre via EBSCO, ebook collection via EBSCO, ClinicalKey, Medline via EBSCO and SocINDEX with full text via EBSCO. For each of the five topic areas included in the review, I searched the five databases using combinations of the relevant keywords. For example, the keywords for the first topic in the literature review, models of care in ARC, were model of care, aged care, nursing home, care home, residential aged care, long-term care.

The literature search strategy for each of the topic areas enabled the identification of articles that represented a broad coverage of the topic. Rather than searching until I had identified every possible article on each topic, I located the articles that represented the diversity of research on the topic. I stopped searching when saturation was reached, that is no new articles were appearing in the search results. While the approach does not represent an exhaustive search similar to that required for systematic reviews, it balances identification of the maximum number of relevant resources with the considerable investment of time an exhaustive search requires (Booth, 2016).

I utilised a similar approach when assessing the suitability of the identified articles for inclusion in the review. Following identification of the articles, I read the abstracts, because reading each article in full would have been too time-consuming. For example, the search for articles relevant to models of care in ARC identified 3200 articles initially, and I identified no new articles after I had read 520 abstracts. The approach enabled the processing of many identified articles. However, the relevant information required to assess the suitability of articles is more likely to be available in the abstracts of quantitative than qualitative articles, particularly older papers (Booth, 2016).

To identify any relevant articles that had been missed during the search process, reference lists of accessed articles were hand-searched. Further resources were obtained through database alerts and via my professional and academic networks. The search was initially conducted in 2016 and updated in September 2019; the topic, models of care in ARC, begins the review.

2.3 Models of care in Aged Residential Care

Ways of conceptualising care are known as models of care. There are two main models of care in ARC internationally, the traditional or classic model of care, focused on the biomedical aspects of care, and the biopsychosocial model of care, a holistic approach encompassing technical competence and the humanistic aspects of care (Ostaszkievicz, Dunning, & Streat, 2018). A recent NZ review of funding models in ARC makes recommendations for a model of care encompassing holistic care promoting wellbeing in home-like environments (EY, 2019). These developments highlight the growing understanding of the need for ARC facilities to provide care for the whole person. Currently, the classic model of care dominates in NZ ARC facilities. There are a small number of facilities using a biopsychosocial model of care. I begin the current section of the literature review by explaining these two models of care before comparing and contrasting them. The explanation starts with the traditional model of care.

2.3.1 The traditional model of care in Aged Residential Care

Characteristics of facilities based on the traditional model of care include wards typically housing more than 20 residents together, staff with discrete skills performing tasks to meet the medical and personal care needs of residents and resident daily life lived according to facility routines (Adams, Verbeek, & Zwakhalen, 2017). People living in ARC facilities often have multiple complex healthcare needs, including dementia (Dyer et al., 2018). The high clinical acuity of ARC facility residents, leading to an increased demand for expert care, would seem to align with the dominance of the biomedical model in ARC. However, when people live in ARC, it is usually also their permanent home, indicating the need to consider the whole person as the focus of care (Australian Association of Gerontology, 2019).

2.3.2 The biopsychosocial model of care in Aged Residential Care

The biopsychosocial model of care is holistic, encompassing expert care of complex health needs, as well as the psychological and social aspects of care (Ostaszewicz et al., 2018). Small-scale living facilities in ARC provide an example of a biopsychosocial model of care. Table 1 below summarises the key elements of the traditional and biopsychosocial models of care.

Table 1. Elements of the traditional and biopsychosocial models of care.

| Model of care | Elements |
|-----------------------------------|--|
| The traditional model of care | Focus is on illness and disability management. The physical environment resembles a hospital rather than a domestic home. Routines are staff and facility-centred. |
| The biopsychosocial model of care | Focus is on the holistic care needs of residents. The physical environment resembles a home. Resident preference guides the routines. |

Most of the research literature about the topic is relatively recent, within the last two decades, originates from Europe and the United States of America (USA) and more recently Australia, and employs quantitative research methods. Overall, the evidence does not conclusively indicate better health or quality of life outcomes for residents in small-scale living facilities as compared with traditional ARC facilities.

In small-scale living facilities in ARC, residents live in home-like environments, either in a single house or apartment or in a cluster of houses, known as the clustered domestic model of care. I identified some common themes in the research literature comparing the classic model of care with small-scale living facilities. They are the physical environment, effects on staff, effects on resident quality of life and quality of care, effects on neuropsychiatric symptoms of dementia and effects on family members. Accordingly, I review the literature relevant to these topics to compare and contrast the two models of care, beginning with the physical environment.

The physical environment

Living in a home-like environment enables daily life for residents to approximate everyday life as it would be in their own homes, participating in household activities

such as meal preparation and other chores. Typically, there are communal living, dining and kitchen areas where residents can see, hear and smell food preparation (de Boer et al., 2018). Involvement in household activities may alleviate the boredom and purposelessness experienced by many people living in ARC.

A comfortable environment with visual access to living area and kitchens supports resident participation in normal daily activities such as food preparation. However, a quantitative study comparing a traditional nursing home with small-scale living facilities notes that residents still require support from staff to gain the maximum benefit from living in those environments. Unfortunately, facility staff may miss opportunities to provide that support (de Boer et al., 2018). This finding highlights the need for staff to understand the role of the environment and the role of staff intersect in supporting resident activities.

An organisational vision of supporting residents to continue to participate in domestic activities often drives the construction of domestic-scale environments in ARC. A recent qualitative study investigated the congruence between the organisational vision and the architecture supporting that vision in a stand-alone small-scale living facility in ARC (Van Steenwinkel, de Casterlé, & Heylighen, 2017). The results of the study indicate the home-like environment is seen by staff as helping the staff to realise their vision of residents living normal lives as much as possible.

Mixed-methods research investigating the Green House model of small-scale living facilities in the USA indicates that while the smaller environment has some advantages for residents, there are inconsistencies in implementation (Cohen et al., 2016). For example, the presence of kitchens in smaller home-like environments does not necessarily mean they are being used by residents who may be unable or unwilling to prepare food. Similarly, even when the outdoors is readily accessible, staff may not take residents outside (Cohen et al., 2016). These findings highlight the critical importance of staff understanding and interpretation of the model of care in its implementation and the subsequent effect on resident quality of life.

Effects on resident quality of life

While it seems intuitive that living in a home-like environment would lead to improved quality of life, the evidence to support this is not conclusive. Researchers using

validated quantitative quality of life assessment tools did not find a significant difference between the quality of life for residents in small-scale living homes and those in traditional ARC homes (Verbeek et al., 2010). Other researchers have found similarly (Palm et al., 2018; Wolf-Ostermann, Worch, Meyer, & Gräske, 2014; Wolf-Ostermann, Worch, Fischer, Wulff, & Gräske, 2012). However, an Australian cross-sectional survey of residents found those people living in clustered domestic model facilities rated their quality of care as better than those living in traditional ARC homes (Gnanamanickam et al., 2018). These results indicate that a qualitative approach may be more useful to aid understanding of the subtle effects of physical environments in ARC on resident quality of care and quality of life. The high proportion of people living in ARC facilities who have dementia indicates a need to understand the effect of the model of care on the symptoms of dementia.

Effects on neuropsychiatric symptoms of dementia

Many people with dementia experience neuropsychiatric symptoms; these are not static and may be affected by the environment. Neuropsychiatric symptoms of dementia such as anxiety, depression, verbal and physical agitation, apathy, delusions and physical aggression are concerning for the person and their family. They are commonly associated with families being no longer able to care for the person who has dementia at home (Lyketsos et al., 2011). There is inconclusive evidence regarding whether neuropsychiatric symptoms of dementia are affected by either the classic model of care or small-scale living facilities in ARC.

While domestic-scale environments in small-scale living facilities positively stimulate residents to move around the house and grounds and perform tasks, institutional settings contain some negative stimuli. Negative stimuli that may cause additional distress to people who have dementia include unfamiliar environments, excessive noise and the presence of large numbers of people (Ministry of Health, 2016).

Commonly in small-scale living facilities, institutional-style aspects of the environment such as storerooms, trolleys and linen rooms are in a part of the building that is hidden from and inaccessible to residents. Additionally, there are no distressing stimuli such as audible call bells in some examples of small-scale living facilities (Smith, Mathews, & Gresham, 2010). Therefore, facilities designed to minimise noxious stimuli could be assumed to be helpful for people who have neuropsychiatric symptoms of dementia.

Some neuropsychiatric symptoms may not present a problem to the person with dementia; however, facility staff may view them as a problem. A quasi-experimental study comparing residents in small-scale living facilities and traditional nursing homes found the residents in the small-scale living facilities exhibited more walking and repetitive behaviours, but no difference in other neuropsychiatric symptoms. Staff acceptance of those behaviours may account for the result (Verbeek et al., 2014). However, the evidence does not conclusively indicate that small-scale living facilities have any impact on neuropsychiatric symptoms of dementia.

Other research demonstrates inconclusive findings regarding the influence of small-scale living facilities on neuropsychiatric symptoms. For example, in a quantitative study comparing several outcomes, including neuropsychiatric symptoms of dementia, no significant difference was found between small-scale living facilities and traditional ARC facilities (Wolf-Ostermann et al., 2012). This result aligns with the results of other quantitative studies, including the research of Verbeek et al. (2010). Therefore, a different measurement tool or strategy may be required to understand the impacts of living in small-scale living facilities for people who have dementia.

There is some evidence that living in a small-scale living facility may reduce resident anxiety, compared with being in a facility based on a traditional model of care. Quantitative research (Kok, Nielen, & Scherder, 2018) found lower levels of anxiety in residents of small-scale living facilities compared with traditional nursing homes. However, the evidence about the effect of small-scale living facilities on neuropsychiatric symptoms of dementia remains inconclusive. Unfortunately, those symptoms can be distressing for family members, who often remain engaged in the person's care after they enter an ARC facility.

Effects on family members

Family participation in the day-to-day lives of residents of ARC facilities may be positively affected when their relative lives in a small-scale living facility. Family members report greater satisfaction with care in small-scale living facilities and decreased burden of responsibility compared with people whose family member is in a traditional ARC facility (Andrén & Elmståhl, 2002). However, this is not necessarily associated with increased contact with their relative (Verbeek et al., 2010). The results

indicate the complex nature of encouraging ongoing relationships between ARC residents and their families.

Staff members have a role to play in facilitating continued contact between residents and their families. Family involvement in the day-to-day life of residents is associated with improved quality of life for residents, compared with those who have family members who do not visit them or those who have no family members. Therefore it is vital to facilitate family involvement in the daily lives of residents (Gräske, Meyer, Worch, & Wolf-Ostermann, 2015). The small-scale living facility environment, where relatives can become familiar with a consistently assigned group of staff, can be conducive to positive relationships between family members and staff, encouraged when family members feel that their feelings are taken into account by staff and the resident is listened to by staff (de Rooij et al., 2012; Verbeek, Zwakhalen, van Rossum, Kempen, & Hamers 2012).

However, consistent assignment of staff to residents means they are also consistently assigned to their families. There is evidence that when the relationships are not positive, for example when family members have unrealistic expectations, staff can feel trapped in these unhealthy relationships (Røsvik, Kirkevold, Engedal, Brooker, & Kirkevold, 2011). This finding highlights the need for organisational support, via the RN, of staff when they are dealing with challenging situations in small-scale living facilities.

Effects on staff

There is potential for using a different staffing model in small-scale living facilities compared with traditional facilities. Residents require support with daily living as well as management of long-term health conditions. Therefore, staff skill mix and communication need to be carefully considered to enable optimisation of the potential of the model for supporting resident health and wellbeing.

A recent Australian cross-sectional quantitative study revealed a difference in the proportion of resident care provided by RNs and HCAs between the two models of care. In the four small-scale living facilities in the study, RN and Enrolled Nurse (EN) time was less and HCA time was higher compared with the 13 traditional facilities, although the HCAs had received more hours of training for their roles (Harrison et al.,

2019). The results of the study indicate the need for providing appropriate training for HCAs and the potential for emphasis on the leadership role of RNs.

The role of direct care staff, or HCAs, is enacted differently in small-scale living facilities compared with classic facilities. Within small-scale living facilities, HCAs have a central and leading role encompassing physical care of residents, household work, and promoting resident autonomy (Verbeek et al., 2012). Professional staff such as RNs act in a consultative role (van Zadelhoff, Verbeek, Widdershoven, van Rossum, & Abma, 2011). The role differences noted previously indicate the complexity of balancing the appearance of normal daily life with the management of the complex long-term conditions experienced by many residents.

In small-scale living facilities, person-centeredness, autonomy, self-directedness, and the ability to detect changes in residents and to problem-solve are all critical (Verbeek et al., 2012). While HCAs, who work closely with residents, can notice health changes, they require the knowledge and skills necessary to recognise the significance of those changes. Therefore, to enable resident health changes to be managed appropriately in small-scale living facilities, HCAs must be trained adequately for their roles (Harrison et al., 2019).

The small-scale living facility model of care in ARC provides an opportunity for RNs and ENs to practice at their full scope in terms of their respective roles in leadership. RNs delegating care to other members of the team such as ENs and HCAs must ensure those staff members keep them informed of any changes in resident health or other adverse events. Excellent relationships are central to maintaining communication between RNs and other care staff. Registered Nurses in ARC work to build relationships with HCAs that enable them to work autonomously but safely, with support from RNs and ENs (McGilton, Bowers, McKenzie-Green, Boscart, & Brown, 2009).

Empirical evidence suggests HCAs in small-scale living facilities being able to make decisions on day-to-day matters enables person-centred care and may promote job satisfaction for staff. In these facilities, staff have greater autonomy than in classic-model facilities and may organise their work to accommodate the desires of residents (Van Steenwinkel, de Casterlé, et al., 2017). Nurses and HCAs in small-scale living facilities may have more job satisfaction than those working in facilities based on the

classic model of care (te Boekhorst, Willemse, Depla, Eefsting, & Pot, 2008; Verbeek et al., 2010; Willemse, Depla, Smit, & Pot, 2014). However, there is some evidence that staff choose to work in facilities where the model of care aligns with their philosophies, perhaps accounting for that finding (Adams et al., 2017).

The evidence about the impact of small-scale living facilities on staff work stress is inconclusive. In addition to experiencing greater job satisfaction when working in small-scale living facilities compared with classic model facilities, nurses and HCAs may experience reduced job stress, particularly in settings where colleagues provide each other with social support (Adams et al., 2017). Conversely, if HCAs work and make decisions alone, this can be a cause of stress for them (Verbeek et al., 2012).

A Canadian qualitative ethnographic study explored the experiences of HCAs working in small-scale living facilities. The majority of facilities had transitioned from being based on the traditional model of care (Andersen & Spiers, 2015). The researchers identified that HCAs were initially pleased to be shifting to a model of care aligned with their humanistic values. However, they began to note some disadvantages with the model, including feeling unable to ask for help, out of their depth clinically and unsupported when consistently assigned to care for residents in one house independently. This finding indicates the importance of the nursing team working together to support HCAs in those roles.

There is some evidence of under-recognition of the value of staff in small-scale living facilities. The staff roles in small-scale living facilities require a high level of skill and a particular set of personal characteristics. However, some staff in small-scale living facilities have reported feeling that management undervalue their contribution to the organisation and do not recognise them as people (Cooke, 2018). This finding contrasts with the aspect of person-centred care that values all people, including staff (Røsvik et al., 2011). I discuss the research evidence about person-centred care, beginning on page 40. De Hogeweyk village is a small-scale living facility including principles of person-centred care in its overarching model of care. I discuss the limited research literature about De Hogeweyk village, in the following section of the chapter.

2.3.3 De Hogeweyk village

There is scant empirical literature about De Hogeweyk Village published in English; additionally, a 2019 literature search by a Dutch colleague failed to find any Dutch research about the facility. Most of the published articles about De Hogeweyk are descriptive reports. The lack of peer-reviewed research literature about De Hogeweyk has also been noted almost a decade ago by Hurley (2012).

As recently noted, the Hogeweyk philosophy is evidence based (Australian Association of Gerontology, 2019). De Hogeweyk has been in operation since 2009 (Anderzhon, Hughes, Judd, Kiyota, & Wijnties, 2012). Therefore, the ongoing lack of research investigating the outcomes of the Hogeweyk care concept is surprising and makes it impossible to evaluate the claims made about the model regarding the effect on resident health and wellbeing.

The central idea, characterised as six supporting pillars underpinning the Hogeweyk care concept, is that the organisation, staff and volunteers support residents, all of whom have dementia, to continue to do things they enjoy, while living in domestic-scale households, with management for health conditions (van Amerongen- Heijer, 2015; van Hal, 2014). People live with others who have a similar background in lifestyle groups, with the homes decorated to be familiar and provide cues to engage in household activities. Housing residents with those who have lived a similar lifestyle in the past rather than those who have the same level of care needs is innovative and inconsistent with usual current practice (Hurley, 2012; Ministry of Health, 2013a).

There are some dementia-friendly design principles used, such as using clocks for orientation and different colours to aid with wayfinding. Although the buildings are two storeys high, residents who live upstairs can readily gain access to the ground floor using lifts equipped with smart technology, and automated doors enabling them to go outside easily. The design of the physical environment facilitates wellbeing by reducing the anxiety of being in an unfamiliar place and supports normal living by providing visual cues (Chrysikou et al., 2018). The intention was to build a recognisable Dutch neighbourhood, however, because the village is already built and not evolving like a neighbourhood would, it does not wholly resemble a naturally occurring village (Chrysikou et al., 2018).

The only reports about the effect of living in De Hogeweyk on resident health are anecdotal. Those reports indicate residents require fewer antipsychotic medications and exhibit less behavioural symptoms of dementia than their peers in traditional ARC homes (Jenkins & Smythe, 2013; Luscombe, 2015; Schumacher-Jones, 2014). In one study, from an architectural perspective, the researcher observed people socialising and preparing meals in publicly accessible areas of the village; however, due to the focus of their study, the researchers were unable to determine whether residents were involved (Chrysikou et al., 2018).

Criticism of the Hogeweyk concept relates to ethical concerns about whether the physical environment and enactment of care constitute deception of residents. Anecdotally, it is reported village staff affirm the reality of residents rather than lying to them (Godwin, 2015). Affirmation of the perceptions of people who have dementia in this way is considered by some to be benign and motivated by kindness (Hurley, 2012).

Telling the truth to people with dementia requires consideration of some critical competing factors, and therefore presents an ethical dilemma. The ethical dilemma of truth-telling with people who have dementia lies in balancing their happiness and lack of distress with the moral good of truth-telling, and the breach of trust lying entails. Advice from ethicists prioritises not causing suffering to the person with dementia, achieved by focusing on their emotions and addressing their current concerns (Nuffield Council on Bioethics, 2009). This advice aligns with reported practice at De Hogeweyk, noted in the previous paragraph.

While anecdotal reports about De Hogeweyk are mainly positive, there is a lack of research about the effects of living and working in the village on the people involved. Evaluation of health and wellbeing outcomes for residents and the results on staff in De Hogeweyk would provide valuable evidence for organisations building facilities inspired by the concept. Internationally and in NZ, several villages are being built or have recently been completed (ILT Foundation, 2019; Paola, 2017; Shannon, Jeffs, Neville, & Wright-St Clair, 2019). While the current study explains the transition from Whare Aroha CARE to The CARE Village, inspired by De Hogeweyk, research about De Hogeweyk itself would assist providers in their decision to build similar facilities.

2.3.4 Summary of the chapter section

The traditional biomedical model of care focuses on the efficient management of physical health problems. However, the model has limited utility in the contexts of older people living their lives in ARC facilities, where a holistic model of care may be more appropriate. A holistic biopsychosocial model of care enables a focus on supporting health and wellbeing for older adults living in ARC facilities. Small-scale living facilities are an example of the operationalisation of a biopsychosocial model of care.

Small-scale living facilities are supportive environments enabling residents to continue daily activities facilitated by staff. In these environments, there is a good fit between the resident and the setting, and there are environmental cues to beneficial activities and behaviour. Additionally, distressing overstimulation such as excessive noise is minimised. Research conducted using quantitative measures of quality of life has found conflicting and ambiguous evidence about whether the resident experience is better and more meaningful in small-scale living facilities than it is in traditional ARC facilities. Evidence about the effect of the small-scale living environment on neuropsychiatric symptoms of dementia is also not conclusive.

Families and friends of residents with dementia are welcomed in small-scale living facilities as they would be in the person's home. Most express satisfaction with the environment and care, although family members remain distressed that their relative needs to live in an ARC facility. There is evidence work in small-scale living facilities is different from traditional ARC facilities for the nursing team. Opportunities exist for RNs to work to their full scope of practice leading teams of ENs and HCAs, who work semi-autonomously with support in small-scale living facilities in ARC.

In addition to reviewing the literature about small-scale living facilities in ARC, this section of the literature review highlights the lack of research about De Hogeweyk village. Small-scale living facilities, including De Hogeweyk village, use a biopsychosocial model of care to provide person-centred care to residents. The person-centred practice framework comprises the elements of person-centred care, leading to person-centred care outcomes. I discuss the person-centred practice

framework and review the research literature about person-centred care in the following chapter section.

2.4 Person-centred care and the person-centred practice framework

Person-centred care is a dominant concept in healthcare that has its origins in the care of people with dementia living in ARC facilities. As noted previously in chapter one, factors such as rising consumer expectations, demographics and legislative change, and evolution of philosophies of care have led to the emergence of a shift towards changing models of care in ARC. The ethos of person-centred care contrasts with the biomedical model of care. Person-centred care is a humanistic concept, drawing from Rogers' person-centred psychology (McCormack, Roberts, Meyer, Morgan, & Boscart, 2012). The concept of person-centred care is enshrined in healthcare strategy and policy internationally and in NZ (Ministry of Health, 2019; Nolan, Davies, Brown, Keady, & Nolan, 2004; World Health Organization, 2017).

The concept of person-centred care originates from a philosophy of caring for people with dementia that appreciates them as people. Personhood occurs in relationship with the people who are providing care within organisations that value all people in the organisation (Kitwood, 1995). Other related concepts, all containing the same fundamental themes, are relationship-centred care, patient-centred care, client-centred care and family-centred care (Hughes, Bamford, & May, 2008). Additionally, these concepts seek to operationalise the biopsychosocial model of care (Soklaridis, Ravitz, Adler, & Lieff, 2016).

The overarching themes in the concepts that centralise the consumer encompass the holistic nature of health, the importance of human relationships, respect for all people and their experiences, partnership, effective communication and equality (Hughes et al., 2008). All the concepts placing the consumer at the centre of care assist healthcare practitioners to frame their work in moral terms. The ideas relevant to the ARC context are relationship-centred care, resident-centred care and person-centred care (Thompson, Shindruk, Adekoya, Demczuk, & McClement, 2018).

Much of the literature about person-centred care originates from nursing. Those advocating relationship-centred care claim the focus on the relationship between nurses and the people they are caring for excludes other health practitioners to the

detriment of consumers (Nolan et al., 2004). Additionally, some see the focus on individual autonomy and independence as related to health consumerism and unrealistic for older people (Nolan et al., 2004).

Ideas of independent, autonomous health consumers working in partnership with healthcare providers reflect a philosophy of healthy and active ageing (Nolan et al., 2004). However, people who are unable to embody those ideas because of physical or cognitive limitations are disadvantaged by them. The interdependence of individuals of differing abilities is more relevant to the care of older, disabled people and more inclusive of them (Nolan et al., 2004).

Claiming that person-centredness is individualistic rather than inclusive, the concept of relationship-centred care recognises the relationships between the people providing and using health services. It is proposed that a focus on quality relationships between all people results in positive healthcare experiences and improved outcomes for service users. Relationship-centred care is a humanistic concept drawing from the biopsychosocial model of care, proposed initially by Engel, a psychiatrist, and influenced by other theories from psychology and sociology (Soklaridis et al., 2016).

Resident-centred care is a related concept, specific to residential care settings such as ARC. The term resident-centred care is most commonly used in the United States of America (USA). It describes the operationalisation of the biopsychosocial model of care in ARC organisations that have adopted culture change principles. In these organisations, HCAs are empowered to share decision-making with residents (Castle & Ferguson-Rome, 2013). I review the literature related to culture change in ARC in the following chapter section, beginning on page 48.

The focus on the individual implied in the concept of person-centred care may fail to recognise the interdependence of people and be culturally inappropriate for some. In some cultures, particularly collective cultures such as Māori and Pacific cultures in NZ, health is a holistic concept including whānau (extended family/people who are important to the individual) and wellbeing (Durie, 1985; Ioane & Tudor, 2017). The tension between the emphasis on autonomy and independence evident in the concept of person-centred care and the collective cultures in Māori and Pacific communities indicates a different approach may need to be incorporated in NZ.

Problems understanding and operationalising the concept of person-centred care have led to the development of frameworks to guide practice, initially for nursing. In the early 2000s, a discussion paper identified this work as being in the early stages of development and failing to recognise practice reality and the expertise of experienced nurses (Dewing, 2004). Frameworks to guide the operationalisation of person-centred practice have continued to evolve since that time.

The continued evolution of frameworks to guide person-centred care reflects the growing use of the term in healthcare policy internationally and in NZ. There is tension between the implicit and explicit requirement to practice in person-centred ways enshrined in policy, and difficulties in operationalising the concept in practice. In practice settings such as ARC, where staff are caring for older people, many of whom have dementia, there are many barriers to person-centred practice (Woods et al., 2017).

In ARC facilities, some barriers to person-centred care originate at a systems level. Ongoing underfunding, combined with the increasing dominance of private providers, for-profit providers that constrain numbers, and the educational preparedness of staff may make delivery of person-centred care challenging to achieve (Woods et al., 2017). However, in the context of ARC practice in NZ, where person-centred care is implicit in health and social policy, practitioners may find elements of frameworks useful to inform their work with older people.

The influential work of McCormack and McCance (2010) has developed the ideas of Kitwood (1995, 1997) to provide a theoretical framework for person-centred nursing care resulting in person-centred outcomes. The theory has been updated in response to feedback and to acknowledge the involvement of multidisciplinary healthcare teams engaging in person-centred practice (McCormack & McCance, 2017). The constructs in the framework represent an ecological model comprising organisational, environmental, personal and processual elements and outcomes, depicted in Figure 2, on the following page.

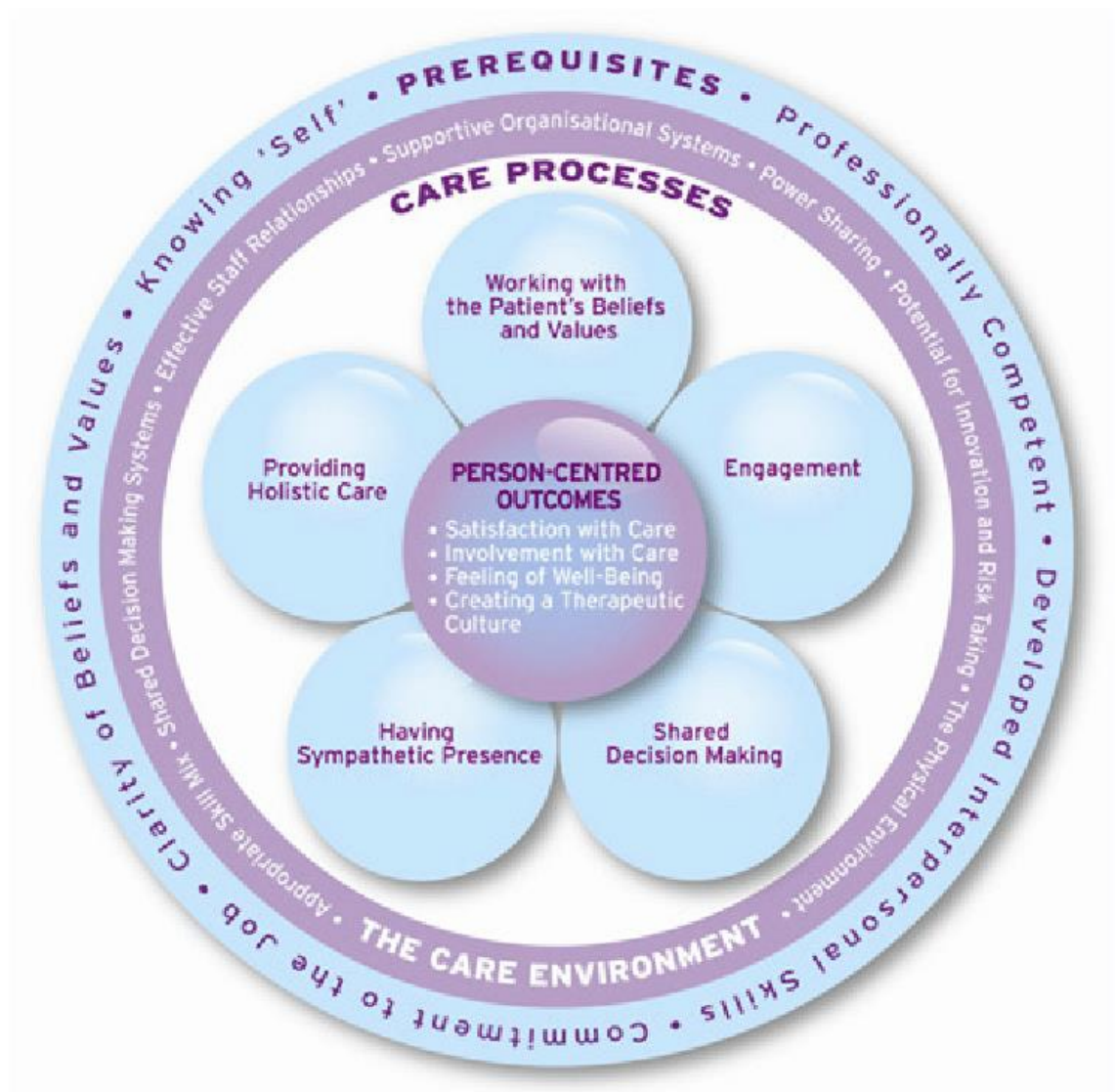


Figure 2. The person-centred practice framework (McCance & McCormack, 2017).

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The constructs within the framework comprise the prerequisites of the practitioner providing care, the care environment, delivery and outcomes of care (McCance & McCormack, 2017). Accordingly, I review the research literature about person-centred care under those headings, below. I begin with the research literature about practitioner prerequisites.

2.4.1 Prerequisites for person-centred practice

The prerequisites for person-centred practice are the attributes required by practitioners that support the delivery of person-centred care. Commitment to the job

influences the way residents experience care. In a mixed-methods study, researchers identified supervision as the most influential aspect of the job on HCA commitment. This “basic supervision” was found to comprise respect for HCAs and willingness to help and problem-solve (Bishop et al., 2008, p. 41). The ability of the supervisors to build relationships with the HCAs is evident in the finding.

The competence of practitioners can be conceptualised as relating to technical aspects of care or ability at interpersonal skills. A synthesis of evidence about person-centredness identified a lack of focus on interpersonal competence, indicating the need for research about how staff develop those skills (McCormack, Karlsson, Dewing, & Lerdal, 2010). The ability to establish relationships with colleagues and the people they are caring for is a pre-requisite for person-centred care.

Sometimes there is a tension between the person-centred values of some staff members and predominant task-focused practices in an organisation. When a minority of staff in an organisation is committed to providing person-centred care, enshrined in policy, those people can experience conflict with other staff members and feel burdened by having to explain person-centred practice to their colleagues (McCormack et al., 2010). This finding indicates a disconnection between organisational policies and daily practice, described as being related to the personal approaches to care of the different staff in the care environment.

2.4.2 Care environments

Person-centred care environments encompass both the physical and the social environment. The physical environment is experienced as being person-centred by residents when they feel at home, have their possessions with them and can see out into a garden (Edvardsson, Fetherstonhaugh, & Nay, 2010). Home-like environments are purposefully created by organisations providing care.

The organisation providing care must support the delivery of person-centred care to enable staff to care for ARC residents effectively. For example, a recent qualitative study has identified a lack of time and the behaviours of residents with dementia as barriers to providing person-centred care perceived by HCAs (Oppert, O'Keeffe, & Duong, 2018). Providers could potentially address both by ensuring adequate staff are

present to care for residents, and those staff have the training they need to help them care for people who have dementia.

A large, randomised controlled study in Australia aimed to investigate the effect of introducing person-centred care with and without person-centred environments for people with dementia living in ARC facilities (Chenoweth et al., 2014). The study was well planned and resourced and included training and ongoing support for managers and staff; however, the outcome was disappointing. Some positive effects on resident agitation, social and environmental engagement, resulting from aspects of the intervention, were demonstrated; however, these were not statistically significant (Chenoweth et al., 2014).

The authors conducted a follow-up qualitative study, seeking to understand the reasons for the inconsistencies in the results of the study from the perspective of facility management and staff and residents' family members (Chenoweth et al., 2015). Significant barriers to the successful implementation of the intervention were identified, including management and staff time constraints, attitudes, language and cultural differences and gaps in communication between management, staff and family members (Chenoweth et al., 2015). The researchers did not identify another possible barrier to change, hinted at when they recognised that changes to enable person-centred care delivery originate with facility management and staff.

Person-centredness encompasses positive relationships among staff as well as between staff, residents and their families. HCAs caring for residents with and without dementia have identified teamwork as a facilitator to providing person-centred care to ARC residents. The study found that while working in teams is necessary to accomplish resident activities of daily living (ADL) care, HCAs obtained support and validation while working with colleagues who shared their ideas about caring for older people (Oppert et al., 2018).

Unfortunately, there can be a paradoxical situation in ARC facilities where staff are expected to provide person-centred care for residents but feel their employers disregard the personhood of staff members. A recent qualitative study found care staff felt undervalued and underappreciated by ARC management, who failed to recognise the complexity of their work (Kadri et al., 2018). Similarly, a Canadian study of HCAs

caring for people with dementia revealed a lack of respect for them as people and a lack of understanding of their circumstances, leaving them feeling undervalued by management (Cooke, 2018). The results of these two studies highlight the importance of congruence between espoused organisational commitment to person-centred care and valuing their staff. Overlooking the personhood of care staff may negatively impact their ability to provide person-centred care for residents.

2.4.3 Person-centred care processes

Person-centred care processes purportedly enable residents who have dementia to continue to do the things they enjoy among people who value and respect them. When staff build relationships with residents, it contributes to their knowledge of residents and their preferences. Unfortunately, the opportunity may be missed by staff, who remain focused on the tasks they are performing rather than on their relationship with the person they are caring for (McCormack et al., 2010). That missed opportunity indicates the intertwined nature of relationship building and person-centred care provision, with a lack of focus on the person aligning with a focus on tasks and routines.

Operationalising person-centred care requires a change in the way staff conceptualise care, from a focus on completion of tasks to a focus on aspects of life that are important to residents, such as the continuation of personal routines. A cross-sectional quantitative study investigated the relationship between resident involvement in daily tasks with the ARC facility, quality of life and person-centred care (Edvardsson, Petersson, Sjogren, Lindkvist, & Sandman, 2014). The small proportion of ARC residents participating in household tasks were more cognitively intact, experienced better quality of life and were more likely to live in facilities delivering person-centred care than the residents who did not participate. The results highlight an opportunity for a simple way to improve resident quality of life while indicating that activities need to be individualised and optional.

In person-centred care environments, routines are flexible in response to resident needs. Time is allowed for residents to do things at their own pace, assisted by familiar staff (Edvardsson et al., 2010; Harrison & Frampton, 2017; Poey et al., 2017). When staff are familiar with residents because they care for them consistently, and residents

feel empowered to discuss health problems with them, there may be a positive impact on resident health (Poey et al., 2017).

An Australian qualitative study sought to identify how ARC staff operationalised person-centred care for residents and how the care was experienced by residents and of personalised and enjoyable activities that enable residents to experience satisfaction and mastery (Edvardsson et al., 2010). Residents experienced person-centred outcomes as a result of person-centred care.

2.4.4 Person-centred outcomes

Person-centred outcomes are subjective, resident satisfaction and feelings of wellbeing are outcomes of person-centred care (McCance & McCormack, 2017). Satisfaction with care can relate to all aspects of holistic care, including physical, social and spiritual care. Researchers have used qualitative and quantitative approaches to investigate the outcomes of person-centred care.

Getting to know residents with dementia as people helps staff to provide care that meets their needs and activities that are continuations of lifelong routines. A recent qualitative study found when care and activities align with the person's preferences and facilitate continuing valued activities, the person experiences life in ARC as being a usual life (Brannelly, Gilmour, O'Reilly, Leighton, & Woodford, 2019). Therefore, living what feels like a normal life in ARC is an outcome of person-centred care.

Neuropsychiatric symptoms of dementia, often in response to unmet needs, indicate distress in the person experiencing them and are a barrier to experiencing normal living in ARC. A randomised controlled trial found an intervention incorporating enjoyable activities, training staff in person-centred care and a review of anti-psychotic medication use resulted in small but statistically significant improvement in quality of life and neuropsychiatric symptoms, compared with usual treatment. There was no reduction in residents' antipsychotic medication use; however, the intervention did not include prescribers (Ballard et al., 2018). The results indicate the potential of person-centred interventions to enhance health and wellbeing for people with dementia living in ARC.

Staff experience positive outcomes such as pride in their work and respect for their work by others in ARC facilities where they can provide person-centred care. When staff are supported to provide person-centred care, they experience greater job satisfaction than ARC staff who are not encouraged to provide person-centred care (Edvardsson, Fetherstonhaugh, McAuliffe, Nay, & Chenco, 2011). The support enables staff to know residents as people, respect their preferences and help them to participate in valued activities. The finding indicates the benefits of facilitating person-centred care extend to both staff and residents of ARC facilities and may have implications for staff recruitment and retention.

2.4.5 Summary of the chapter section

Person-centred care is a philosophical care concept that developed in response to the dehumanising treatment of people with dementia in care environments in the late twentieth century. Person-centred care aims to recognise the personhood of the person being cared for, in relationship with others, who also have their personhood acknowledged. Person-centred care as a concept has been critiqued, and alternative ideas seeking to operationalise the biopsychosocial model of care have been proposed. However, the idea is evident in NZ and international health policies. A nursing theory, the person-centred practice framework identifies the personal characteristics and preparedness of the practitioner for caring work and the influence of the physical and social environments on whether care can be person-centred.

There are many barriers to the operationalisation of person-centred care. However, residents of ARC facilities experience person-centred care when they are cared for in ways that respect their values and desires, in environments that are conducive to participating in activities they enjoy, by staff who are valued and take pride in their work. The movement to change the culture of ARC organisations to facilitate the delivery of person-centred care is known as the culture change movement. I review the literature about culture change in ARC in the following section of the chapter.

2.5 Culture change in Aged Residential Care

The culture change movement in ARC began in the late 1990s in the USA. It aimed to improve the quality of life in facilities by refocusing to resident-centred care provided by empowered staff. By the late 2000s, the movement had grown significantly.

However, there was a shortage of empirical evidence about the effects of culture change on the lives of residents. Additionally, there was an absence of a clear definition of culture change that went beyond description (Rahman & Schnelle, 2008). Subsequently, a review of the literature was conducted to identify the elements of culture change and propose the operational definition below:

Culture change in long-term care is a longitudinal, systemic, holistic process of transforming a long-term care organisation (people, culture, beliefs, actions) and its physical surroundings, from being embedded in a traditional institutional medical model or philosophy to operating as a holistic therapeutic community based upon resident-centred care and dignified workplace practices. Culture change is a multitude of efforts aimed at transforming the psycho-social, organizational, operational and physical environment in order to enhance quality of care, quality of experience, quality of life and create a viable sustainable business through developing a triadic setting that is simultaneously a healthy, positive, enjoyable workplace, a loving, supportive home and a thriving community that meets resident-identified physical, social, emotional, and spiritual needs as well as facilitating a high quality of life for all individuals involved. (Chapin, 2010, p.192).

Advocates for culture change noted that people living in ARC experienced life in institutional settings as conforming to hospital-based daily routines focused on the management of illness and disability. Residents were isolated from the wider community and lived lives devoid of purpose, becoming passive recipients of care (Brune, 2011). Therefore, the need to change the culture in ARC facilities, to improve resident quality of life was evident.

Culture change is a process of continuous quality improvement, undertaken to refocus the underlying philosophy and care delivery in ARC. The focus shifts from managing illness and disability to maximising choice and quality of life while maintaining health (White-Chu et al., 2009). Culture change processes aim to enable the delivery of person-centred care (Petriwskyj, Parker, Brown Wilson, & Gibson, 2015). In the culture change literature, person-centred care is also described as being 'resident-directed,' or 'resident-centred.'

There is some overlap in the use of terms such as 'person-centred,' 'resident directed' and 'resident centred' in the literature. Resident-centred care is a term specific to the culture change movement in ARC in the USA, acknowledging the central position of the

resident in decision-making processes. The relationship between facility residents and management, whereby residents and frontline care staff make daily decisions, supported by management is a feature of resident-centred care (Brune, 2011). The term 'resident-directed care' signals the active decision-making role taken by residents in facilities undergoing a culture change process (Lines, Lepore, & Wiener, 2015).

When care and activities are resident-directed, this means as far as possible, residents are in control of matters affecting them. Various means of identifying resident preferences have been identified, including organisational processes such as reports and surveys, working with residents, learning about them and asking them directly (Abbott, Heid, & Van Haitsma, 2016). Much of the literature about the resident direction of care and activities focus on the day-to-day matters such as preferences in daily routine; staff, organisational and professional factors can be barriers to the resident direction in ARC.

Staff must change the way they approach their work for resident direction to be genuine. While resident choice in day-to-day matters is regarded as significant by some, others prioritise getting their job done, leading to them disregarding the preferences of residents (Abbott et al., 2016). Refocusing the way they think about their work to change from task-focused and staff-centred to resident-directed care can be challenging for HCAs in busy environments (Corazzini et al., 2014; Roberts & Pulay, 2018).

ARC homes are resource-constrained environments, creating a challenge for culture-change initiatives. Generally, there is no funding available for extra staff and existing staff describe having no spare time to consider resident preferences during their working day (Corazzini et al., 2014). There is some evidence indicating that staff in organisations that have adopted culture change models may pay lip service to the provision of resident-directed care. However, constrained staff levels related to inadequate funding inevitably lead to shortcuts and a task focus dominating their work (Corazzini et al., 2014; Engle et al., 2017; Lopez, 2006, 2014).

Much of the literature concerned with resident choice mentions the day-to-day aspects of their lives that residents have greater control over in culture change facilities. However, for care to be genuinely resident-directed, there must be resident

involvement in decision-making processes at a higher level. There is a shortage of research literature about resident participation in operational decision-making in ARC.

One study conducted in the USA addresses the issue of resident direction concerning operational matters in ARC. In a mixed-methods cross-sectional study investigating Green House facilities, researchers found that residents were not included in some critical operational decisions (Cohen et al., 2016). The result highlights the complexity of operationalising resident-direction in ARC, a challenge for leaders of culture change processes.

2.5.1 The process of culture change in Aged Residential Care

Ongoing change is a feature of healthcare practice, driven by factors such as the need to update practice to align with current evidence and the need to improve the experience of service users. The process of changing the culture within ARC facilities requires planned change, and committed leaders (White-Chu et al., 2009). When the change involves challenging embedded assumptions about workplace culture resistance to change may be encountered (Battilana & Casciaro, 2012). Efforts to change practice encounter barriers such as organisational factors or staff beliefs and attitudes, and may be more successful if they are guided by a theory of change (Mitchell, 2013).

Theories of change relevant to changing practice in healthcare contain some common elements related to the phases of the process. Typical stages of the change process include activities related to the identification of the need for change and beginning the change process, activities related to changing practice and events associated with embedding change to ensure sustainability (Mitchell, 2013). Effective and inspirational leadership is a central feature of the culture change process.

The process of leading organisational transformation incorporates elements necessary for initiating, undertaking and sustaining change. These elements have been identified as an eight-stage process by one highly influential author (Kotter, 1995). I list the stages of the process, along with their constituting elements, in Table 2, on page 52.

Table 2. The eight stages of organisational transformation (Kotter, 1995, p. 61).

| Stage | Elements |
|---|--|
| Create urgency | Identify crises or opportunities. Generate discussion. |
| Form a group to lead change | Ensure the group contains members who have the power to bring about change. Encourage collaboration among the leadership group. |
| Develop a vision | Develop a vision to guide the change. Develop strategies to support the achievement of the vision. |
| Communicate the vision | Communicate the vision to management, employees and other stakeholders. Leaders model the behaviour that aligns with the vision. |
| Empower people to put the vision into action | Remove barriers to change including systemic and structural ones. Promote enablers, such as by encouraging creative thinking. |
| “Plan for and create short-term wins” | Create and plan improvements. Recognise staff who contribute to achieving improvements. |
| Consolidate improvements while continuing to promote change | Continue to change aspects of the organisation that don’t align with the vision. Hire or develop staff who can implement the vision. Continue to implement additional aspects of the vision. |
| Embed the changes and ensure sustainability | Make links between the changes and organisational success explicit for staff. Leadership succession planning to ensure sustainability. |

I now review the research literature relevant to the process of culture change in ARC. It is evident that nurses need to be involved in groups leading the culture change processes. A study of the early Green House transformation in the USA identified that nurses felt there was no role for them in the new model of care, due to the focus on the roles of frontline staff. The authors identified the lack of inclusion of nurses in the early stages of planning change, and the lack of appreciation of the value of their contribution to resident care, which contributed to this perception (Kane & Cutler, 2008). As discussed on page 54, nurses have concerns about the quality of clinical care in organisations pursuing culture change. Inclusion of them in the planning process may help address these concerns and remove a potential barrier to progress.

Some organisations undergoing a process of culture change choose to affiliate with a subscription-based organisation such as The Eden Alternative or the Green House movement to enable them to access support and guidance. Members of these organisations have access to structured support for the implementation of changes in their guiding vision, and the way care is delivered (Petriwskyj, Parker, Brown Wilson, & Gibson, 2016). While membership of subscription-based services entails an ongoing cost, individual organisations do not have to 're-invent the wheel' by developing their organisational visions of care.

A recent qualitative study in the USA highlights the importance of communicating the organisational vision of care to frontline care staff in the process of culture change. Participants in the research indicated their intuitive understanding of the need to change practice and awareness of some of the outcomes of culture change, such as changes in terminology. However, they did not know the reasons for implementing culture change in their organisations or how to operationalise it in their practice (Roberts & Pulay, 2018).

The authors of the study frame the staff's lack of understanding as a deficit in their education and training. However, the inclusion of frontline staff such as HCAs at all stages of culture change processes is likely to have a positive impact on their understanding, contributing to changing attitudes of other staff to changes. These staff can be a vital part of communicating the vision that guides the transition to their peers, supporting to the success of initiatives.

Nurses work in ARC as managers and clinical leaders, thereby exerting influence over care delivery. Utilising a Foucaultian lens, scholars have identified the acquisition of specialised knowledge and procedural training as factors shaping the disciplinary perspective of nursing, producing skilled but unquestioning practitioners (Perron, Fluet, & Holmes, 2005). Those who do not acquire the necessary knowledge and skills will not meet the requirements for practice as regulated health professionals, thus ensuring a workforce of practitioners who embody the cultural understandings of the discipline.

In ARC facilities, RNs have traditionally worked in teams with HCAs and others such as ENs. In NZ, the RN holds overall responsibility and accountability for the planning and

delivery of nursing care, while some aspects of care are delegated to ENs and HCAs (Shannon & McKenzie-Green, 2016). Similar jurisdictions internationally, such as the USA, have similar structures and accountabilities in care teams (Bowers & Nolet, 2014). Therefore, the RN is traditionally the leader of the care team in ARC facilities.

In ARC facilities that subscribe to the Green House model of care, the care team is structured in a non-traditional way. HCAs are consistently assigned to the same group of residents, who live in small houses, and HCAs are responsible for managing the day-to-day aspects of care. To support the aim of promoting a home-like, de-medicalised environment HCAs report to a 'Guide', who is not a nurse, for non-clinical concerns, while RNs have a 'visiting' role and retain responsibility for clinical oversight (Bowers & Nolet, 2014).

It is unsurprising, therefore, that nurses have raised concerns about the possible limitations of the Green House model of care in managing residents' long-term health conditions. A review of the literature identified that nurses working in Green House facilities believed the model was likely to result in inadequate care for residents with long-term health conditions. The concern was based on the belief that opportunities for early intervention in deteriorating conditions may be missed (Zimmerman & Cohen, 2010).

Nurses have been identified as acting as barriers to culture change in ARC. Survey data indicates some nurses may find the transition to resident-centred care challenging and perceive that they are de-skilled in the process; however, others may welcome the opportunity to think more broadly about resident care (Mueller, Misorski, & Ortigara, 2016). The finding highlights the need to support nurses in facilities undergoing culture change to broaden their thinking beyond biomedical care and hospital-based routines and indicates that without such support they may be limited in their ability to lead others.

Strong leadership is needed in organisations undergoing culture change processes, to guide staff to commit to and adopt a new way of conceptualising and delivering care. Transformation leadership is a goal-orientated process whereby leaders and followers motivate each other and followers are mentored to enable them to accomplish organisational goals without high levels of direction (Lynch, McCormack, & McCance,

2011). Situational leadership theory aligns with transformational leadership and encompasses leadership styles on a continuum from highly directive to highly supportive (Lynch et al., 2011).

Leadership style affects the impact of culture change processes. An action research study in Ireland has identified the positive impact of supportive leaders developing a leadership style that helped them to guide others as part of culture change processes. The study identified coaching by leaders facilitates staff to build an understanding of the application of person-centredness in practice, increasing commitment to change (Lynch, McCance, McCormack, & Brown, 2018).

Staff selection processes can be supportive of efforts to promote resident-centred care in ARC facilities undergoing culture change. For example, ARC administrators have noted the need to selectively employ staff who exhibit resident-centred values, while actively choosing not to engage those whose values don't support resident-centred care (Corazzini et al., 2014). The finding demonstrates the role of organisational leaders in building teams of people who have personal values that align with the corporate vision.

For culture change processes to lead to long-term sustainable change, some challenges need to be overcome. A qualitative study of Green House homes in the USA investigated the sustainability of culture change, including barriers to change. The authors identified that, despite staff stability, there were many instances of reversion to previous practice in the facilities studied. For example, food preparation practices, accumulation of supplies in areas that are supposed to be home-like and a focus on familiar aspects of their role to the detriment of additional responsibilities such as rehabilitation and activities (Kane & Cutler, 2008). These findings provide evidence that frontline staff require ongoing support in their complex roles to ensure the model of care continues to align with the vision guiding its development.

2.5.2 Summary of the chapter section

The culture change movement in ARC is a recent movement begun with the aim of providing residents with care that is person-centred and resident-directed, delivered by empowered staff in supportive environments. Resident direction of care and other matters that affect them is a central component of the culture change movement; the

term reflects active decision-making of residents. Resident direction can mean having control over day-to-day issues such as when to wake up, or more overarching matters.

There are many barriers to culture change in ARC, indicating the need for strong leadership. Some staff have difficulty adapting to working in ways that foster resident direction of care, particularly those who are enculturated in a disciplinary perspective such as nursing. Staff attitudes can be a barrier to change, highlighting the necessity of following a systematic process of change. Effective change processes are inclusive of staff, enabling them to understand new ways of delivering care that encompass positive relationships with residents and their families.

As part of developing an innovative model of care, the managers of Whare Aroha CARE undertook a process of changing the culture of the workplace. The process is explained in chapter five. Management also collaborated with senior officials from other organisations in a governance network to support the transition from Whare Aroha CARE to The CARE Village. I review the literature about governance networks in public administration in the following chapter section.

2.6 Governance networks in public administration

Governance networks in public administration are groups of officials from different sectors working collaboratively in the arena of public policy. Governance networks have evolved in response to events such as globalisation, the growth of complex problems in public administration, devolution of government services, privatisation, and the rise of sophisticated interest groups (Koliba, Meek, Zia, & Mills, 2017).

Governance networks are:

Relatively stable patterns of coordinated action and resource exchanges; involving policy actors crossing different social scales, drawn from public, private, or non-profit sectors and across geographic levels; who interact through a variety of competitive, command and control, cooperative, and negotiated arrangements; for purposes anchored in one or more facets of the policy stream. (Koliba et al., 2017, p. 60)

Governance is not equivalent to government. Governance is a process involving "coordination and control as an integral dimension of public policy-making and implementation" (Koliba et al., 2017, p. 46). Networks are an integral part of

governance; network membership comprises representatives from states, non-government organisations and the business sector operating with an expectation of accountability (Behagel & Arts, 2014).

There is disagreement about the extent to which governance networks represent a move away from central government control towards greater citizen participation in governance. The rise of networked governance may represent the genuine participation of individuals and interest groups (Ison & Watson, 2007). However, actors from central government often hold the most power in networks, meaning the inclusion of citizens including interest groups may not change the degree of control of policy and its implementation held by the central government (Eberhard, Margerum, Vella, Mayere, & Taylor, 2017; Martin, 2011; McGuire & Agranoff, 2011).

A theoretical model of governance networks in public policy drawn from the literature encompasses four types of variables. These variables are “actors,” “ties,” “network-wide characteristics” and “systems-wide” characteristics (Koliba et al., 2017, pp. 61-64). I summarise and describe the types of variables in Table 3, on the following page.

Table 3. The types of variables in governance networks in policy. (Koliba et al., 2017, pp. 61-64)

| Type of variable | Variable (examples) | Descriptors (examples) |
|------------------------------|-----------------------------|---|
| Network actors | Social scale | Individual Group Organisational/Institutional Inter organisational |
| | Social sector | Public Private Non-profit |
| Ties | Resources exchanged/pooled | Financial Physical Human Social Political Knowledge |
| | Accountability relationship | Owners/shareholders Collaborators/partners/peers Bureaucrats/supervisors/principals |
| Network-wide characteristics | Policy tools | Regulations Grants Contracts |
| Systems-wide characteristics | Systems dynamics | Systems-level inputs, processes, outputs and outcomes |

I explain the types of variables below and review the research literature under those headings. I then review the research literature about the role of governance networks in fostering innovation, relevant to the current study. The explanation and review begin with the research literature about network actors.

2.6.1 Network actors

Network actors are the people comprising governance networks, who bring different attributes to networks. These attributes relate to whether they are representing themselves or an organisation and their organisational sector. Additionally, whether the network is local, national or international, the types of capital network actors

bring, who they are accountable to and who is responsible to them and whether there are any performance outcomes expected of them (Koliba et al., 2017). Furthermore, actors may have goals that align or conflict with the purposes of the organisations they represent (Koliba et al., 2017), including interest groups.

The characteristics required of network actors vary with the purpose of the network. A Danish longitudinal qualitative study investigated the digitisation of services in a university library and found that policymakers led a governance network formed to enact policy change, needed in response to trends in society. The authors also found the involvement of service users as network actors help to ensure services are responsive to their needs (Scupola & Zanfei, 2016). Networks may be formed in response to the need for innovation in public services.

One example of public services is publicly funded services for older adults. In a case from Denmark, the inclusion of actors who had differing or non-mainstream ideas contributed to the development of an innovative rickshaw-ride service for nursing-home residents. Collaboration between an entrepreneur and local government resulted in the development of the service (Sørensen & Torfing, 2017).

The ties between network actors may be formal or informal. For example, in some networks, the organisations represented by network actors have contractual arrangements with each other, formalising accountability (Cristofoli, Markovic, & Meneguzzo, 2014). I address the topic of network ties in the following section of the review.

2.6.2 Network ties

Network ties are the links between network actors. These connections are complex and characterised by their strength and degree of formality, the exchange of resources between network actors and the possession of power and authority by individual actors (Koliba et al., 2017). Resources brought to the network by actors may take the form of knowledge, finances, time or social capital (Koliba et al., 2017).

The strength of ties between actors in a network is frequently related to social capital. High social capital is possessed by actors who can draw on a large number of connections with other individuals (Provan & Lemaire, 2012). High social capital results

from actors spending time together, exchanging resources and perceptions of the emotional bond between them (Koliba et al., 2017). When actors spend time together and develop relationships, trust is established.

Building trust takes time, particularly when trust between actors is initially low. A Scottish qualitative case study noted that when network actors initially distrust each other, taking time to build genuine relationships can result in trust (Ison & Watson, 2007). The development of trust can be especially challenging, given the differing perspectives actors bring to networks.

Strong ties between network actors may be positive or negative. Sometimes, there is a lack of trust between network actors who are tied together in a regulatory relationship. Paradoxically, in this situation, distrust can result in strong ties (Lee & Dodge, 2018). In an example from the mining industry, researchers found that actors with very different motivations for network membership were driven to remain networked by a complex set of rationales including monitoring, gaining insider information and attempting to work together (Lee & Dodge, 2018).

The nature of network ties may influence the effort actors are willing to put into working towards network goals. Canadian researchers utilised quantitative methods to investigate the relationships between network actors in an extensive network of organisations serving the needs of children across multiple sectors (Lemaire & Provan, 2018). The researchers found the relationship between actors and network champions, who are not necessarily leaders but promote the purposes of the network among network actors, is influential. Actors will expend more considerable effort if they share organisational norms and practice domains (Lemaire & Provan, 2018).

There are several sources of power and authority in governance networks. If the network has been formed because of a contractual relationship between an agent representing a government department (the principal-agent), that agent will possess power and authority over the contractor. However, in other networks, power may be shared among members depending on the characteristics of the network (Koliba et al., 2017).

2.6.3 Network-wide characteristics

Network-wide characteristics relate to policy tools, functions, structures and configurations of networks. Policy tools can connect to grants or regulations, for example. In contrast, functions may relate to operational matters such as sharing information or be policy-related, such as policy implementation in a variety of domains. Network governance structures encompass governance that is shared or led by one of the organisations involved in the network, which may be configured as a partnership between government and private enterprise or related to regulation, for example (Koliba et al., 2017).

An example of governance networks enacting policy tools is related to the devolution of services from central government to local government or other services. In response to public pressure for more significant localisation of government services, some UK government services were devolved to the regional government. However, researchers found that governance networks formed during the devolution process were controlled by central government officials. Government control ensured adherence to central policy foci, demonstrating the persistence of power at the central-government level despite the appearance of devolution (Bailey & Wood, 2017).

An example from governance networks in the field of water policy has similar findings. Longitudinal case studies of water-policy networks in Australia, the USA and France found that central and state governments retained control in the networks. They were set up to enable collaboration between central, state and regional governments, state authorities and other stakeholders to address the complex and contested issue of water management. In some cases, the creation of new bodies or ministerial portfolios further consolidated the power of the central government (Eberhard et al., 2017).

Researchers in the UK, using qualitative case study methodology, have found similarly regarding the central government retaining control in governance networks. Central or local government is accountable for spending public money and the policy implementation outcomes of that spending. Therefore, preserving a controlling or steering function in networks implementing policy contributes to that accountability (Fenwick, Miller, & McTavish, 2012), an aspect of systems-wide characteristics of governance networks.

2.6.4 Systems-wide characteristics

Governance networks are complex systems. Consideration of networks as systems contributes to the understanding of the internal network processes contributing to outcomes. Complex systems can be described concerning “inputs, processes, outputs and outcomes” as well as feedback (Koliba et al., 2017, p. 163).

I briefly explain the elements of complex systems as follows. Inputs can be internal, comprising, for example, human and financial resources; or external, for instance, finance obtained externally and regulations. Network processes include decision-making and other network tasks undertaken by actors. Network outputs vary according to the purpose of the network and include plans and reports; while outcomes relate to the goals of the network and may be tied to feedback, such as audit reports or stakeholder feedback (Koliba et al., 2017).

The effectiveness of governance networks is related to the presence of several structural elements. Findings from a qualitative case study of water management in Australia indicate that network actors need to agree about the goals of the network and how they are to be achieved, the goals need to be aligned with the intended outcomes, and network structures must support the ability of actors to work together as a team. Additionally, the legislation and policy framework needs to support the network goals (Robins, Bates, & Pattison, 2011).

Another factor that influences the ability of networks to achieve their goals is trust between network actors. Trust is the willingness to make oneself vulnerable with the understanding that others will not behave opportunistically. In a study comparing networks working on spatial planning in three countries, researchers found a positive association between trust within networks and network outcomes; network management processes enabling actors to work together within defined parameters facilitated trust (Klijn et al., 2016).

Management style includes the types of connections between network managers and network actors. In a study investigating the impact of network manager background, connection style, and turnover in The Netherlands, managers who were more connected to other network actors, and demonstrated an open management style, positively influenced the outcome of network actor satisfaction. Additionally, low

manager turnover positively influenced the same result (Edelenbos, Van Buuren, & Klijn, 2013).

An example from the UK found similarly. In a case study comparing mandated health networks, Ferlie, Fitzgerald, McGivern, Dopson, and Bennett (2011) found networks with a flat rather than a hierarchical management structure, including clinicians, were most effective in achieving desired outcomes. Sharing of management responsibility was found to contribute to the longevity of management teams through not over-burdening busy individuals.

An example from border security, guided by a memorandum of understanding between responsible agencies, indicates improvements in outcomes resulting from a collaborative governance network. Researchers found that collaboration enhanced the positive outcomes desired by each of the organisations involved in the network while reducing adverse consequences; facilitated by a deeper understanding of the contribution and goals of other actors (Emerson & Nabatchi, 2015).

However, governance networks do not always achieve the desired outcomes. Comparing water management networks across three countries, researchers found the complexity of issues driving the need for governance networks contributed to constraining the ability of those networks to achieve outcomes. Additionally, matters evolved, leading to changes in policy goals (Eberhard et al., 2017).

The regulation of industry can be achieved through traditional means involving mandated inspections to ensure compliance. However, an alternative method of control is through collaborative networks comprising regulators and industry representatives. While seeming to offer a solution to the complexity and expense of traditional regulation, an example of a case study investigating an oil-industry disaster illustrates the negative effect of competing interests of network actors on the integrity of the process and outcome (Mills & Koliba, 2015).

The level of complexity of the problem a governance network is addressing has an impact on the measurement of outcomes and consequently on accountability. Global governance networks formed to address the complex issue of climate change are diverse, can have a lack of transparency, have their performance measured against

different standards and have varying accountabilities, including to future generations. All of these factors combine to create a situation where there is a lack of accountability, or it is variable (Zia & Koliba, 2011). However, despite the difficulties of achieving outcomes when problems are complex, governance networks have a role to play in fostering innovation.

2.6.5 The role of governance networks in fostering innovation in services

Innovation may provide novel solutions to complex social problems. An idea does not have to be completely new to be innovative; innovative ideas may be novel to the context. Additionally, innovative ideas can be new ways of thinking about existing problems (Agger & Sørensen, 2018).

Managing governance networks to achieve innovative outcomes is complex and challenging. Network leaders were found to respond differently to the challenges of fostering collaboration to achieve innovative outcomes in local government depending on whether they represented local government or the community (Agger & Sørensen, 2018). Additionally, managing the aspects of the network related to encouraging actors to collaborate are privileged over fostering innovation (Agger & Sørensen, 2018).

However, a successful outcome was demonstrated in a study of service innovation in the library sector, in response to the rise of information and communications technology (ICT). During the 1990s Danish public and university library services were disrupted by the introduction of ICT, while simultaneously responding to fiscal constraints. Longitudinal case study research demonstrated the value of a governance network, led by policy-makers, and increasingly including service users in developing innovative service responses to the rise of technology in the sector (Scupola & Zanfei, 2016).

In addition to fostering innovative services governance, networks can play a role in changing the way services for populations groups are conceptualised. A governance network developed a novel service enabling residents of ARC facilities to experience rickshaw rides with volunteer drivers, who listened to the older peoples' life stories. The network comprised of a local government official, the innovator of the idea, ARC service representatives, sponsors, social entrepreneurs, volunteers and older residents

of ARC. In addition to providing the service, encouraging people to think differently about older people and the services they might use has been a positive outcome of the innovation (Sørensen & Torfing, 2017).

2.6.6 Summary of the chapter section

Governance networks in public policy are groups of people from different sectors who collaborate to achieve goals related to governance. Typically network actors are drawn from government, the private or not-for-profit sectors and interest groups. Ties based on social capital, trust, resource exchange and authority bind network actors together.

The characteristics possessed by networks are their structures, functions and configurations as well as policy tools. Systems-wide characteristics include items such as network processes and the outputs and outcomes of those processes. Innovation in the delivery of public services is a potential outcome of governance networks.

In the current study, a senior official created a goal-directed governance network to support the transition of Whare Aroha CARE residents to The CARE Village. As part of the innovative model of care at The CARE Village, residents are encouraged to continue engagement in valued activities. Supporting residents to continue to engage in activities they value is aligned with the capability approach, discussed in the following section of the chapter.

2.7 The capability approach and wellbeing in older adults

Long-term care supports healthy ageing by maximising remaining abilities and compensating for disability. The World Health Organization (2015, p. 127) defines long-term care, including ARC, as:

The activities undertaken by others to ensure that people with or at risk of a significant ongoing loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity.

The concept of healthy ageing acknowledges the likelihood of accumulated health conditions in older age. It focuses on health as “a fundamental and holistic attribute that enables older people to achieve the things that are important to them” (World

Health Organization, 2015, p. 27). The concept of healthy ageing aligns with the capability approach (Sen, 1993). I now describe the capability approach.

The capability approach is a theoretical framework that is useful for evaluating wellbeing. According to Sen (1993), well-being relates to the capability to participate in valued activities or ways of being. The individual determines the value placed on activities and ways of being, or functionings (Sen, 1993); the elements of the capability approach are described in Table 4, below.

Table 4. The elements of the capability approach.

| Element | Description |
|--------------|---|
| Functionings | States of being, activities a person can achieve, for example being healthy. |
| Capabilities | The functionings that a person can achieve. |
| Wellbeing | The subjective state of the person, related to their achievement of desired functionings. |

The capability approach aligns with the concept of person-centred care as exemplified by the person-centred practice framework, explained, beginning on page 43. A person-centred approach facilitates consideration of ARC resident views regarding things that matter to them. There are, however, some criticisms of the capability approach.

Among the criticisms of the approach is that it is too non-specific to be useful. Consequently, Nussbaum (2000) has specified a list of capabilities. However, the broad nature of Sen's capability approach means there is scope to apply it to a wide variety of contexts (Nordbakke, 2013). The key concepts central to the capability approach concerning the evaluation of wellbeing are wellbeing, functionings and capability (Sen, 1992).

Broadly, there are two ways of conceptualising wellbeing. These are the hedonic approach, relating subjective wellbeing to the achievement of desires, and the eudaimonic approach that relates wellbeing to the use of resources to achieve things that people want to do (Koopman-Boyden & Waldegrave, 2009). The capability approach takes a eudaimonic approach to wellbeing.

Within the capability approach, wellbeing is the subjective state of the person concerning their achievement of desired functionings. Functionings are the way the person can be and the things they can do (Meijering, van Hoven, & Yousefzadeh, 2019). Examples of functionings include physical health, nutrition, mobility, happiness, self-respect and community engagement.

Human agency is the action that is taken to accomplish change, including the ability to choose functionings and may also influence wellbeing (Sen, 1992). The capability of the individual to achieve desired functionings is integral to well-being. Sen sometimes uses the terms 'wellbeing' and 'quality of life' interchangeably (Stephens & Breheny, 2018).

The capability approach is inclusive, recognising the subjective experience of wellbeing as a holistic one. People may experience well-being, or good quality of life, regardless of the ageing process or the presence of disease. People who live in ARC are living with limitations as a consequence of health or other conditions; however, in accord with the capability approach, they may experience wellbeing if they can achieve valued functionings.

Capabilities are opportunities to achieve desired functionings, mediated by factors constraining their achievement. Constraints include the physical and social environments, available resources and personal physical and cognitive limitations (Meijering et al., 2019). The inclusivity of the capability approach, encompassing recognition of all levels of support and ability, together with the alignment of the theory with person-centred models of care, indicate its suitability for explaining wellbeing in ARC residents; however, studies are scarce.

The capabilities approach has been operationalised and applied by scholars and researchers. The ICECAP-O (ICEpop CAPability measure for Older people) is an operationalisation of Sen's capability theory that has primarily been used in health economics (Proud, McLoughlin, & Kinghorn, 2019). One study has used the measure to study the wellbeing of older adults requiring psychogeriatric care while validating the measure (Makai, Brouwer, Koopmanschap, & Nieboer, 2012). The study found decreased wellbeing in participants (as reported by proxies) when they were physically restrained; despite study limitations the authors (Edvardsson et al., 2019) indicate the measure is a way of exploring the wellbeing of older adults in long-term care.

The capability approach has guided a shift to a culture of care for ARC residents with dementia that is person-centred and focuses on valued aspects of daily life. In the project using the work of Nussbaum (2000), mentors were integral to the success of the programme at the two facilities involved. The project enabled staff to see residents as people with individual needs and preferences, encouraging them to shift from task-focused care to person-centred and resident-focused care (Moyle et al., 2013).

The change in focus had some positive results for residents, family members and staff. Residents and family members reported satisfaction with the greater respect for the individuality of residents shown by staff and the improvement in relationships between staff and residents and their families. Staff valued the opportunity to get to know residents as people, and reflected on the resulting increase in job satisfaction (Moyle et al., 2013); a quantitative study measuring staff attitudes to working with people with dementia and resident (proxy) quality of life confirmed the results of the qualitative research (Moyle et al., 2016).

There were challenges encountered during the implementation of the programme. These included negative attitudes of staff, continued task focus of some staff members, often due to time and staffing constraints, and the organisational culture reflecting management attitudes (Moyle et al., 2013). Mentoring of staff was built into the intervention, and the decline in person-centred care when mentoring ceased highlights the importance of mentoring the team to enable them to care for residents with dementia in ways that are person-centred and respectful of matters that are important to them (Moyle et al., 2013).

The study described above indicates the alignment between person-centred care and the capability approach. Additionally, it confirms the suitability of the capability approach as a useful theoretical framework to inform studies relevant to the wellbeing of people who live in ARC, particularly those who have dementia. The environments in ARC facilities are both social and physical.

2.7.1 Summary of the chapter section

The capability approach conceptualises wellbeing as being related to an individual's ability to be who they want to be and to engage in valued activities, known as

‘functionings.’ The approach recognises the agency of the individual to determine their desired functionings. The capability approach includes all levels of ability.

The social and physical environments where people live influence their capability to achieve valued functionings, affecting wellbeing. The influence of the social environment, including models of care and person-centred care, on the lives of ARC residents have been discussed previously, beginning on pages 29 and 40. A high proportion of people who live in ARC have dementia (Seitz, Purandare, & Conn, 2010); therefore the characteristics of supportive physical environments for people living with dementia in ARC are discussed in the following chapter section.

2.8 Dementia-friendly physical environments in Aged Residential Care

There is a global movement to support the development of age-friendly communities, with the aim of continued connection in and contribution to the community and enhanced wellbeing (Turner & Morken, 2016). Age-friendly communities are socially inclusive of older people; however, they may inadvertently marginalise those who have disabilities, such as those related to dementia. Dementia-friendly communities incorporate some elements of age-friendly communities, for example, continued community engagement as well as a disease-specific focus, for instance on the reduction of the stigma surrounding dementia; therefore they are inclusive of older people with and without dementia (Turner & Morken, 2016).

People who have dementia may experience memory and other cognitive impairments. There may be limitations in memory, processing information and orientation in time and space. In turn, the individual’s ability to manage ADL such as eating and bathing, or the more complex instrumental activities of daily living (IADL), such as making and receiving phone calls or negotiating public transport, is negatively impacted (Barberger-Gateau, Fabrigoule, Amieva, Helmer, & Dartigues, 2002). Physical environments can cause or exacerbate disability for people who are experiencing impairments related to dementia.

Conversely, environments can be supportive rather than causing excess disability. The physical environment can provide support for people who are living with dementia, compensating for limitations (Marquardt & Schmieg, 2009). Recommendations for the

design of secure environments for people with dementia living in ARC align with this principle (Ministry of Health, 2016).

When dementia-related disabilities cause the person to be unable to live independently, they may need to live in ARC. The CARE Village houses ARC residents who require private hospital, rest home or specialist dementia services. CARE Village residents are housed with peers who have lived a similar lifestyle rather than with peers who need the same level of care; therefore, the entire village must be a suitable environment for people who require specialist dementia services.

A suitable environment for people who live in ARC and have dementia is a dementia-friendly environment in aged care. Davis, Byers, Nay, and Koch (2009, p. 187) offer the following definition of a dementia-friendly environment in ARC: “a cohesive system of support that recognises the experiences of the person with dementia and provides assistance for the person to remain engaged in everyday life in a meaningful way.” A dementia-friendly environment in ARC is distinct from a dementia-friendly community.

A dementia-friendly community is usually, but not always, a geographically defined locality. Dementia-friendly communities enable people who have dementia to participate in the life of the community for as long as possible, including being socially connected. The aims of initiatives to make communities dementia-friendly are destigmatisation of dementia and empowerment of people who have dementia (Alzheimer's Disease International, 2016).

Within ARC facilities, some residents who have dementia, but not all, will require specialist (secure) dementia services. In NZ, the requirements for specialist dementia services, according to the contract between DHBs and services, include separation from residents who do not need specialist dementia services. Additionally, those residents must have access to a separate, secure outdoor area (Ministry of Health, 2013a).

Every person with dementia is an individual, and their needs will vary accordingly. Design guidelines for ARC facilities for people with dementia should include consideration for the preferences of residents who have dementia and their families

(Fisher, Edwards, Pärn, & Aigbavboa, 2018). Additionally, expert opinion and the views of facility staff and others contribute to the evidence base.

The NZ Ministry of Health (2016) has published evidence-based design guidelines for secure dementia care (including specialist dementia services) environments, consistent with the principles of person-centred care, human rights and cultural responsiveness. The design principles contribute to the well-being of people with dementia. They are “home-like therapeutic environment, gardens and environs, secure dementia care home size and density, managing environmental stimulation, memory aides/cues, floor plans and community links” (Ministry of Health, 2016, p. iii). I list the key elements of evidence-based design for secure dementia care environments in Table 5, below, before reviewing the literature in this chapter section under the majority of those headings, beginning by discussing the research literature relevant to home-like therapeutic environments.

Table 5. Design principles for secure dementia care environments. (Ministry of Health, 2016)

| Principle | Key elements |
|------------------------------------|---|
| Home-like therapeutic environment | Domestic appearance, a mix of private and communal spaces, visible access to outdoor spaces, security features are not obvious. |
| Gardens and environs | Indoor/outdoor flow, walkable spaces, spaces for socialising, provides sensory stimulation, enables people to garden independently. |
| Size and density | Facilities contain clusters of small houses where residents live. |
| Colour and contrast | Colour and contrast are used to minimise the effects of disability. |
| Lighting | Lighting, including natural lights is used to minimise the effects of disability. |
| Managing environmental stimulation | Stimuli that are helpful to residents are maximised, while those that are unhelpful are minimised. |
| Memory aides/cues and floor plans | The environment provides cues to help residents with navigation and activities. |
| Community links | Design facilitates engagement with the surrounding community. |

2.9 Why is the philosophical perspective called ‘critical’ realism?

Scholars have proposed some different interpretations of the use of the term ‘critical’ in critical realism, including the identification of underlying mechanisms causing outcomes (Archer, 1998) and the challenging of assumptions perpetuating social inequalities (Cruickshank, 2003; Sayer, 2000). Both these interpretations have relevance to the current study. They are discussed in the following paragraphs, beginning with the identification of underlying generative mechanisms.

As the recognition of a stratified ontology implies, social actors do not consciously experience all of our environment, nor are we always consciously aware of it being shaped. Consequently, the ‘critical’ aspect of critical realism relates to the ability to reveal the way environments are shaped outside of our awareness, that is, below the surface of observable events (Archer, 1998). Research informed by a critical realist perspective enables the surfacing of unseen mechanisms, leading to the development of explanations of events, including social change.

Some social understandings perpetuate beliefs that may disadvantage some members of society. It is part of the work of social scientists to identify incorrect perceptions, particularly those perpetuating inequities (Sayer, 2004), or those perpetuating human suffering or ill-being (Sayer, 2011). A critical realist approach may enable researchers to identify the causes of ongoing social inequality, and the mechanisms generating, blocking or facilitating social change (Cruickshank, 2003; Reed, 2009).

The current research is about a new model of ARC in NZ, developed to change the lives of people who live in ARC, and therefore would not be possible without challenging the assumptions underlying the current dominant model of ARC delivery. The assumption that people who require specialist dementia services must be segregated from people who don’t within ARC facilities is challenged by the development of a dementia-friendly community in ARC. Within The CARE Village residents who require specialist dementia services are integrated with other residents in a supportive physical environment. Critical evaluation of social phenomena is an integral part of developing explanations of them (Sayer, 2010). Criticism of accepted wisdom is a legitimate part of research, particularly when assumptions enable the continuation of authority and power (Ackroyd, 2004); reflexivity regarding the role of the researcher is

implicit in criticism of accepted wisdom. I continue the chapter with a discussion of epistemology and the epistemological position of critical realism.

Home-like therapeutic environments

As noted previously, supportive environments can enable people who are living with dementia to remain engaged in usual daily life as much as possible. In the Hogeweyk care concept, normal living means people live in and manage their households, with support from staff. The ability to go outside the house readily is a part of everyday life (van Hal, 2014).

There is widespread recognition that home-like environments are most appropriate for people with dementia who require residential care. Residents have reported being unable to feel at home in institutional-scale care homes (Fisher et al., 2018).

Additionally, they may feel they are being controlled by their environment when living in traditional secure dementia-care homes (Fisher et al., 2018; Innes, Kelly, & Dincarslan, 2011).

Several factors can contribute to a home-like feel in ARC. Residents have reported that having their possessions with them in ARC makes the facility feel more home-like (Innes et al., 2011). The presence of a kitchen in the care environment contributes to a home-like feel and, if it is part of an open plan area along with the living and dining areas, enables staff who are working there to observe residents (Chau et al., 2018). However, Chau et al. (2018) did not consult facility residents in their comparison of designs for people with dementia in ARC facilities, indicating their results may not reflect residents' views.

The ARC environment should include private spaces, communal spaces and spaces that afford privacy with visitors. Residents report satisfaction with their quality of life when dementia care environments enable a balance between privacy and contact with others (Fleming, Goodenough, Low, Chenoweth, & Brodaty, 2016). Additionally, living in a home-like environment affords residents the opportunity for healthy conversation, enhancing social wellbeing (Nordin, McKee, Wijk, & Elf, 2017).

When people move into ARC facilities, they may cease participation in lifelong valued occupations. Being in recognisable spaces can support people to continue with valued

activities such as household chores and socialising (Morgan-Brown, Newton, & Ormerod, 2013; Richards, D'Cruz, Harman, & Stagnitti, 2015; Van Steenwinkel, Van Audenhove, & Heylighen, 2017). Having access to a garden contributes to a home-like environment for some people (Fisher et al., 2018).

Garden and environs

Being able to go outside is a normal part of life for New Zealanders. Similarly, it is essential for people with dementia who live in ARC (Kelly, Innes, & Dincarslan, 2011; Van Hecke, Van Steenwinkel, & Heylighen, 2019). Spending time in a garden is associated with improved mood for some people who have dementia (White et al., 2018).

Increasing housing density in major cities, in particular, has highlighted the lack of accessible outdoor space for people with dementia living in ARC facilities. The Ministry of Health (2016) identified the importance of access to outdoor areas, including gardens, in supporting wellbeing for people with dementia who live in ARC. The Ministry of Health (2016) guidelines noted the concerns of many of the people consulted during the development of the guidelines about the growing trend of multi-storey ARC facilities and the consequent limitations to outdoor access for residents.

There is some conflicting evidence about resident perceptions of being able to see the outdoors without necessarily being able to go outside. People with dementia who live in ARC report valuing looking out the window at people going past (Van Hecke et al., 2019), animals, nature and the weather, and being outside feeling the weather and looking at nature (Gibson, Chalfont, Clarke, Torrington, & Sixsmith, 2007). However, the presence of outdoor spaces that are not able to be used can lead to residents experiencing depressive symptoms (Potter, Sheehan, Cain, Griffin, & Jennings, 2017).

Contrastingly, there are definite benefits when ARC residents with dementia can go outside. Being able to go out enables residents to exercise and supports emotional wellbeing (Fisher et al., 2018). Spaces, where residents can garden, walk and exercise dogs, are valued (Kelly et al., 2011), and subjective quality of life is enhanced by the presence of a path that takes residents past interesting objects and activities (Fleming et al., 2016).

Unfortunately, there are barriers to the use of outdoor space by residents. Residents who have high-level care needs may require staff encouragement or support to go outside; therefore, inadequate staff numbers can be a barrier to residents accessing the outdoors (Fisher et al., 2018). Shaded balconies and patios should be accessible and visible from the areas where staff work most often, such as the kitchen, enabling residents to be supervised by staff who are inside the facility, and providing a sense of security for residents who like to remain near staff members (Marquardt & Schmieg, 2009).

Secure dementia care facility size and density

In alignment with previous sections of the review, about the biopsychosocial model of care in ARC, beginning on page 30, De Hogeweyk village, beginning on page 37, and the culture change movement in ARC, beginning on page 48; the current consensus is that smaller and less stimulating environments are preferred for people with dementia living in ARC facilities. The Ministry of Health (2016) recommend taking context into account when designing dementia-care environments, noting the average number of people living in a dwelling in NZ was approximately 2.7, according to 2013 census data. If people are moving into an ARC facility from their own home, where they were one of an average of 2.7 residents, large and crowded spaces could be overwhelming for them, particularly if they have dementia.

Large physical spaces, with large numbers of people present, and no apparent purpose, provide no cues to encourage residents to engage in normal activities. Contrastingly, small recognisable spaces offer environmental cues to action and facilitate social engagement with peers (Morgan-Brown et al., 2013). A recent review of the literature indicated that when there is a low density of people in the care environment, such as in a small house model of care, behavioural symptoms such as aggression may be reduced, and resident social engagement increased. However, there may be reduced opportunities for social interaction when fewer people are present (Marquardt, Bueter, & Motzek, 2014).

Managing environmental stimulation

Environmental stimulation can support resident participation in valued activities, including social events. However, too much stimulation can be overwhelming for

people who have dementia. In a longitudinal study comparing a traditional aged-care facility with a domestic-scale facility Lee, Chaudhury, and Hung (2015) found the overstimulating environment in the traditional ARC facility led to residents being less socially engaged and having less adequate nutrition and hydration than the residents in the domestic-scale facility.

Noise levels contribute to environmental stimulation. Noisy environments in ARC care homes, for example, where there are overhead paging systems or loud television sets can be overstimulating, causing distress (Wong, Skitmore, Buys, & Wang, 2014). Noise caused by other residents can also add to distressing noise levels, leading to exacerbation of behavioural symptoms (Garcia et al., 2012).

Memory aides/cues and floor plans

People with dementia can become distressed if they cannot find their way around their environment. Therefore care environments should be easy to navigate and have a familiar appearance (Ministry of Health, 2016). Residents can find their bedrooms more quickly if their names are on their doors (Fisher et al., 2018; Kelly et al., 2011), or if memory boxes containing recognisable items are outside their doors (Chau et al., 2018).

Floorplans can aid or impede resident navigation in ARC facilities. Resident navigation is facilitated by straight corridors that can be seen in their entirety (Marquardt & Schmieg, 2009). However, institutional environments, with long corridors, do not facilitate navigation for people with dementia (Lee, Chaudhury, & Hung, 2016), such settings are not familiar or recognisable.

Recognisable household features such as a kitchen can assist the residents with navigating the environment. For this reason, it is recommended that there only be one kitchen per home, if other features such as the door out to the garden are near the kitchen, residents will find them more easily (Marquardt & Schmieg, 2009).

Additionally, being in a recognisably domestic environment encourages residents to participate in household chores such as tidying up after meals (Chaudhury, Hung, Rust, & Wu, 2017). Participating in everyday activities such as going out into the garden or tidying up after meals promote a sense of normality; as does remaining connected in the community outside the ARC facility.

Community links

ARC residents may need support to remain connected in the broader community.

Residents can have contact with the community outside the ARC facility when the facility has services such as a café and a hairdressing salon (Fisher et al., 2018).

Additionally, residents value the opportunity to be in an environment that welcomes children and animals (Innes et al., 2011; Kelly et al., 2011; Van Hecke et al., 2019).

Contrastingly, people with dementia who live in residential care facilities have identified the lack of children and animals in the outdoor spaces of the facilities as contributing to a feeling of segregation from the rest of the community (Innes et al., 2011).

2.9.1 Summary of the chapter section

Dementia-friendly physical environments in ARC feature elements that are supportive of residents who have dementia by compensating for disability. The evidence that small, home-like facilities are beneficial environments for people who have dementia intersects with the literature about culture change in ARC and the biopsychosocial model of care in ARC. In general, recognisable, home-like spaces that offer opportunities to interact with a small number of people and participate in the day-to-day running of the household are supportive of ARC residents with dementia, enabling them to do the things they value.

Valued activities for ARC residents include going out of doors and participating in community activities. Making the facility accessible to community members is a way of enabling ARC residents with dementia to continue to have access to the community, diminishing the feelings of segregation they may have. The current study is about the transition from a traditional ARC facility to a village where residents who require specialist dementia services are not segregated from the community within The CARE Village. I discuss the opportunities for further research in the following section of the chapter.

2.10 Conclusion and opportunities for further research

Quantitative studies have resulted in equivocal evidence about whether residents experience better and more meaningful quality of life in small-scale living homes than in traditional ARC homes. Therefore, it is possible that evidence about the subtle and

individual things that matter to residents may be amenable to discovery using qualitative research methods. There is scant evidence about either the process of developing dementia-friendly De Hogeweyk village or the outcomes for the people living, visiting and working there. This knowledge gap provides an opportunity for a study to make a significant contribution to the research evidence about the development process and the outcomes of this particular innovative model of care.

There is a strong evidence base about both the culture change movement in ARC and person-centred care in ARC. Therefore, the current study provides an opportunity to contribute to this evidence base by researching an organisation that began the process of transitioning from an ARC based on a classic model of care to an innovative model of care by changing the culture in the workplace to enable the delivery of person-centred care. Furthermore, the study will add to the small body of evidence about ARC facilities in NZ, including contributing evidence from the perspective of ARC residents.

The development of a governance network facilitated the transition to an innovative model of care in ARC. The review of the literature has identified the importance of governance networks in contributing to innovation in public services, including one service for ARC residents. The current study is an opportunity to add to the evidence about the value of governance networks in supporting innovation in ARC services.

The capability approach is inclusive and recognises the importance of continuing valued activities throughout the lifespan, including when support is required.

Dementia-friendly physical environments support ARC residents who have dementia to maximise their remaining abilities. In chapter three I set out the study's aim and describe and discuss critical realism and case study research methodology, the philosophical perspective and research methodology used to research the transition of Whare Aroha CARE residents to The CARE Village.

Chapter 3 The epistemological and theoretical perspectives and methodology underpinning the study

3.1 Introduction

In the previous chapter I reviewed the research literature relevant to the topic of the current study. The review of the literature identified a lack of research explaining the process and outcome of transitioning from a traditional model of care in ARC to a village model of care. The need to utilise a qualitative approach for developing an explanation of the effects of an innovative model of delivering ARC on the lives of the people experiencing the new model of care was also identified.

The identification of those opportunities for further research led to the development of the research aim; to explain the resettlement of Whare Aroha CARE residents into The CARE Village, and the effects of the resettlement on the lives of the residents. The research questions align with the study aim; these are:

- How has the transition of Whare Aroha CARE residents to The CARE Village been accomplished?
- What is the effect of the transition of Whare Aroha CARE residents to The CARE Village on the lives of the residents?

This chapter explains the epistemological and theoretical perspectives and methodology guiding the current study. The choice of an underpinning theoretical perspective involves assumptions about how we understand the world (epistemology) and the nature of reality (ontology), influencing subsequent decisions in the research process (Denzin & Lincoln, 2018b). These assumptions relate to the scientific paradigm guiding the research that researchers must acknowledge and make explicit (Twining, Heller, Nussbaum, & Tsai, 2017).

Paradigms are guiding positions in the natural and social sciences, consisting of congruent understandings of epistemology, ontology and methodology. “Positivism, post-positivism, critical theory, constructivism and participatory action frameworks” are the main paradigms in qualitative research (Denzin & Lincoln, 2018b, p. 97). Critical realism is in the post-positivist paradigm, encompassing epistemological, ontological and methodological differences from other paradigms (Denzin & Lincoln, 2018b).

3.2 Background to critical realism

Critical realism is a relatively modern philosophy in social science, developed in the 1970s by English philosopher Roy Bhaskar. Bhaskar's early seminal work enables the reader to understand the philosophy relative to the development of causal explanations in social research (Bhaskar, 1975, 1979). Two of Bhaskar's phrases, 'transcendental realism' and 'critical naturalism' have been combined to form the term 'critical realism.' The phrases were put together by others and subsequently endorsed by Bhaskar.

The term 'transcendental realism' relates to Bhaskar's ontological position, while 'critical naturalism' relates to Bhaskar's development of the implications of his ontological position "for the human sciences" (Collier, 1994, p. xi). *A realist theory of science* (Bhaskar, 1975) explains the ontological position of critical realism. *The possibility of naturalism* (Bhaskar, 1979) relates the position to the generation of causal explanations in social science.

Bhaskar's later work introduces additional complexity concerning axiology, metaphysics and philosophy, leading to difficulties in the use of the perspective (Wynn & Williams, 2012). However, in recognition of the difficulties encountered by scholars who want to read and apply critical realism, subsequent authors have interpreted and developed Bhaskar's work, enabling the reader to gain access to the ideas and use them to guide research. Therefore, this study is guided by Bhaskar's early seminal work and the subsequent work of other authors who have contributed to the growth of the perspective (Archer, 1998; Collier, 1994; Cruickshank, 2003; Danermark et al., 2002; Danermark et al., 2019; Sayer, 2000, 2010).

3.3 Epistemology

Ideas about epistemology and ontology are congruent within theoretical perspectives. The choice of a theoretical perspective to guide a study implies related epistemological and ontological assumptions (Denzin & Lincoln, 2018a). Scholars tend to explain epistemology and ontology by using examples relevant to a range of theoretical perspectives (Merriam & Tisdell, 2016).

The terms epistemology and ontology are often used interchangeably in the literature because views about what makes up knowledge about reality and the nature of reality are closely related. The research literature often intertwines understanding of what constitutes the world and how to know about it (Merriam & Tisdell, 2016). The concept of ontology relates to ideas about the world and the nature of reality (Crotty, 1998). I explain the concept of ontology and the ontological perspective of critical realism beginning on page 84.

While ontology provides the philosophical position relevant to the nature of the world, epistemology provides the philosophical basis for determining how knowledge is obtained. The research aim leads the researcher to the most appropriate way of obtaining knowledge about the research problem. Epistemology encompasses understandings about how people comprehend the world and obtain knowledge about it, and there is a range of views about how the world can be known. Congruence between the theoretical perspective and epistemological position underpinning research establishes a legitimate foundation for research (Crotty, 1998).

The epistemological position that aligns with the theoretical perspective guiding a study influences the design of the study and the methods used to collect study data. The theoretical perspective guiding the current study is critical realism. Two dominant epistemological perspectives are positivism and constructionism, and these approaches are briefly explained in the following paragraphs of this section of the chapter, followed by an explanation of the alternative epistemological position of critical realism.

The positivist epistemological perspective aligns with an empirical realist ontology, viewing reality as able to be identified and therefore, able to be measured. Knowledge of the social world is obtained using the statistical and experimental techniques of natural scientists (Ackroyd & Fleetwood, 2000). Observation of the world gained using these techniques enables the identification of patterns in events, regularly occurring, without exception and invariably, thereby enabling generalisations to be made. However, the identification of regularities does not provide causal explanations (Easton, 2010) or include the views of social actors.

The absence of the voices of social actors from social research utilising a positivist approach is problematic for some. The matters that concern people are individual, with subtle differences that may not be amenable to measurement or discoverable using statistical or experimental techniques (Sayer, 2011). An alternative approach, aligned with a relativist ontological perspective, and privileging the voices of social actors, is social constructionism (Lincoln, Lynham, & Guba, 2018).

The term 'constructivism' is used by Denzin and Lincoln (2018b) when explaining paradigms in social science. The terms constructivism and constructionism are often conflated, unproblematically, according to Bryman (2012). Critical realist authors cited in this thesis refer to 'constructionism' when discussing epistemology and ontology, therefore, the term 'constructionism' is used in the remainder of this thesis.

According to the constructionist approach, reality is determined by human concepts and constructed by social actors. There is no one truth, to be found by researchers; instead, knowledge is co-created by the researched and the researcher, using an interpretive approach (Lincoln et al., 2018). While this approach enables understanding of the way social actors interpret meaning, it precludes generalisation or explanation-building. Critical realism offers an alternative epistemological and ontological position allowing the researcher to explain phenomena of interest. Therefore, I utilise a critical realist theoretical perspective to underpin the current study, aiming to explain the process and outcomes of the development of an innovative dementia-friendly community in ARC. The stratified ontology of critical realism is explained beginning on page 85, while I now explain critical realist epistemology.

3.4 The epistemological position of critical realism

Critical realism represents an alternative to positivism and social constructionism. The critical realist approach accepts knowledge as socially constructed; however, it also recognises the existence of a single reality. Critical realism is relativist in its epistemological position, implying ways of knowing the world are influenced by the knower's experiences and environment, therefore, while there is a single reality, there are many ways of knowing about it (Lawson, 2003). In the current study, different perspectives of the process and outcomes of the transition to an innovative model of

care in ARC are explored via the inclusion of research participants who are key informants, facility staff, residents and their family members.

Meanings both describe and partially constitute social phenomena. Additionally, meanings must be understood; therefore, a critical realist epistemology has an interpretive, or hermeneutic aspect (Sayer, 2010). Similar to the constructionist approach, critical realism recognises the fallibility of claims to scientific truth (O'Mahoney & Vincent, 2014).

Because reality is independent of our experience or understanding of it, identification of unseen mechanisms enables causative explanations to be developed by critical realist researchers. The use of a critical realist approach enables the development of explanations of events occurring in complex open systems, rather than the descriptive accounts of events occurring in closed systems resulting from the positivist approach (Ackroyd & Karlsson, 2014). As demonstrated in the current study, the development of explanations of events occurring in open systems requires the use of intensive research methodology and a process of retrodution.

The use of an intensive research methodology enables the researcher to identify causation in context. The researcher uses empirical data and theory in an iterative process of retrodution to identify mechanisms that generate events (Reed, 2009). The process of retrodution identified by Bhaskar (1979) and described by Danermark, Ekstrom, and Karlsson (2019), and exemplified by Blom and Morén (2011), is explained in chapter four, beginning on page 123.

Bhaskar's work provides broad guidance for researchers but does not prescribe the use of any particular methodology. Many methodologies may be used for studies guided by critical realism, enabling the researcher to choose the most appropriate methodology relevant to the aim of the study (Sayer, 2000). Choice of methods is, however, guided by the epistemological and ontological assumptions consistent with a critical realist position (Danermark et al., 2019). Choice of methods in critical realist research will be discussed in the section of this chapter entitled 'Critical realist research,' beginning on page 91.

The distinction between epistemology and ontology is an important aspect of critical realism. As noted previously, epistemology and ontology are closely related, and the nature of the world is sometimes confused with knowledge of the nature of the world; however, they are not the same thing. Bhaskar (1975) describes the conflation of epistemology and ontology, evident in some theoretical perspectives, as the epistemic fallacy.

In the social sciences, an example of the epistemic fallacy in action would be when researchers mistake their interpretation of participants' views of the world for participants' views of the world (Sayer, 2000). The double hermeneutic of social science entails researchers constructing interpretations of participants' interpretations of their worlds. Therefore, the researcher's interpretation of the world is not the same as the world as interpreted by participants.

Identification and explanation of the epistemic fallacy is noted to be one of the significant contributions Bhaskar made to philosophical thought (Collier, 1994). Distinguishing between reality and ways of knowing about reality allows a focus on the ontological position of critical realism. Ontological depth is a characteristic feature of critical realism. I explain ontological depth in critical realism below.

3.5 Ontological depth in critical realism

Ontological understandings concern the nature of the world and reality. Theoretical perspectives guiding qualitative research align with a range of ontological positions. Ideas about the nature of reality are intertwined with those about how reality can be known. Assumptions about reality and how reality can be known about inform the choice of research approach (Crotty, 1998). Depth is a feature of the ontological position aligned with critical realism.

There are three types of depth in critical realist ontology: the intransitive nature of the real world, transfactuality (the enduring nature of mechanisms generating outcomes) and the stratified nature of reality (Archer, 2000). Critical realism recognises two dimensions of science, the transitive and the intransitive (Bhaskar (1975). The intransitive, or ontological, dimension includes all entities and objects that exist in the natural and social worlds. These objects exist independently from a human interpretation of them.

An entity is something that can have an effect, for example, organisations, legislation, people and molecules (Fleetwood, 2005). An example of an entity in the current study is the service development group, brought together to support the transition of Whare Aroha CARE residents to The CARE Village, comprising people, who are also entities. Entities exist in context, and in relationships with other entities.

In contrast to the intransitive dimension of science, the transitive, or epistemological, dimension contains human knowledge of the intransitive dimension and changes as understandings develop (Bergin, Wells, & Owen, 2010). Recognition of the transitive and intransitive dimensions of science informs understanding of the idea that the world is not the same as the human view of it (Bhaskar, 1975). The transfactual nature of generative mechanisms acting in the domain of the real forms part of the intransitive dimension of science.

Although the outcomes of the actions of mechanisms are variable, the mechanisms themselves and their activities do not change; that is, they are transfactual. The transfactuality of mechanisms is contingent on “their relatively enduring properties and powers” (Archer, 1998, p. 195), and enables social scientists to identify mechanisms acting in the domain of the real, one of the three stratified domains of reality identified by Bhaskar (1975).

The stratified ontology of critical realism contains three overlapping domains: the domain of the real, the domain of the actual and the domain of the empirical. These three domains correspond with the world existing independent of human experience or understanding, events occurring in the world, and human experience of those events (Bhaskar, 1975). The domain of the real is the world, both physical and social, “the realm of objects, their structures and powers” (Sayer, 2000, p. 11).

Within the domain of the real, the physical and social worlds both contain objects; these may be physical or social objects and may exist independent of our knowledge or understanding of them. An example of a physical object is a mineral, whereas an example of a social object is a bureaucracy (Sayer, 2000). An example of a social object relevant to the current study is Central TAS, an influential bureaucratic organisation. Objects are structures or parts of structures in the physical or social worlds.

Similarly to objects, structures exist objectively in the physical and social worlds. For example, in the social world, bureaucracies are structures and possess characteristics such as organisational structure and access to information (Sayer, 2000). The characteristics of objects and structures give rise to powers, and these may or may not be activated.

Powers exist whether or not they are activated, and if activated, whether or not other powers block them. For example, in a bureaucracy, a power is activated when bureaucratic processes enable information to be classified (Sayer, 2000). Activations of powers cause events to occur in the domain of the actual (Sayer, 2000): for example, in the current study the structures and powers of senior officials from organisations such as Central TAS, acting in the domain of the real, have caused a variation of the contract between Lakes DHB and The CARE Village, occurring in the domain of the actual.

The domain of the empirical consists of experience, comprising what is experienced in the domains of the real and the actual. In the current study, this domain consists of the experiences of study participants during and after the process of transitioning from Whare Aroha CARE to The CARE Village. In the example given in the previous paragraph, the variation of the contract between Lakes DHB and RCCT enabled The CARE Village to be certified to provide ARC services in an innovative way. Residents, staff and family members experienced the outcome of the variation of the contract as the enabling of residents to be housed with like-minded peers and desegregation of residents requiring specialist dementia services. The manager, who was part of the collaborative governance network supporting the transition, experienced the events related to the process of varying the contract. The stratified ontology of critical realism is represented in Table 6, on the following page.

Table 6. The stratified ontology of critical realism (Bhaskar, 1975, p. 13). Reproduced with permission.

| | Domain of Real | Domain of Actual | Domain of Empirical |
|-------------|----------------|------------------|---------------------|
| Mechanisms | √ | | |
| Events | √ | √ | |
| Experiences | √ | √ | √ |

From a critical realist perspective, the world exists independent of human knowledge of it. Humans can develop socially produced, flawed and continually evolving knowledge of the world focused on explaining events caused by unseen mechanisms. There are several central aspects of critical realism, considered below.

3.6 Central aspects of critical realism

Scholars have identified some central aspects of critical realism in addition to the epistemological and ontological positions. These are the distinction between “the transitive and intransitive dimensions of knowledge,” “causation,” “emergence” (Sayer, 2000, pp. 1-13), the roles of structure and agency in causation (Archer, 2003), and generative mechanisms (Bhaskar, 1975). This section of the chapter continues with an expansion of the discussion of the transitive and intransitive dimensions of knowledge.

3.6.1 The transitive and intransitive dimensions of knowledge

Scientific endeavour produces the transitive dimension of knowledge, whereas the intransitive dimension of knowledge endures regardless of human interpretation (Bhaskar, 1975). Social phenomena such as collaboration between Whare Aroha CARE management and senior government officials and physical aspects such as the physical environments at Whare Aroha CARE and The CARE Village are examples of objects of inquiry in the intransitive dimension of knowledge in the current study. The explanation produced as a result of the research process is an example of an object in the transitive dimension of knowledge.

Depending on the methodological perspective used, the transitive dimension of knowledge contains scientific knowledge that is socially produced, fallible and variable. In addition to the possibility of creating different interpretations of the same objects of

inquiry, scientific work builds on previous knowledge to develop new knowledge. The goal of critical realist research is the identification of mechanisms, acting in the domain of the real to cause phenomena of interest.

3.6.2 Causation

The enduring objects comprising the domain of the real may or may not be experienced or understood by humans. In this domain, mechanisms exist in context and complex relationships with other mechanisms, and produce outcomes, but not in a regular pattern of occurrence due to constraining or enabling features of other mechanisms or contextual factors (Bhaskar, 1975). The interactions between generative mechanisms cause the actions of some mechanisms to be blocked or redirected, causing no outcome or a different outcome to occur (Reed, 2009).

Mechanisms that are not blocked or redirected are actualised, causing events to occur in the domain of the real. Social actors experience these in the domain of the empirical. Social actors experience events through their lenses, or ways of viewing the world, including ways of seeing the world developed as part of conforming to the norms of a professional discipline or social position. Some events occur, and actors do not experience them. Additionally, actors may misinterpret the events they experience, necessitating the work of science (Bhaskar, 1975). Social structures and human agency are both considered to have a role in the causation of events (Archer, 2003).

The development of explanation in social research includes identification of causation attributable to human agency and social structures, with the relative influence of each being contestable. Critics claim that critical realism focuses on the role of structure while paying inadequate attention to the role of agency in generating outcomes (Reed, 2009). Archer (2003) acknowledges the truth of this claim while noting the ongoing development of the scholarship of critical realism regarding the impact of agency in the relationship between the causative powers of human agency and social structures.

3.6.3 The roles of structure and agency in causation

An explanation of both concepts will assist the reader to gain a deeper understanding of the role of structure and agency in critical realist explanations of social phenomena. The intentional acts of human actors cause events to occur; thus, they are the bearers

of agency, incorporating intentionality and praxis, the process of applying ideas (Hartwig, 2015). Human agency incorporates thought processes such as ideas and aspirations (Porpora, 1989).

While agents may intend to cause events to occur, the outcome of human intention may be enabled or constrained by structures within society (Archer, 2003). There is an ongoing debate among sociologists about what constitutes social structure. Ideas about social structure align with differing philosophical positions.

Common ideas about social structure centre on the roles of human behaviour and human relationships. The concept of social structure that aligns with realism is that social structures comprise relationships between people occupying differing social positions (Porpora, 1989). Human agency thus has a role in producing social structures.

The properties possessed by social structures have the potential to block (constrain) or promote (enable) the exercise of human agency. Causation is the result of the interaction of human agency and social structures, which are developed via the exercise of human agency (Cruickshank, 2003), resulting in different outcomes for people depending on these influences (Archer, 2003). When considering the concept of constraints and enablers, agency is evident, with the outcome of its exercise potentially influenced by constraints or enablers (Archer, 2003).

In contrast to the subjective nature of human agency, structures are objective things in society and have causative powers. Social structures are dependent on social relations for their production (Bhaskar, 1979), for example, economic systems (Sayer, 2000). Causative powers are possessed by human agents and by social structures, and are exercised by both in complex interactions in specific contexts, causing the emergence of new phenomena (Archer, 2003).

3.6.4 Emergence

Understanding of the concept of emergence in critical realism entails recognition of the stratified nature of reality. New phenomena emerge as a result of the interactions of generative “mechanisms and powers” at discrete layers of ontological depth (Reed, 2009, p. 431). Emergent phenomena have properties that distinguish them from the aspects of human agency and social structures that constitute them (Sayer, 2000).

For example, in the current study the caring practices at The CARE Village, entailing an emphasis on doing things with residents as opposed to merely doing things for them, have emerged from the ongoing changes in the organisational culture. The changes in practice are evident in the domain of the empirical and are not reducible to (the same as) the changing culture from which they emerge. In turn, the changing culture evident in the domain of the actual is not reducible to work undertaken to change the organisational culture, occurring in the domain of the real.

3.6.5 Generative mechanisms

In natural science, identification of regularly occurring events (known as ‘regularities’) enables generalisations to be made (Easton, 2010). Scientific experiments that are conducted to produce regularities to identify causation eliminate the influence of mechanisms not being studied; this is known as creating a closed system (Danermark, Ekstrom, Jakobsen, & Karlsson, 2002). Closed systems are useful for identifying mechanisms causing events in the natural world; however, the social world is an ‘open’ system not controlled by researchers (Bhaskar, 1975).

In contrast with positivist scientific endeavour in the natural world, concerned with the identification of regularly occurring patterns of events, critical realists focus on the identification of often unseen causal (generative) mechanisms (Sayer, 2000). Causal powers (mechanisms) are properties of things and people to act, and they exist regardless of whether they are exercised (Danermark et al., 2002). Critical realists recognise that causal mechanisms in the social world do not act regularly.

The powers of generative mechanisms may or may not be exercised and may or may not be actualised if they are exercised. If those powers are actualised, the result(s) may or may not be perceived (Bhaskar, 1998). Additionally, they may block each other or cancel each other out (Archer, 2015), and the outcome of the exercise of causal powers is context dependent (Sayer, 2000). Generative mechanisms act in the domain of the real to produce events in the domain of the actual, leading to outcomes, experienced in the domain of the empirical.

Generative mechanisms do not produce outcomes in isolation; they do so by interacting with each other (Archer, 2015). Generative mechanisms are often quite ordinary and everyday, such as in the example given by (Sayer, 2000, p. 14) that could

relate to the current study: “They built up a network of political connections.” The discovery of generative mechanisms in open systems such as the social world requires a different mode of scientific inquiry, such as critical realism (Sayer, 2000).

3.7 Reflexivity in critical realism

A lack of focus on reflexivity regarding the role of the researcher in the production of knowledge is a criticism of critical realism. Baert’s critique on this topic, cited in Reed (2009), focuses on the critical realist ontological claim of objective reality, consequently risking producing knowledge aligned with the outmoded spectator model of researching exotic groups. Baert, cited in Reed (2009), further criticises the downplaying of the role of the researcher in the social process of constructing knowledge.

However, critical realists acknowledge the importance of reflexivity and the double hermeneutic of social science. The use of reflexivity in critical realist research will enable the researcher to acknowledge the impact of their position concerning the objects of research (Sayer, 2000). The double hermeneutic, the human interpretation of the interpretations of social actors, is explicitly acknowledged by critical realist scholars (Mutch, 2006).

3.8 Critical realist research

Research guided by a critical realist theoretical perspective focuses on building explanations of social phenomena by identifying the mechanisms causing them. Because the need to explain social phenomena can occur in response to a problem in society, the research can result in identification and critique of oppressive social structures. Therefore, critical realist research can be seen as emancipatory because the surfacing of unseen mechanisms causing social problems can be the beginning of a change in thinking about those problems (Collier, 2000).

A variety of research methodologies are suitable for use by critical realist researchers. Therefore, it can be challenging for researchers who want to use critical realism as a meta-theory to guide research to know where to begin. Explanation building begins with the proposal of a potential generative mechanism, then the evidence is collected

to support or refute the existence of the proposed mechanism and, finally, possible alternative mechanisms are eliminated (Outhwaite, 1998).

The identification of generative mechanisms is accomplished by using a series of logical processes while analysing study data. These processes are abduction and retroduction. The processes used to analyse the study data are described in chapter four, beginning on page 107.

The critical realist focus on explanation in social science research guides the researcher to include the perspectives of social actors in study data. Because the views of people are individual and context-dependent, they are not amenable to investigation using quantitative data collection methods (Sayer, 2010). Therefore the critical realist researcher is further guided to include a qualitative component, capturing the subjective aspects of the phenomena under investigation (Sayer, 2010).

The lack of a prescribed approach is seen as a weakness by some critics (Reed, 2009); however, it can also be seen as a strength, offering the researcher some flexibility to choose methods appropriate to the aim of the research (Sayer, 2000). The critical realist researcher should possess theoretical knowledge of the topic of investigation and choose the most appropriate methodology for building an explanation of the phenomena being investigated (Sayer, 2000). Critical realist research involves the use of theory at the beginning of the study to develop beginning propositions for the study, and during the analysis to retroduce the study data.

3.8.1 The role of theory in critical realist research

Even when it is not explicitly acknowledged, all research begins with theory. The use of theory is integral to the process of understanding the topic of investigation in critical realist research (Ackroyd, 2004). The use of theory-driven methods guides the researcher to identify the underlying and unseen mechanisms that are responsible for things that happen in the social world (Danermark et al., 2002).

The researcher begins with theories about possible mechanisms generating the phenomena of interest, derived from literature or expert knowledge. The social world is complicated because it contains knowledge, which is socially constructed, so it is dependent on some knowledge for its existence (Sayer, 2000). The research

process, resulting in the construction of fallible and incomplete knowledge, is “iterative and ongoing” (Ackroyd, 2004, p. 158).

When generating new knowledge, it is not adequate to use everyday understandings to explain the phenomena of interest. These understandings must be interpreted using theoretical understandings, enabling new knowledge to be produced (Danermark et al., 2002). As described previously, during data analysis causal explanations are developed using existing theory, identified during the review of the literature to redescribe the events in the data (O'Mahoney & Vincent, 2014).

There are several different types of theory, identified by Danermark et al. (2019) as metatheory, normative theory and descriptive theory. Metatheories are the foundational scientific theories, incorporating ontological and epistemological perspectives; critical realism is an example of a metatheory. Normative theories encompass concepts relating to the difference between current and ideal situations, while descriptive theories are useful for interpreting social phenomena (Danermark et al., 2019).

Descriptive theories are those “claiming to be able to describe and characterise more fundamental properties, structures, internal relations and mechanisms” (Danermark et al., 2019, p. 137). There are two types of descriptive theories: those that are specific to certain situations, such as the person-centred practice framework (McCance & McCormack, 2017) used in the current study, and those that are more general (Danermark et al., 2019). Using descriptive theory during the analysis enables the conceptualisation of mechanisms and events (Danermark et al., 2019).

Conceptualising study data using theory is the same as abstracting and isolating fundamental qualities, and enables researchers to speak about properties, structures and mechanisms (Danermark et al., 2019). Theory is fallible and continually changing (Danermark et al., 2019). However, when using theory, the researcher explains why they believe a particular theory is relevant to the analysis, enabling the reasoning to be understood by the reader (Jagosh, 2017). The use of theory enabled me to interpret and explain the events occurring in the domain of the actual, experienced by study participants in the domain of the empirical and captured in the study data, to identify the underlying mechanisms, in the domain of the real, causing them to happen.

Critical realists use a process of retrodution to identify generative mechanisms causing outcomes, answering questions about causation in social research. The process involves a backwards movement to consider what must have been responsible for the occurrence of the phenomena or phenomenon of interest (Lawson, 1997). The outcome of the process of retrodution is an explanatory model, indicating how the mechanisms producing the phenomena of interest were identified (Reed, 2009).

The work of Bhaskar provides the meta-theoretical framework to guide research. Subsequent authors, including Danermark et al. (2019), have described the process of developing explanations in critical realist research. The model developed by (Danermark et al., 2019) is utilised for the study because it provides detailed guidance to the researcher; an explanation of the process is provided in the following chapter, beginning on page 123.

Researchers from a range of disciplines, including health, have noted the value of critical realist research, using it to identify causation and to develop explanations of events in context. These include researchers in human geography (Yeung, 1997), business (Ryan, Tähtinen, Vanharanta, & Mainela, 2012) and emancipatory practice development in nursing (Parlour & McCormack, 2012). In ARC, research informed by a critical realist perspective has been used to explain the implementation of evidence-based practice (Masso, McCarthy, & Kitson, 2014).

In the field of human geography, Yeung (1997, p. 65) was dissatisfied with the inconclusive results and Western ethnocentric stereotypical assumptions of previous research about the organisation of “transnational corporations from Hong Kong.” His research explained the causative power of interpersonal relationships in the complex network of Hong Kong transnational corporations. The use of a critical realist framework to guide the research facilitated the application of theory to develop a novel explanation of business organisation in an evolving global economy.

In business, critical realism guided the work of Ryan et al. (2012) seeking to explain the process of the evolution of relationships within business networks. For example, use of retroductive reasoning enabled the researchers to identify the underlying mechanisms generating changes in sponsor/sponsee relationships over time, relevant to the management of financial crises in the art world. While study data enabled the

development of a timeline describing the sequence of events, retroductive reasoning enabled the researchers to move beyond description to explanation.

A realist evaluation guided by critical realism enabled Parlour and McCormack (2012) to understand the effect of context on the implementation and sustainability of practice development strategies to support the delivery of person-centred care in an older people's care setting. The researchers utilised a cyclical emancipatory practice-development model to enable them to identify the mechanisms most likely to be effective in initiating and sustaining changes in workplace culture, leading to person-centred care. An interacting group of mechanisms acting in context to generate outcomes was identified, illuminating the complex nature of supporting the development of person-centred cultures in care settings for older adults.

In the field of practice development in ARC, Masso et al. (2014) aimed to identify causation of implementation of evidence-based practice and the interactions between those mechanisms in complex settings. Grounded theory methods guided by critical realism enabled the identification of four generative mechanisms encompassing the shared understandings of co-workers, developed through conversation and continuing to evolve. Other mechanisms, such as staff agency, managing competing priorities, and connecting new and existing knowledge, may enable or constrain evidence-based practice in ARC organisations.

The studies by Yeung (1997), Parlour and McCormack (2012), Ryan et al. (2012) and Masso et al. (2014) indicate the suitability of critical realism as a framework to guide the current study. The explanation of the impact of interpersonal relationships in business organisations has similarities to the influence of personal networks evident in the present study. Similarly to the work of Parlour and McCormack (2012), changes in the organisational culture at Whare Aroha CARE and The CARE Village have enabled resident care to become more person-centred than previously.

Although critical realism does not prescribe a particular research methodology, case study research methodology aligns well with critical realist research. Case study is useful for intensive research seeking to explain phenomena in context, beginning with possible theoretical explanations, utilising qualitative and quantitative data (Yin, 2014). This alignment between critical realism and case study has led to researchers

across disciplines choosing a case study research methodology informed by critical realism to conduct intensive research seeking causal explanations.

Research can be extensive or intensive. Extensive research is useful for broad population-based studies seeking to identify patterns. In contrast, intensive research is useful when seeking to develop explanations of causation suited for case study and aligned with a critical realist ontology (Easton, 2010). Additionally, a critical realist case study is suited to developing explanations of phenomena in "relatively clearly bounded, but complex phenomena such as organisations" (Easton, 2010, p. 123).

Case study research methodology is useful for both describing and explaining phenomena, with case studies seeking to describe suited to an interpretive approach while explanatory case studies align well with a critical realist approach. By seeking an explanation, the researcher is acknowledging the existence of truth that can be explained (Dobson, 2001). Case study research methodology in critical realist research is useful for developing explanations of events in complex situations by identifying the unseen mechanisms enabling phenomena to occur (Ackroyd, 2004), providing a new understanding of the case (Ackroyd & Karlsson, 2014; Milligan, Gilmour, & Huntington, 2018).

3.9 Case study research methodology

There are several divergent views about the applicability of qualitative case study research methodology, such as utilised for the current study. Some researchers believe qualitative case study research methodology is only suitable for exploratory studies or descriptive rather than explanatory studies. In contrast, others claim that case study methodology is useful for gathering preliminary data to assess whether a topic is worthy of further study (Yin, 2014). However, there is increasing recognition that case study research methodology is useful for exploratory, descriptive, explanatory and evaluative studies in the social sciences and health (Byrne, 2009a; Yin, 2014).

There are several different uses of the term 'case study.' Case study is described by some authors as a methodology (Cresswell, 2007), by others as a method (Byrne, 2009a; Yin, 2014), or as a research topic (Stake, 1994; Yin, 2014). The current study uses case study methodology and methods that offer a rigorous approach to research.

As stated in the previous chapter, researchers utilising a critical realist theoretical framework are not restricted to a particular methodology. For research using a critical realist theoretical perspective, the study aims and questions guide the choice of methodology. The current study aims to explain causation, via the research questions, prefaced by the words 'how' 'why' and 'what.' Case study research is particularly useful for investigating contemporary research problems, that are out of the researcher's control and seek to answer questions about social phenomena in context (Luck, Jackson & Usher, 2006). Therefore, case study is the appropriate methodology for this study, explaining the processes and outcomes of the transition of Whare Aroha CARE residents to The CARE Village.

Several scholars have contributed to the development of case study research methodology. These include Eisenhardt (1989), who describes a method of inductively deriving theory from study data; Burawoy (1998), who describes a method of building on existing theory utilising a reflexively-informed ethnography; Stake (1995), whose work is guided by a constructivist epistemology (Ridder, 2017); and Yin (2014), who claims his interpretation of case study methodology can align with a realist or with a relativist epistemological perspective. The suitability of the work of Yin for research utilising a realist perspective led to the decision to use the work of Yin (2014) to guide the current study.

The study utilises the technical definition of case studies, comprising two parts, provided by Yin (2014, p. 18).

- A case study is an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between the phenomena and the context are not clearly evident.
- The case study inquiry copes with the technically distinctive situation in which there will be many more variables of interest than data points, and as one result; relies on multiple sources of evidence, with data needing to converge in a triangulating fashion, and as another result, benefits from the prior development of theoretical propositions to guide data collection and analysis.

The first part of the definition, above, points to the suitability of case study research methodology for the current study, investigating a real-life, contemporary

phenomenon; and to the alignment of critical realist research, beginning with theory (Danermark et al., 2002). The second part of the definition of case study provided by Yin (2014) states that the development of theoretical propositions at the beginning of a study enhances data collection and analysis. Accordingly, the current study began with theoretical propositions derived from the Hogeweyk care concept and developed in consultation with the management team at Whare Aroha CARE.

3.9.1 The theoretical propositions for the study

There were two beginning theoretical propositions for the study, as described by Yin (2014); the first proposition was developed following conversations with managers of Whare Aroha CARE about why and how they chose to develop a village based on the Hogeweyk care concept. The first proposition is that the need to move to new premises created an opportunity for Whare Aroha CARE management to explore alternative models of care for their residents. Furthermore, the desire to improve the lives of Whare Aroha CARE residents led to Whare Aroha CARE management using their industry knowledge and networks to accomplish the transition to a new model of care.

The second proposition was developed from the Hogeweyk care concept and relates to the effect of the transition on the lives of the residents. The Hogeweyk care concept is based around care for people who have advanced dementia that respects their individuality, fosters social engagement and enables them to live normally, in small group households that function like any other household, supporting the quality of life. Underpinning the framework that enables quality of life for residents are the six pillars of “a favourable surrounding, pleasure in life and meaning in life, health, lifestyle, organisation and employees and volunteers” (van Amerongen- Heijer, 2015, n.p.).

The second beginning theoretical proposition is that, following the transition to The CARE Village, Whare Aroha CARE residents will live in familiar domestic-scale environments that support their normal living, their individuality will be respected, and social engagement will be fostered. The new domestic-scale environment has access to the outdoors and opportunities for formal and informal social interactions. The new environment will support greater normalisation of daily life, and enhanced opportunities to enjoy life’s pleasures for residents.

3.9.2 The different types of case study research

There are several different types of case study, undertaken depending on the rationale for the research. Intrinsic case studies and instrumental case studies have different purposes. An intrinsic study is one conducted to increase understanding of the case itself. An instrumental case study is conducted to assist the development of theory or develop an understanding of an issue; therefore, the case itself is of secondary importance (Stake, 1994).

Furthermore, case study research may be used to explore, describe or explain the phenomenon under investigation: in other words, the case (Yin, 2014). Additionally, single or multiple case study research designs may be used, depending on the purpose of the research. Both single and multiple case studies may be holistic, or they may incorporate embedded units of analysis, where the analysis focuses on multiple outcomes within the case (Yin, 2014). A single case study design with multiple embedded units of analysis was chosen for this study.

3.9.3 The essential components of case study research

Yin (2014, p. 29) has identified five components of case study research methodology. These are the research questions, the study propositions, the case or unit of analysis for the study, “the logic linking the data to the propositions; and the criteria for interpreting the findings.” The study propositions have been discussed previously; the remaining four components of the case study research methodology are described, and discussed concerning the research, below, beginning with the research questions.

The research questions

The questions for the study led to the choice of case study methods. As stated previously, on page 97, case study research is useful for questions beginning with ‘how’ or ‘why’ (Yin, 2014, p. 29). The research questions for the study were:

- How has the transition of Whare Aroha CARE residents to The CARE Village been accomplished?
- What is the effect of the transition of Whare Aroha CARE residents to The CARE Village on the lives of the residents?

Answering the first research question has explained the process of the transition of Whare Aroha CARE residents to The CARE Village. The answers to the second research question explain the outcome of the transition. The two research questions for the study were developed following consultation with Whare Aroha CARE management about the case.

The case and units of analysis for the study

The case or unit of analysis for the study needs to be defined, and has boundaries to enable the research project to be manageable; for case study research, a case is a phenomenon occurring in real life, manifesting concretely (Yin, 2014). For the current study, the case was already selected at the beginning of the project because the management team at Whare Aroha CARE approached the Centre for Active Ageing at AUT University with a request for research to be conducted about the transition to The CARE Village. Therefore, the case or unit of analysis for the study was the transition of Whare Aroha CARE residents to The CARE Village.

The researcher may investigate a single case or multiple cases. A multiple case study is considered to be a stronger design than a single case study because theoretical concepts developed from multiple case studies may be more readily generalised to other situations than those developed from single case studies (Foley, 2012). In a multiple case study design, a comparison of the results of data analysis across cases either confirms or refutes the theoretical propositions for the study (Foley, 2012).

The comparison of the results of analysis and theory development across cases contributes to the internal validity of the study by enabling rival theories to be rejected, further strengthening the argument for utilising a multiple case study design (Foley, 2012). However, in this instance, the rationale for selecting a single case with embedded units of analysis, rather than multiple cases, to study is that the case is unique. The rationale aligns with that described by Yin (2014). The current study is a single case study with embedded units of analysis.

In a single case study design, an embedded unit of analysis is a subunit of the case. An example of an embedded unit could be a household within a neighbourhood when the neighbourhood is the case (Yin, 2014). A single case study design with no embedded

units of analysis is a holistic design, selected when there are no logical subunits in the case (Yin, 2014).

Where there are logical embedded units in the case, such as in the current study, there are some advantages and disadvantages, compared with a holistic design. A holistic design risks the results of the study being abstract, whereas an embedded design allows the researcher to explain phenomena at an operational level (Yin, 2014). For example, in the current study, the embedded units of analysis are the residents, family members and staff of Whare Aroha CARE and The CARE Village. The embedded design enabled me to explain how the transition has been operationalised from the perspectives of those three groups of people.

I chose these logical units of analysis because the perspectives of those three groups of participants are all relevant to developing an explanation of the process and outcomes of the transition to The CARE Village. My rationale aligns with that recommended by (Patton, 2002). The use of subunits of the case has a further advantage over a holistic single case study. Embedded design can serve to focus the researcher on the topic of the study, guarding against an unobserved shift in focus (Yin, 2014).

There are, however, potential disadvantages in using embedded case study design. There is a risk the researcher will focus on one aspect of the study to the detriment of others. An additional risk is that a focus on the subunits results in a change in orientation of the study; focusing on the original case as well as the embedded units of analysis will help avoid this problem (Yin, 2014). In the current study the research questions, focused on both the process and the outcome of the transition from Whare Aroha CARE to The CARE Village, have maintained focus on the whole of the case as well as the embedded units of analysis.

The logical link between the data and the study propositions

The link between the study data and the study propositions is established when designing the study and continues during the analysis of study data. The beginning programme theories for the study guided the development of the semi-structured interview guides (Appendices C, D, E & F) and the observation protocol (Appendix G); inductively derived questions were added to the interview guides as data collection progressed, as recommended by Yin (2014). Data analysis began with deductively

derived codes, developed from the beginning theoretical propositions for the study, aligning with the recommendations of Danermark et al. (2019) and Yin (2014).

The criteria for interpreting the findings of the study

The criteria for interpreting the results of the study are applied during data analysis but considered when designing the study. For quantitative studies, these criteria relate to the statistical analysis; in qualitative studies, the consideration of rival explanations for the study findings provide the criteria (Yin, 2014). The range of data collection instruments and the inclusion of study participants with a range of perspectives have provided the ability to develop rival explanations for the phenomena under investigation during data analysis.

3.10 Criticisms of case study methodology

As with any research methodology, case study research has strengths and weaknesses; I have discussed some of the strengths of case study research previously, and in the following paragraphs, I will further discuss some strengths and criticisms of case study research. As described previously, case study research is seen by some as a way of providing exploratory data. This occurs before a more extensive study aimed at providing evidence able to contribute to the development of “predictive theory” about the topic under investigation (Flyvbjerg, 2011, p. 104).

The assumption behind the use of case study in a preliminary study is that case study evidence is not able to contribute to “predictive theory” development and is therefore not useful. However, because evidence about human society is always contextual, it can be argued that the development of “predictive theory” is not possible. What is achievable is the development of an in-depth understanding of human society in context (Flyvbjerg, 2011, p. 104).

A strength, therefore, of case study methodology is that it enables the researcher to gather in-depth evidence about the case or cases to develop an explanation of the phenomenon in context. Additionally, the use of theory during explanation development via the retroductive processes described by Danermark et al. (2019) strengthens the explanations. The resulting explanation may be generalisable to theoretical propositions (Yin, 2014).

The inability to generalise from a single case study can be seen as a weakness of case study research methodology. Also considered a weakness is the lack of ability to generalise, because generalisable study results are useful for contributing to theory development. However, a rigorous theoretically driven case study such as the present study provides a deep understanding of the phenomena under investigation, thereby potentially enabling the identification of data that confirm or falsify the theory being tested or developed (Flyvbjerg, 2011).

Another criticism of case study research methodology is the potential for bias towards confirming the preconceived ideas of the researcher (Flyvbjerg, 2011). This criticism may apply to any research methodology, and awareness of it contributes to rigour. Indeed the in-depth understanding of the case that is a product of a rigorously conducted case study may lead to discoveries that falsify the researcher's preconceptions (Flyvbjerg, 2011).

Finally, some see the difficulty summarising a complex and detailed case study as a weakness. However, Flyvbjerg (2011) describes the complex and detailed nature of case study results as a strength and argues against summarising case studies. The in-depth understanding of the process and outcomes of the transition of Whare Aroha CARE residents to The CARE Village developed during the present study has enabled me to contribute to the body of theoretical knowledge about normalised living for older people living in residential care.

The research aimed to explain the processes and outcomes of the transition of Whare Aroha CARE residents to The CARE Village by identifying the underlying causal mechanisms. The use of qualitative case study research methodology and methods underpinned by a critical realist research theoretical perspective provided a robust methodologically sound framework for the study, appropriate to the explanatory aim of the research. I discuss the alignment between critical realism and case study research methodology in the following section of the chapter.

3.11 Critical realist case study research

Ontological and epistemological perspectives influence the way cases are described. From a critical realist perspective, cases are complex and autonomous, and they may

exist independently of human knowledge. Case study research methods can be used to develop explanations of phenomena occurring in society (Byrne, 2009b).

The use of case study methods in research informed by critical realist ontological and epistemological perspectives enables the researcher to develop explanations about causation. Case study research, concerned with the particular, is how the researcher can understand generative mechanisms (Steinmetz, 2004). Access to understanding generative mechanisms is made possible in case study research by using theory to explain mechanisms acting in the stratified reality of critical realism (Steinmetz, 2004).

The stratified ontology of critical realism, as described by Bhaskar (1975) and Sayer (2000), aligns with the aims of explanatory case study research (Easton, 2010).

Generative mechanisms acting in the domain of the real cause events to occur in the domain of the actual that are experienced by actors in the domain of the empirical, with some overlap between domains (Sayer, 2010). Therefore, the explanation of the phenomena under investigation necessitates identification of the underlying, or generative, mechanisms causing them.

Retroduction, as part of data analysis, enables the researcher to identify the events in the data that are part of the domain of the actual, experienced by social actors in the domain of the empirical. The researcher uses retroduction to look at the data, using existing theory to identify the causes of those events (Danermark et al., 2019; Sayer, 2010). Retroduction involves using deductive and inductive logic and abstraction to work back through study data and develop explanations of causation (Danermark et al., 2019). I describe the process of retroduction in the section of the following chapter relevant to the analysis of the study data, on page 125.

Scholars in a variety of fields have utilised case studies guided by critical realism; these include industrial marketing (Easton, 2010) and aged care nursing (Milligan, 2016). Because critical realist case studies aim to identify generative mechanisms in context, there is increasing recognition of the generalisability of the results of such studies. This recognition is in contrast to the positivist view that the results of case study research are not generalisable, as discussed by Ackroyd (2004).

Easton (2010) investigated the causes of problems and their solutions in a business service relationship. Within the complex context of a dysfunctional relationship between a service provider and customer, three possible generative mechanisms were developed, regarding expectations each of the parties had of the other, the events that took place and the level of responsibility borne by each of the parties. The mechanisms identified may apply to similar relationships between buyers and sellers (Easton, 2010).

In the field of aged care nursing in NZ, Milligan (2016) identified three intersecting mechanisms enabling, redirecting or blocking each other in the process of RN decision-making during the resident care trajectory. The study explains RN decision-making as utilising specialised knowledge and skills and occurring in the context of relationships with medical practitioners, residents and their families in a regulated and resource-constrained environment. Milligan (2016) demonstrates the suitability of using case study research methodology informed by a critical realist perspective for research seeking to develop explanations of events in an ARC setting.

3.12 The current study

The current study is guided by a critical realist theoretical perspective drawing from the work of Archer (1998); Bhaskar (1975, 1979); Collier (1994); Cruickshank (2003); Danermark et al. (2002); Danermark et al. (2019), Sayer (2000) and Sayer (2010), and utilising a case study research methodology as described by Yin (2014). Intensive research is suitable for explaining causation and is suitable for a single case or a small number of cases, as opposed to extensive research which is more useful for population-based studies. Therefore, I have selected a single case study research methodology with multiple embedded units of analysis (Yin, 2014) as being most appropriate to answer the research questions:

- How has the transition of Whare Aroha CARE residents to The CARE Village been accomplished?
- What is the effect of the transition of Whare Aroha CARE residents to The CARE Village on the lives of the residents?

The case or unit of analysis for the study (Yin, 2014) is the Whare Aroha Care relocation to a bespoke dementia-friendly village. In this instance, the rationale for

selecting a single case rather than multiple cases to study is that the case is unique (Yin, 2014). The embedded units of analysis or subunits of the case are the perceptions and experiences of facility staff, residents and their family members.

3.13 Conclusion

In chapter three I have discussed the epistemological and ontological perspectives of critical realism, a philosophical perspective in the post-positivist paradigm in social science. I have explained the central aspects of critical realism and identified and discussed some criticisms of the perspective. I have explained case study research methodology and identified its suitability for use in research informed by a critical realist philosophical perspective. Finally, I have discussed some examples of the application of critical realism in research, including research conducted in ARC settings and case study research methodology, illustrating the applicability of the approach to developing causative explanations in complex situations with similarities to the current study. Chapter four describes and explains the research methods used to conduct the study.

Chapter 4 The research methods used for the study

4.1 Introduction

In chapter three I described the theoretical framework that underpins the study, identifying its epistemological and ontological positions and central components. Critical realism has been selected as an appropriate theoretical perspective for the study, a case study research methodology, seeking to explain the process and outcomes of the transition of residents of a traditional ARC facility to a dementia-friendly village. In chapter four I will describe the case study research methods utilised to answer the research questions for the study: How has the transition of Whare Aroha CARE residents to The CARE Village been accomplished, and what is the effect of the transition of Whare Aroha CARE residents to The CARE Village on the lives of the residents?

In this chapter I will present the methods used to conduct the study and make explicit the alignment between the theoretical perspective, research methodology and the research methods. Consideration for the rights of the participants throughout the study is demonstrated with the inclusion of an explanation of the ethical and cultural aspects of the conduct of the study. A detailed explanation of the research methods selected for the study will help enable the reader to understand the research process leading to the results of the study.

The chapter begins with an introduction of the ethical considerations relevant to the study. A description of the study participants will be provided, including the justification for their selection. Finally, I describe the data collection and analysis methods chosen for the study, together with a justification for their use, and the procedures for ensuring study quality. In the following chapter section, I provide an overview of ethical conduct in NZ research.

4.2 Ethical conduct in New Zealand research

Overall responsibility for ensuring a study is conducted in an ethically responsible way rests with the researcher (National Ethics Advisory Committee, 2012). In NZ, research involving human participants must be approved by a human research ethics committee to ensure the rights of participants are protected and no harm will come to them as a

result of their participation in the research (Tolich, 2001). Health and disability research must meet the ethical standards set out by the National Ethics Advisory Committee, may require approval by a Health and Disability Ethics Committee and must comply with NZ legislation (National Ethics Advisory Committee, n.d.).

Health and Disability Ethics Committee approval was obtained for the study. The approval number is 16/NTA/133 (Appendix N). 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 (Appendix O). Additionally, the Chief Executive Officer of Whare Aroha CARE and I signed a locality agreement (Appendix P). The signing of a locality agreement between the study site(s) for the research and the researcher ensure matters of research governance specific to the sites for the study have been addressed (Ministry of Health, 2014c).

4.2.1 Guiding ethical considerations for the study

The study is observational and, as such, is guided by the principles most relevant to ethical conduct in observational studies. The ethical principles relevant to observational studies are respect, justice, beneficence and non-maleficence, integrity, diversity, conflict of interest and ethical considerations important to Māori (National Ethics Advisory Committee, 2012). These principles are addressed during the research in the following ways.

Balancing respect for participants' autonomy in decision-making with protecting vulnerable participants who require support with decision-making, addressed the principle of respect. Extending the invitation to participate to all facility staff, residents and their families, rather than placing the burden of participation on any particular group, addressed the principle of justice. For example, at the beginning of the study, residents of Whare Aroha CARE requiring all levels of care were invited to participate in the research.

The study poses minimal risk of harm to participants, in alignment with the guidance provided by National Ethics Advisory Committee (2012); nonetheless, the principles of

beneficence and non-maleficence are addressed by preserving the confidentiality of participants and by developing the project in consultation with the management of Whare Aroha CARE. The principle of integrity is addressed in the study by ensuring the study meets the standards for quality. Including diverse participants in terms of role, age, gender, ethnicity, and cognitive capacity has addressed the principle of diversity.

I have addressed the principle of conflict of interest by reflection and transparency during the study; for example, I was offered accommodation at the home of one of the Whare Aroha CARE management team. I chose to decline the invitation because it may have led to a conflict of interest if I had felt obligated, either consciously or unconsciously, to report favourably on the organisation in the results of the study. Ethical considerations important to Māori about the study are discussed below.

4.2.2 Ethical considerations important to Māori

The Rotorua district has a high proportion of Māori residents relative to the whole of NZ (Statistics New Zealand, 2013a), reflecting the demographic characteristics of the study participants. However, regardless of the demographic characteristics of the people living in the area where research is conducted, all research conducted in NZ is important to Māori because they are the tangata whenua (people of the land) who have guardianship of the land (Health Research Council, n.d.). The Health Research Council (n.d.) provides guidelines for the conduct of research in NZ based on Māori ethical principles, intended to help researchers and ethics committees with research design and decision-making about ethical approval for research.

I am Pākehā (a New Zealander who is not Māori) and lived in Australia from 1978 until 2011. Consequently, I missed the postcolonial revitalisation of te reo Māori, the Māori language. Included in the revival was the adoption of te reo Māori as one of the official languages of NZ in 1987 (Ministry for Culture and Heritage, 2015). To address the gap in my knowledge, I have completed a Certificate of Proficiency in Te Reo Māori, enabling me to pronounce the names of people and places correctly. Correct pronunciation demonstrates respect for Māori research participants, facilitating the building of constructive relationships, essential for research outcomes benefiting Māori and Pākehā (Health Research Council, n.d.). Te reo Māori is present in participant quotes in the thesis, accompanied by the English translation in brackets:

these translations are all drawn from *Te aka: Māori-English, English-Māori dictionary and index* (Moorfield, 2011).

There are several ways of describing the involvement of Māori in research. The Health Research Council (n.d.) describes the characteristics of research as either mainstream research involving Māori as participants or junior researchers, Māori-centred research using mainstream methods to research Māori, or kaupapa Māori research by Māori researchers using Māori research methods. A brief description of Māori ethical principles as described by the Health Research Council (n.d.), together with how these principles were addressed in the research, is proved below. The Māori ethical principles described by the Health Research Council (n.d.) are: whakapapa, relevant to the origin and aims of the research; tika, relevant to the validity of the research; manaakitanga, relevant to cultural and social responsibility and respect for people; and mana, relevant to equity and justice.

The ways the research addresses the principles of whakapapa, tika, manaakitanga and mana are described below. The principle of whakapapa is addressed in the research by developing the project in consultation with the management team at Whare Aroha CARE; the team had Māori membership at that time. The team approached the Auckland University of Technology Centre for Active Ageing to ask for a project to be developed to research the transition of their residents to The CARE Village.

I was invited to conduct the study by the co-directors of the Auckland University of Technology Centre for Active Ageing. I have consulted with the members of the management team at Whare Aroha CARE and The CARE Village about the research, and about who the other key informants might be. Members of the management team at Whare Aroha CARE and The CARE Village are co-authors on some of the research outputs from the study.

The principle of tika is addressed in the project as follows. As described previously the project was developed at the request of and in consultation with the management team at Whare Aroha CARE and The CARE Village, which had Māori membership. The research proposal has been peer-reviewed as part of my confirmation of candidature for doctoral study.

Additionally, Māori were participants in the research as key informants, facility staff, and residents and their families. I met face to face with people who indicated that they would like to participate to explain the project to them, which is necessary to Māori. Participant ethnicity data was collected using the Statistics New Zealand format, enabling potential future researchers to use this aspect of the published data.

The principle of manaakitanga is addressed in the project as follows. The participant information sheets advised participants they were free to discuss the project with friends, family/whānau or legal advisors, and they contained the contact details of persons or organisations that participants could contact if they had concerns about the project, including a contact person who is Māori. The participant information sheets advised participants that their confidentiality would be respected unless abuse was disclosed, and whānau were invited to support participants with and without dementia during data collection.

The principle of mana is addressed in the following ways in the project. As described previously, the project has been developed and implemented in partnership with the management team at Whare Aroha CARE and The CARE Village. The participant information sheets for the study have been written clearly and transparently, with statements about the risks and benefits of participation in the research. Participants were offered a koha (gift), a \$20 petrol voucher, in recognition of their contribution to the research.

4.2.3 Ethical considerations particular to the study

There are several ethical considerations concerning the vulnerability of study participants. Some participants were vulnerable because they had dementia and required support with making decisions. The transition to The CARE Village aimed to improve the lives of residents, including those who had dementia. Therefore, it was essential to include them as study participants.

Participants who were cognitively impaired were supported to consent to their participation in the study by their next of kin, who also consented to their participation in the study. The consent was supported based on the belief of the next of kin that the person's participation was in their best interests under Right 7 (4) of the Code of Health and Disability Services Consumers' Rights (Health and Disability Commissioner,

2016). Some participants were not able to provide informed consent; for these participants, the consent of the next of kin was sought.

Some participants were vulnerable because they were family members of people who were residents of Whare Aroha CARE and The CARE Village and relied on those facilities to provide care for their family member. Some participants were vulnerable because they were employees of Whare Aroha CARE or The CARE Village and relied on those facilities to provide them with employment. For those vulnerable participants, the initial invitation to participate in the study came from the facility receptionists, who were not perceived as powerful people within the organisation.

The project is about an innovative way of providing long-term residential care for older people. Therefore, the organisation will be recognisable in any published outputs from the study. Where individual participants may be identified because of their roles, they have been consulted about the relevant sections of the outputs; otherwise, individual participants are not identifiable in the study outputs.

4.3 The recruitment of the study participants

Recruitment of the study participants was accomplished in several different ways. Potential participants who were residents or their family members were initially identified by the Nurse Manager. A letter of invitation (Appendix I) was given to them by the receptionist at Whare Aroha CARE, who collected the contact details of those who were interested in participating in the study and gave them the relevant participant information sheet (Appendices J & K). I then contacted them to negotiate data collection.

Potential participants who were staff members or volunteers were identified by the Nurse Manager and given a letter of invitation by the receptionist and were also invited via the letter of invitation being placed on staff notice boards in the facility. Potential participants who expressed an interest in participating in the study were given the appropriate participant information sheet (Appendix L) by the facility receptionist, who collected their contact details and passed them on to me; unfortunately, no facility volunteers consented to participate in the study. I emailed the letter of invitation and the appropriate participant information sheet (Appendix M)

to potential key informants, identified by the management team at Whare Aroha CARE.

4.3.1 The study participants

The 42 participants in the study were selectively sampled. Selective sampling enables the selection of participants who can provide insights that contribute to developing answers to the research questions and theoretical explanations about the phenomena under investigation (Fletcher & Plakoyiannaki, 2012). It is useful to include participants who have different perspectives in the sample (Patton, 2014).

For example, in the current study facility staff, residents and their families contributed different perspectives about resident life in Whare Aroha CARE and The CARE Village. The key informants were three members of the management team at Whare Aroha CARE at the time the decision to move to a new facility was made or subsequently, as well as four senior officials from regulatory and funding organisations. These key informants were chosen because of their specialist knowledge and unique insights into the study topic, in alignment with the recommendation of Fletcher and Plakoyiannaki (2012). Other participants were 11 residents of Whare Aroha CARE and The CARE Village (including residents living with dementia) and seven members of their families and 17 staff of Whare Aroha CARE and The CARE Village.

Data were collected at two time points, before and after the transition from Whare Aroha CARE to The CARE Village. Four participants who were staff members were recruited after the first data collection point because of their expertise in the process of the transition and the operationalisation of the model of care. Six participants were lost to follow-up between the first and second data collection points, one resident and one family member died, two residents moved to other facilities to be closer to family, one participant was the family member of one of those residents, and one participant who was a family member was unable to be contacted for follow-up data collection.

4.4 The collection of the study data

There were multiple ways of collecting data for the study. These were the observation of resident daily life, interviews with study participants, the examination of documents, including my project journal written during periods of data collection and

other visits to the facilities. Photographs of the environments Whare Aroha CARE and The CARE Village form part of the documents that were examined and provided an additional means of explaining the effect of the environment on resident daily life in each of those facilities.

There were two main study sites for the project. Before the transition data were collected at Whare Aroha CARE, and after the transition data were collected at The CARE Village. Key informants chose the locations of their interviews, which were the informant's homes or offices and cafés.

The participation of people with dementia in the research was an important consideration for data collection for the study. Before collecting data, it is recommended that the researcher take time to build relationships with participants who are living with dementia (Dewing, 2007). McKillop (2002) stresses the importance of the researcher being genuine with participants. Ideally, the researcher should have experience interacting with people who have dementia (McKeown, Clarke, Ingleton, & Repper, 2010). I have extensive experience working with people who have dementia, gained during a nursing career spanning more than three decades.

4.4.1 The observation of resident daily life

Resident life, both in the Whare Aroha CARE before the transition and in The CARE Village after the transition, was observed in a structured and replicable way using an observation protocol (Appendix G). The development of the protocol was guided by the theory informing the second beginning theoretical proposition for the study. I developed the observation protocol based on the Hogeweyk care concept, described by van Amerongen- Heijer (2015).

Use of the observation protocol enabled me to focus on the physical environment and the extent of resident participation in everyday life in Whare Aroha CARE before the transition and in The CARE Village post-transition. Additionally, observation of interactions between the residents who were study participants and other people who were in the facilities enabled observation of manifestations of organisational culture. For example, the ways staff and residents interacted with each other and the ways residents participated in daily life in the facilities.

The observation protocol for the study drew from Dementia Care Mapping, a tool that provides a structured way to observe care and wellbeing in people with dementia in institutional settings. Dementia Care Mapping is a validated observational tool used for evaluating the care of people with dementia (Bradford Dementia Group, 1997). The tool has been used by many researchers and practitioners to provide evidence about the quality of life and quality of care for people with dementia (Brooker, 2005).

However, I chose not to use Dementia Care Mapping for this study for two reasons. First, not all the residents of Whare Aroha CARE and The CARE Village have dementia. Second, the theoretical perspective of person-centred care for people with dementia informs Dementia Care Mapping (Heller, 2003).

Consistent with the critical realist theoretical perspective for the study and case study research methodology, the observational tool needed to be guided by the beginning theoretical proposition related to the outcome of the transition. That is, Whare Aroha CARE residents will be enabled to live life as usual and to experience a greater enjoyment of life's pleasures after the move to The CARE Village. Therefore, I chose to use the basic structure of Dementia Care Mapping to develop an observational tool that was guided by that theoretical proposition.

The observation protocol included prompts to observe for the home-like environment, social interactions, participation in normal daily activities, maximisation of remaining abilities and enjoyment of life's pleasures. The front page of the protocol form drew from Dementia Care Mapping (Bradford Dementia Group, 1997). Facility staff completed this page before data collection; it included information on the resident's usual demeanour and ways of expressing themselves.

Having information about their usual demeanour and ways of expressing themselves enabled me to become familiar with each resident who participated in the observation of daily life. Additionally, the information allowed me to determine whether or not the resident participants were behaving in ways that were usual for them. No residents became distressed during periods of observation; however, had this occurred, I would have been sensitive to their expressions of distress because of the information previously provided to me, enabling me to stop data collection and seek help and advice from facility staff.

Before data collection took place, staff introduced me to the resident participants. I took the time to explain the purpose of the study and provide details about what I would be doing in the facility in general and what data collection with them would involve. Building rapport with research participants is essential for all qualitative research and particularly important when participants are people who have dementia; spending time with resident participants, many of whom have dementia, before data collection enabled me to build a rapport with them and reduce potential anxiety about what their participation would require them to do.

Additionally, spending time to get to know the resident participants allowed me to understand each person's usual demeanour and communication style (Novek & Wilkinson, 2017). The understanding of each person that was developed during this time added to the information provided by staff and contributed to the successful organisation of observation of resident daily life. For example, understanding a resident's preferences enabled me to organise observation times to match each resident's daily routine.

Dementia Care Mapping informed the structure of the observation times (Bradford Dementia Group, 1997). For each resident, observation of daily life took place over two consecutive days, in blocks of one hour, for up to four hours each day. Up to three residents were observed at a time, because the physical environments and the activities residents chose to participate in made it difficult to observe more significant numbers together.

Specific observation times were determined in consultation with the resident participants, the Nurse Manager and care staff at each facility, and were flexible in response to facility and resident routines. For each resident participant, daily life was observed for four hours over two consecutive days. The reason for conducting observations over two consecutive days was to capture different activities the participants might be involved in on different days (Innes & Kelly, 2007).

During periods of observation, I was an onlooker rather than a participant (Patton, 2002). While not participating in the daily life of the facilities while observing it, I did engage naturally with the participants, other residents, families and staff members, who all became familiar with me during the study. The observation took place in

common areas of the facilities as well as in resident's rooms, the grounds of Whare Aroha CARE and The CARE Village and the surrounding locality in Ngongotahā. I observed resident daily life for an hour at a time at approximately mid-morning, lunchtime, mid-afternoon and during the evening meal.

After the transition to The CARE Village, I observed the daily life of the eight remaining resident participants using the same protocol and structure. I spent a total of 48 hours observing daily life after the transition. Observation was not able to be conducted when a resident was absent from the facilities or in their room with the door closed, accounting for missing data.

In addition to recording observational data onto the protocol form, I kept a reflective diary during data collection. I made entries into the diary at intervals during the day while data collection was in progress. The entries contained my observations, learnings and thoughts during the data collection process. For example, my reflections on data collection with participants who had dementia enabled me to develop the understanding necessary to support their participation in the study via interviews and observation of their daily life.

4.4.2 Interviews

In-depth interviews were conducted with key informants, including facility management, board members, and members of other relevant organisations such as HealthCert, the organisation responsible for granting certification to The CARE Village on behalf of the Ministry of Health. The management team at Whare Aroha CARE and The CARE Village were key informants for the study and provided me with introductions to the other key informants. Additionally, I interviewed facility staff and volunteers, residents and their family members, to gather multiple perspectives on the case.

I used interview guides for the semi-structured interviews, tailored to each type of participant, with interview questions aligned with the beginning theoretical propositions for the study, consistent with Danermark et al. (2019). The benefit of using the semi-structured interview format is the topics important to the researcher are covered in the interview, and the participant can speak about additional topics relevant to the study that matter to them (Jones & Hocking, 2015). The interview

guides (Appendices C, D, E and F) were amended during data collection; new questions were added to seek more information as initial data analysis, taking place as data were collected, enabled refinement of the theoretical propositions, consistent with the recommendation of Danermark et al. (2019).

It was essential to capture the views of residents because the transition aimed to improve their lives and wellbeing. Challenges in capturing the views of people with dementia and concerns about their ability to meaningfully contribute to research have meant that there is limited research that directly involves participants who have dementia; however this situation is changing, and researchers are exploring ways of including the voices of people with dementia in their data (van Baalen, Vingerhoets, Sixma, & de Lange, 2011). Because people with dementia can interpret an interview situation as threatening (Murphy, 2007), I chose the go-along interview as a way of gathering data in a non-threatening way.

Participants who are residents were offered the option of standard face to face interviews or go-along interviews. Go-along interviews are a way of conducting interviews where the researcher accompanies the participant on their normal activities. The interview questions are woven into the conversation about what the participant is doing. In this way, the participant is provided with cues to discuss their daily life (Carpiano, 2009; Evans & Jones, 2011).

Go-along interviews are a useful way of exploring the ways that participants interpret their environments and interact with them, while simultaneously exploring those environments (Carpiano, 2009; Kusenbach, 2011). The use of the go-along technique may provide insights into the way participants interpret their surroundings that may not be made evident in face-to-face interviews or observation of daily life (Kusenbach, 2011). This method of interviewing has been used successfully with people with learning disabilities (McClimens, Partridge, & Sexton, 2014). Successful use of the method with participants with learning disabilities indicates the likely suitability of the technique for research with participants who have cognitive difficulties.

In the first phase of data collection, before the transition to The CARE Village, one participant who was a resident of Whare Aroha CARE chose to be interviewed using the go-along interview technique. The remaining nine resident participants chose a

face-to-face interview in either their room or in a common area of the facility. I interviewed participants who were facility staff at Whare Aroha CARE and The CARE Village.

Participants who were family members were interviewed at their homes, in cafés, at Whare Aroha CARE and The CARE Village, and one family member interview took place at her workplace. Key informant interviews took place at the home of one key informant and in cafés, and one key informant participated in a telephone interview. I interviewed two of the key informants together. Interviews lasted from 11 minutes for one resident participant, to two hours and 37 minutes for one key informant. I recorded the interviews and subsequently transcribed the recordings.

4.4.3 The inclusion of documents as study data

Documents were part of the data for the study. Documents should be included as part of the data in case study research (Yin, 2014); they can be used to supplement, corroborate or contradict other data (Patton, 2002). If contradictory information is found during document analysis, the researcher is alerted to seek further information (Yin, 2014).

Documents contain a broad range of information, including details about events and the people involved in them. Additionally, the researcher can go back to them at any time (Yin, 2014). On the other hand, it may be challenging to find all of the documents relevant to the case, some may be deliberately withheld, and documents may be biased (Yin, 2014).

Organisational documents such as policies, staff orientation guides, resident admission documents and administrative documents are included as data for the study. I negotiated access to organisational documents with the management team at Whare Aroha CARE and The CARE Village before the commencement of data collection and on an ongoing basis during the study. Audit reports accessed via the Ministry of Health website were included in the study data.

Additionally, the study data included media reports about the transition process. I used the Google search engine and the *Rotorua Daily Post* newspaper website to conduct regular searches for media reports about the transition from the Whare Aroha

CARE facility to The CARE Village during the study. I examined the documents during data analysis, using the codes based on the theoretical propositions for the study, and derived from the data, consistent with Danermark et al. (2019).

4.4.4 The inclusion of photographs as study data

Photographs taken at Whare Aroha CARE and The CARE Village are included as data for the study. From a realist perspective, photographs record the world as it is; however, this view is contested by some who argue that the researcher constructs the photograph, and selects the subject and what is included and excluded from the image (Buchanan, 2001). Consistent with the critical realist perspective for the study, study data included photographic images to assist me in understanding the environments in the Whare Aroha CARE facility pre-transition and The CARE Village post-transition.

The physical environment in The CARE Village is a vital part of the vision of people living normal lives that guided the transition to The CARE Village and guides care delivery. Most of the photographs that form part of the study data are of the physical environment. However, some contain images of people participating in daily life in the environment.

Photographs of people were included as data with the informed consent of the person who was photographed. Informed consent was obtained by the processes for obtaining informed consent to participate in the study. During data analysis, I examined the photographs using the codes drawn from the theoretical propositions for the study, and inductively derived from the data.

4.5 The procedures used to analyse the study data

The study aimed to explain the resettlement of Whare Aroha CARE residents into The CARE Village, and the effects of the resettlement on the lives of the residents. Explanation building was an iterative process involving comparing the data to the theory, revising the theory, comparing the data to the revised theory and repeating the process, considering rival explanations and keeping in mind the purpose of the study. Several different processes were used in combination during the analysis of the study data. Miles, Huberman, and Saldana (2014) apply a realist approach to data analysis; I used the procedures they outline, along with those described by Danermark

et al. (2019) to analyse the project data. Following data collection, the first stage of data analysis was the transcribing of the audio recordings of the participant interviews.

4.5.1 The transcription of the recordings of the participant interviews

I transcribed the recorded participant interviews myself as the first stage of data analysis, ensuring the resulting transcripts contained all of the relevant data, consistent with Miles et al. (2014). Transcribing the interview recordings myself allowed me to begin analysing the data as I was transcribing. Data analysis began during data collection; beginning to analyse the data while still collecting it enabled me to think about the data and address any gaps while data collection was ongoing by adding inductively derived questions to the interview schedule, as recommended by Miles et al. (2014).

4.5.2 The decision to use NVivo 11 to assist with the analysis of the study data

Initially, data were analysed manually; however, reasonably early in the analysis, I realised that there would be a large amount of study data. I decided to use NVivo 11 (QSR, 2016) computer-assisted qualitative data analysis system (CAQDAS) to facilitate the management of the data and assist with analysis. Using NVivo or any other CAQDAS requires training.

Without appropriate training, the quality of the analysis is adversely affected (Bringer, Johnston, & Brackenridge, 2004). I accessed the training provided by the software developer and through my institution to learn to use NVivo 11. NVivo 11 has been used during the development of codes and themes from the study data and the identification of the underlying mechanisms generating the phenomena of interest.

4.5.3 The development of the analytic codes

Analysis and data display processes described by Miles et al. (2014) were used in the study, beginning with coding, a process of grouping similar sections of data together under a descriptive title, prompting me to think about the data. Initially, coding began with deductively derived codes, drawn from the beginning theoretical propositions for the study, consistent with the recommendation of Danermark et al. (2019). Because it is vital to hear the voices of participants, including facility residents, in vivo coding, using the participants' words as code names, was used where appropriate, as was

process coding, the naming of codes with gerunds to indicate an action, consistent with Miles et al. (2014).

As analysis progressed, new codes were developed inductively from the data to ensure consistency of coding, and operational definitions for the codes were developed, as recommended by Miles et al. (2014). The operational definitions for the codes specified the focus of the code. The study codebook contains the codes and their operational definitions.

4.5.4 The development of second cycle codes

Following initial coding, the coded data were re-analysed and second cycle codes, or pattern codes, were developed. During the process of second cycle coding, I grouped the codes to form a smaller number of themes. The development of themes enables identification of areas to focus on during subsequent data collection (Miles et al., 2014).

The theme 'culture change' is an example of a theme that was checked in subsequent data collection. The theme was developed while analysing the data obtained during a key informant interview. I had not previously considered this component of the transition; therefore, a question about workplace culture change was added to the interview schedule to enable the collection of further data about the theme.

Additionally, the development of themes enhanced my understanding of the information contained in the study data. For example, my understanding of the interactions between people and organisations involved in supporting the transition from Whare Aroha CARE to The CARE Village. The use of data display tools provided another way of seeing and understanding the data.

4.5.5 The use of a data display tool to aid understanding of the data

I developed an event listing matrix to assist with the understanding of the events in the transition. An event listing matrix displays the events in chronological sequence (Miles et al., 2014). The matrix guided the development of the narrative description of the historical events in the transition that begins chapter five. Additionally, I shared the matrix with a senior member of the management team at The CARE Village to check my understanding of the sequence of events was correct.

Finally, I identified underlying mechanisms generating events relevant to the process and outcomes of the transition of Whare Aroha CARE residents to The CARE Village using retroduction. Retroduction is a process of looking back and considering what has made the events occur (Blom & Morén, 2011; Danermark et al., 2019). Retroduction is the process of identifying the mechanisms below the surface of the observed phenomena.

4.5.6 The process of explanation building during data analysis

Consistent with critical realist methodology and with the aim of the study, data analysis was directed towards building an explanation of the resettlement of Whare Aroha CARE residents into The CARE Village, and the effects of the resettlement on the lives of the residents. An integral part of explanation building in critical realist research is the identification of generative mechanisms, acting in the domain of the real, causing events, experienced by actors in the domain of the empirical (Bhaskar, 1975).

Danermark et al. (2019) provide a model for developing explanations in social science. The model is a five-stage process that can be used flexibly to guide critical realist explanatory research. The stages in the model are “descriptions,” “analytical resolution,” “abduction/theoretical redescription,” “retroduction” and “retrodition and contextualisation” (Danermark et al., 2019, p. 130).

Data analysis occurred parallel to data collection and was guided by the programme theories identified at the beginning of the study and refined during the study as recommended by Danermark et al. (2019) and Yin (2014). Beginning the analysis of the data while data collection was still in progress allowed me to look for gaps in the data as I was collecting it, and collect further data to address those gaps, consistent with the approach recommended by Miles et al. (2014). The steps in analysing the data to build explanations of the phenomena of interest are described below.

- The first stage of data analysis is descriptions. During the descriptions stage of data analysis, quantitative and qualitative data may be used to describe events and convey the research participants’ interpretations and understandings of the phenomena being investigated (Danermark et al., 2019). A description of the qualitative data for the current study is given, previously. During the descriptions stage of explanation building, study data were prepared for further

analysis. I transcribed the recorded interviews, hearing the participants' interpretations of events and beginning to make notes about possible codes. Verbatim transcription, with notes in brackets about the tone of voice or expressions such as laughter, was used, as described by Kowal and O'Connell (2014).

- The second stage, analytical resolution, is a process of identifying the parts of the data. This stage begins with decisions about including data that are relevant to the aim of the study and excluding those that are not (Danermark et al., 2019). I coded relevant data using NVivo 11 software (QSR, 2016). Data relevant to the transition process focused on the transition timeline as described previously, and the organisational structures at Whare Aroha CARE and The CARE Village, the structure of the service development group guiding the transition, and the physical environments of Whare Aroha CARE and The CARE Village. Data relevant to the transition outcomes focused on the experiences of the study participants. During stage two of explanation building, I read the transcript, document, memo or record of observation and assigned codes to pieces of data based on their "content or meaning," consistent with Miles et al. (2014, p. 73). I derived some codes from the beginning programme theories, and some were inductively derived, using the words of the participants, as described by Danermark et al. (2019).
- Stage three, abduction/theoretical redescription is a process of interpreting and redescrbing aspects of the phenomena under investigation, using extant theory. The process enables further development of the ideas being investigated by comparing them to existing ideas. During this stage, several theories that could interpret and explain the study components may be identified (Danermark et al., 2019). The model described by Danermark et al. (2019) is flexible rather than prescriptive and, in practice, the stages may not occur in sequence. For the current study, stages overlapped. For example, the person-centred practice framework was used to theoretically redescrbe parts of the study data, simultaneously contributing to retroductively identifying the generative mechanism 'they changed the culture of the organisation to enable person-centred care,' explained in chapter five, beginning on page 134.

- Stage four, retroduction, is a process of looking at the components of the data to identify what their necessary conditions are; that is, what must have occurred for them to be possible. Additionally, an attempt is made to identify contingent circumstances. Contingent circumstances are external circumstances not central to the purpose of the study (Danermark et al., 2019). During retroduction, the researcher moves from the empirical data to identify the unseen mechanisms, acting in the domain of the real, causing events and social relations. The process is one of transcendental argumentation, so called because the argument developed goes beyond the empirical. The idea of transcendental argumentation aligns with the critical layered ontology of critical realism, acknowledging the existence of events outside our knowledge of them (Collier, 1994; Danermark et al., 2019). In the current study the generative mechanism ‘they changed the culture of the workplace to enable person-centred care,’ acting in the domain of the real to produce events in the domain of the actual, was identified using retroduction, during the process of theoretical redescription described previously. For example, the person-centred practice framework (McCance & McCormack, 2017) aligns with many of the themes contributing to the identification of the generative mechanism. The theme ‘valuing people,’ identified in the data, aligns with the “shared decision-making systems” component of the person-centred practice framework. The component “shared decision-making systems” is an aspect of the care environment, the context where care is delivered, that can enable or constrain person-centred care (McCance & McCormack, 2017, p. 39). Shared decision-making encompasses staff, residents and family members, and incorporates the aspect of person-centred care that values all people in the care environment, including staff (McCormack & McCance, 2010).
- Stage five of the process of generating explanations is retroduction and contextualisation (Danermark et al., 2019). During this stage, I explored the complex relationships between structures and generative mechanisms relevant to phenomena of interest, in context. In practice, retroduction and contextualisation, using theory, often coincide with the previous two stages (Danermark et al., 2019). As with retroduction, retrodiction is a process of comparing and sometimes integrating extant theories. Assessment of the

usefulness of a theory is made based on whether it can explain and distinguish between structures and mechanisms in context. Examples relevant to the current study are the social structure of the management and staff at Whare Aroha CARE and The CARE Village, and the generative mechanism ‘they changed the culture of the workplace to enable person-centred care.’

The person-centred practice framework is a recognised nursing theory (B. McCormack, personal communication, May 24, 2019). In the current study, the person-centred practice framework (McCance & McCormack, 2017) has been used to explain the influence of the organisational structure and the generative mechanism ‘they changed the culture of the workplace to enable person-centred care’ in context. The overall context was the desire by the management team at Whare Aroha CARE to find a model of care that respected resident individuality and choice. The following section of the chapter describes the procedures used to maintain study quality.

4.6 Procedures to maintain the quality of the study

There are several criteria for evaluating quality in qualitative research and case study research. The study is underpinned by an appropriate theoretical perspective, discussed in the previous chapter, and utilises a rigorous theory-driven research methodology, ensuring quality, consistent with the recommendations of Flick (2008) and Yin (2014). Despite the contested nature of what the criteria for evaluating quality in qualitative research might be, it is necessary to consider quality criteria relevant to the chosen methodology and methods when designing a study (Flick, 2008). Those criteria relevant to the current study are auditability, reliability, validity and credibility; each of the relevant criteria will be explained below, with a description of how they have been addressed in the study, beginning with auditability.

The study should be able to be audited; Yin (2014) recommends maintaining a chain of evidence enabling the tracking of data sources. Similarly, Lincoln and Guba (1985), cited in (Flick, 2008), recommend that qualitative researchers maintain auditable documentation during the study. The procedures for maintaining auditable documentation include keeping records of the following; all study data and steps in analysing the data and the results of the analysis; notes about the process of the

research; and the development of study instruments. An audit trail, comprising Word documents, and NVivo 11 memos is maintained for the current study.

Similarly, the concept of reliability refers to the transparency of the production of study data and includes “reflexive documentation” (Flick, 2008, p. 6). In the current study, reliability has been addressed by the use of a case study protocol, setting out procedures for recruitment of participants, data collection, transcription of participant interview recordings, and analysis of the study data (Appendix Q). Where direct quotes from the participants appeared in the field notes, they were noted in a way that enabled them to be distinguished from my interpretation of what they said, as described by Flick (2008).

Within the thesis, the words of participants are set out in quotation style, enabling the reader to distinguish them from my interpretations of them. Additionally, the study data is kept in an electronic database, theoretically enabling the data to be available to other researchers. The use of a database enhances study reliability; that is, the ability of the study to be repeated and achieve the same results (Yin, 2014).

The concept of validity has several components: construct validity, internal validity and external validity. Construct validity is the extent to which the measures used for the study aligned with the concepts being examined and was addressed in the following ways. Data were collected in multiple ways, as described previously. Triangulation of data sources by collecting data from multiple sources contributes to the construct validity of the study (Yin, 2017).

Construct validity has also been addressed by maintaining a chain of evidence and by checking the study results with participants. A chain of evidence has been maintained so that the information in the final report is traceable back through the database, the evidence, the case study protocol and the case study questions. Additionally, I have accomplished analytical triangulation by key informants and other study participants reviewing a summary of the study results and confirming the conclusions drawn resonate with their experiences, as discussed by Patton (2014).

I have addressed the internal validity of the study or the strength of the link between the causes of events and their effects during data analysis, in alignment with Yin

(2014). Explanation building included the consideration of rival explanations for causation. Data analysis included the use of logic models as described previously.

External validity is the extent to which the results of the study can be generalised to other situations (Yin, 2014). As described previously, the results of individual case studies are not considered generalisable; however, they may generate theories that are applicable to other situations (Flyvbjerg, 2011). The use of theory-driven research methodology has contributed to the external validity of the study.

I have checked the credibility of the results of the study in several ways, as recommended by Seale (2011). I offered all participants the opportunity to receive a copy of their transcript and to suggest changes to the transcript. Two participants opted to receive a copy of their transcript, and neither of these participants requested any changes.

Additionally, I provided interim and post-data collection reports of the study (Appendices R and S) to the management of The CARE Village, who did not suggest any changes to the reports. I provided a summary of the results of the study to all participants who requested one (Appendix T). Further, I invited participants to a discussion of the results of the study to check that my understandings matched those of the participants, consistent with the recommendation of Flick (2008).

4.7 Conclusion

In this chapter the ethical considerations for researching in NZ have been detailed, along with the ethical considerations relevant to this study. I have described the study participants, and the methods used for their recruitment. I have outlined the methods of data collection for the study and how I analysed these data and built explanations of the phenomena of interest. Finally, I have explained how the quality of the study was maintained.

In the following chapter I will begin to present the results of the study. The chapter begins with a narrative account of the events in the transition. The second part of chapter five explains the generative mechanism 'they changed the culture of the organisation to enable person-centred care.'

Chapter 5 Beginning the explanation of the transition from Whare Aroha CARE to The CARE Village

5.1 Introduction

In this chapter, I begin to present the results of the study, undertaken to explain the resettlement of Whare Aroha CARE residents into The CARE Village, and the effects of the relocation on their lives. The results of the study relate to both the process of the transition of residents from Whare Aroha CARE to The CARE Village and the outcomes of the transition. First, I will provide a temporal narrative of the significant events that took place during the transition planning and implementation.

The narrative, drawn from and illustrated with study data, begins to answer the first research question: How has the transition of Whare Aroha CARE residents to The CARE Village been accomplished? Chapter six provides further answers to the first research question, and chapter seven will answer the second research question: What is the effect of the transition of Whare Aroha CARE residents to The CARE Village on the lives of the residents? Data from interviews with facility staff, residents and their families are labelled to indicate whether the interview was before or after the transition from Whare Aroha CARE to The CARE Village.

5.2 The beginning stages of the transition from Whare Aroha CARE to The CARE Village

The narrative provides the background, setting the scene for the explanation of causation, enabled by the identification of three generative mechanisms. Generative mechanisms act in the domain of the real, producing events occurring and experienced by social actors in the domains of the real, the actual and the empirical as identified by Bhaskar (1975). Three mechanisms come into play at points in this temporal narrative. They are: 'They changed the culture of the workplace to enable person-centred care,' 'they formed a governance network to support the transition to an innovative model of care' and 'they created a physical environment to support the vision of people living normal lives.'

All three generative mechanisms support the change to a new model of care in a new environment and have effects on the experiences of the three groups of participants

comprising the embedded units of analysis for the study, in accord with Yin (2014). The three groups of participants are residents, their families and staff of Whare Aroha CARE and The CARE Village. Concurrently with the planning and building of the village, the management team at Whare Aroha CARE were working collaboratively with senior officials from Lakes DHB, HealthCert (the organisation responsible for certification of health services including ARC facilities) and Central Region Technical Advisory Service (Central TAS). Central TAS is an organisation that works with the Ministry of Health and DHBs to facilitate better services for older people in NZ (Central Region Technical Advisory Services, 2015).

The creation of a governance network facilitated by a senior official from Central TAS enabled the collaboration. Collaborating with senior officials from Central TAS, HealthCert and Lakes DHB enabled the transition to proceed in a way that was compliant with regulatory and contractual obligations. Additionally, all parties had an interest in ensuring the continuation of safe and appropriate care for all residents.

In the context of a willingness to explore different ways of delivering ARC services, support at government and DHB level, changes in the physical environment and changes in the way care is delivered have enabled a change in the way residents of The CARE Village can live their lives. Three generative mechanisms acting in the domain of the real have enabled this change to happen, and these are explained in detail in the following sections of the thesis. In addition to explaining the process of the transition by identifying the generative mechanisms that enabled it to occur, I will explain the outcomes of the transition. The Venn diagram, Figure 3, on the following page, illustrates the relationship between the generative mechanisms.

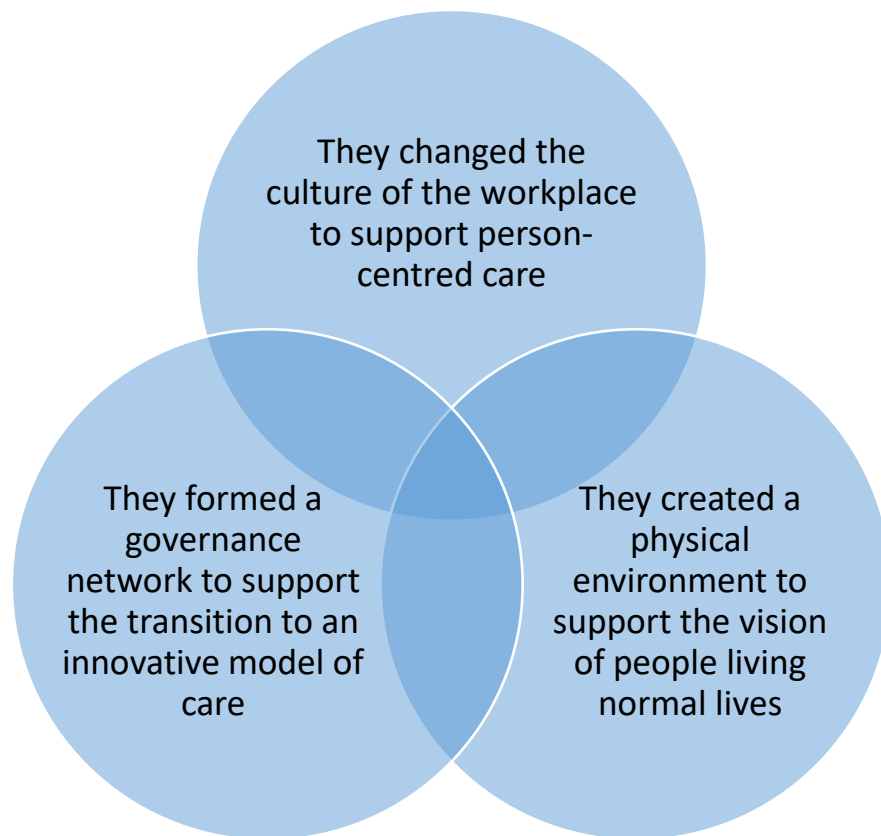


Figure 3. The generative mechanisms that enabled the transition to occur.

The first of the generative mechanisms to be brought into play was ‘they changed the culture of the workplace to enable person-centred care.’ The process of changing the culture of the workplace began before a new model of care was identified and work on constructing the new facility started. I explain the generative mechanism ‘they changed the culture of the workplace to enable person-centred care’ and its component themes in the following section of the current chapter, beginning on page 134.

As described previously, the need to vacate the CBD site due to the expiry of the lease on the property prompted the relocation of residents from Whare Aroha CARE, an ARC facility at the edge of the Rotorua CBD to The CARE Village, on the shore of Lake Rotorua at Ngongotahā. Whare Aroha CARE was in the former Queen Elizabeth Hospital Nurses Home on the corner of Hinemaru and Whakaue Streets. The landowner, Pukeroa Oruawhata Trust, is the holding company for Ngāti Whakaue (Stafford, 1999), a hapū or sub-tribe of Te Arawa (Hall, 2009).

Shareholders in the trust are the descendants of the 293 original owners of the Pukeroa Oruawhata land block in the Rotorua CBD (Manley, n.d.). The Whare Aroha CARE facility was on the edge of the CBD, opposite the Rotorua lakefront, and there is a geothermal resource under the land. The redevelopment will enable the use of the land for tourism-related activities.

Pukeroa Oruawhata Trust is leading development on the site that will include a spa and luxury hotel (Climo, Blair, Stott, Mroczek, & Addison, 2017). The development of the site aims for optimum utilisation of their natural asset according to their mission. The mission of Pukeroa Oruawhata Trust is to ensure their assets are managed in a way that ensures the sustainability of their wealth and benefits for their shareholders, their tribe and the community (Pukeroa Oruawhata Trust, n.d.).

With the end of the lease for Whare Aroha CARE in mind, the board of RCCT and the management team at Whare Aroha CARE began to plan for the future. They knew they would have to build a new ARC facility; however, they were not sure how that would look. Several alternatives were considered, including closing the facility and building a new facility for the residents containing, as Whare Aroha CARE had, separate accommodation for people requiring hospital level, rest home level and specialist dementia services.

We knew that we were going to have to build a new facility because we would have to get off the land that we were on. For a long time, there had been an assumption that it would just be a new building.
(Participant 28, key informant)

A description of the characteristics of the key informants for the study is provided on page 113. The participant demographic data are provided in Appendix H. The process of changing the workplace culture at Whare Aroha CARE was foundational in the eventual transition from Whare Aroha CARE to The CARE Village. Whare Aroha CARE management had already undertaken work to change the culture of the workplace using the Eden Alternative, supporting staff to feel valued and work in ways that respect the personhood of residents of the facility. The culture of workplaces influences the subjective experiences of their team and clients.

In 2012 a new management team had commenced working at Whare Aroha CARE and begun the process of changing care delivery in the facility, by changing the culture of the workplace. Broadly, the change was from staff-centred ways of working to more person-centred care, underpinned by a philosophy of valuing all people. The philosophy of valuing all people is reflective of the element of the person-centred practice framework that highlights the need for practitioners to be aware of their personal values, described in chapter two, beginning on page 43. Articulated beliefs and values shared by the workplace team underpin practice (McCance & McCormack, 2017).

The physical environment is one element of the overall care environment; chapter six explains the change in the physical environment as part of the transition, beginning on page 156. Together with the physical environment, workplace culture forms part of the care environment (Roberts & Pulay, 2018). As part of the process of moving towards person-centred care, the facility was redecorated, within the limitations of the available budget, to create a more home-like and inviting atmosphere. The physical environment influences the subjective experiences of staff and residents of the facility (Van Steenwinkel, de Casterlé, et al., 2017).

The building was so dilapidated and disgusting, and we didn't have ensuites or lovely lounges and things like that. So immediately we repainted the place those colours that you saw, because then it was a dirty prison beige, put new curtains up, got new bedspreads.
(Participant 35, key informant)

In her interview, Participant 35 describes redecorating as the first stage of the culture change process at Whare Aroha CARE. She then goes on to discuss the rapid pace of changes that ensued. It is clear from her narrative that the new management team considered there was an urgent need for change.

The facility had had a good reputation, but that was diminishing because of the quality of care, and we didn't have a modern building so the only point of difference could be our quality of care. We completely changed the culture three days after we redecorated. We moved to the Eden Alternative. It was like a revolution more than an evolution. Everything became focused around asking the questions around loneliness, helplessness and boredom, and setting up that whole Eden thinking. (Participant 35, key informant)

I identified 'they changed the culture of the workplace to enable person-centred care' using retroduction, as one of the generative mechanisms contributing to the process of transitioning from Whare Aroha CARE to The CARE Village. Changing the culture of the workplace was one part of causing a change in the way residents can live their lives in Whare Aroha CARE and The CARE Village. I explain the generative mechanism 'they changed the culture of the workplace to enable person-centred care', below.

5.3 Generative mechanism: They changed the culture of the workplace to enable person-centred care

A process of retroduction (Danermark et al., 2019), described in the previous chapter beginning on page 125, was used to identify the generative mechanism 'they changed the culture of the workplace to enable person-centred care.' I identified the generative mechanism using themes identified in the data, and a mid-range theory, the person-centred practice framework (McCance & McCormack, 2017). The themes in the data that enabled the identification of the generative mechanism 'they changed the culture of the workplace to enable person-centred care' are 'culture change,' 'valuing people,' 'like family,' 'special feeling' and 'the organisation.' These are displayed in Figure 4 and described in subsequent chapter sections.

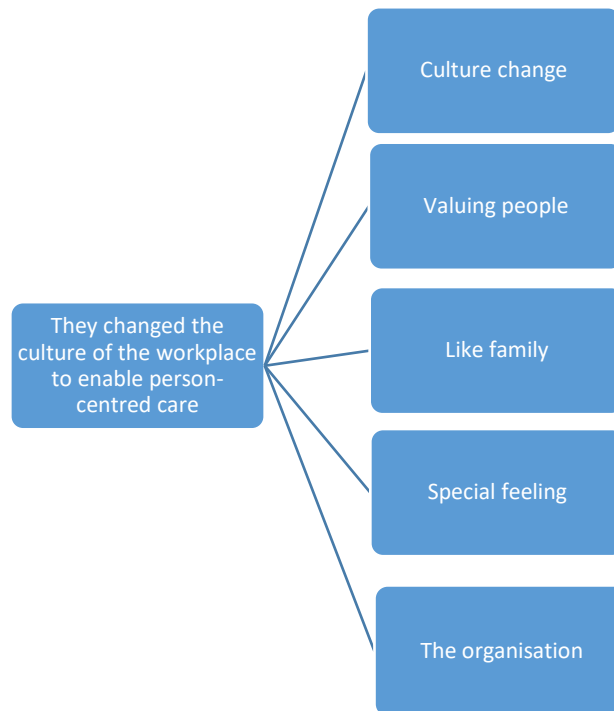


Figure 4. Themes in generative mechanism one.

5.3.1 Theme: Culture change

The theme ‘culture change’ is operationally defined as containing data about the efforts made by the management team at Whare Aroha CARE and The CARE Village to change the culture of the workplace. The new management team saw the need for change because they had come from sectors other than ARC. Therefore they did not share the taken-for-granted assumptions, nurtured in resource-poor environments, that have led to care that does not consider the individual resident as a person, as described by McCormack and McCance (2010).

The three of us did not come from an aged care background; none of us had worked in aged care before. That gives you the freedom to ask why. So, the three of us worked very hard at challenging some of the things that were being done. It was all about making life easy for staff, and so that's why everybody got up at 6.30 am and got put through the shower because that's easy. Any everybody got spit and polished and was sitting there by 7 o'clock, and then the breakfast comes. But no thought was given to the fact that this lady used to sleep in until 9 am and then get up and have tea and toast in her dressing gown. (Participant 28, key informant)

Initially, the organisation began the process of culture change by seeking to become affiliated with the Eden Alternative. The Eden Alternative is an organisation that offers a subscription-based framework for transforming ARC facilities into places where residents are empowered to live lives that have meaning for them (Brownie, 2011). Implementing the Eden Alternative involves a refocusing of thinking, away from care processes that prioritise the needs of staff to considering the facility to be the resident's home, with their needs prioritised.

We knew that we had to do something different, so part of our journey to change the culture was implementing the Eden Alternative. Where it was the resident's home, and everything was around the resident and what was right for the resident. (Participant 28, key informant)

The document prepared by the team at Whare Aroha CARE for discussion of the transition to the Hogeweyk care concept with a group of clinicians and Central TAS officials confirms the organisation's initial engagement with the central ideas of the Eden Alternative. Adoption of the Eden Alternative principles enabled staff to work closely with residents and their families, fostering resident choice. The initial process of changing the culture of the workplace at Whare Aroha CARE was informed by the Eden Alternative.

Whare Aroha CARE used the Eden Alternative as a platform to change the culture some two years ago; we are not registered as an Eden home; however, the philosophy has informed our model of care. (Organisational document)

The effect of the work undertaken by management to embed the Eden philosophy into the organisation is illustrated by staff interview data. In the excerpt below, a staff member, Participant two, demonstrates his understanding of the operationalisation of the Eden philosophy. The understanding illustrates the inclusion of family members in helping to articulate resident preferences.

It was just like working more closely with the residents, knowing them much better and having them more involved in their personal choices or cares, and even the family was more involved. Families are always involved, but we are actually getting more suggestions from the family, Mum wants this or that, so they were giving us more input. I think the Eden philosophy does more towards working towards those

personal goals for the residents. (Participant 2, staff member, pre-transition interview)

In 2012, when the new management team began working at Whare Aroha CARE, it entered an organisation where the building and equipment were poorly maintained, and staff and residents did not seem to be valued. Staff needed their jobs and income; however, they were not caring for residents with compassion or with regard for their preferences. The data extract below illustrates the lack of care for the environment and staff at that time.

What we found when we came into Whare Aroha CARE was quite a broken organisation. An organisation that we felt the people at every level had not been valued, so that was residents and staff. Not a lot of money had been spent on upkeep or wages or replacing equipment, it just generally felt unloved. It didn't sit well with us. (Participant 28, key informant)

Participant 28 has described an organisation that had allowed the buildings and equipment to become run down. Additionally, staff were paid the minimum wage for their roles. One outcome of the organisation neglecting the environment and the people who worked and lived in it was the uncommitted staff who came to work because they needed the income, despite a negative workplace culture.

There was a real bullying culture, people were ruled by fear, and they came to work. People still needed to come to work to do their job to get paid, but there wasn't a lot of care and compassion that went on. That was because they were so bullied by other staff and by management. (Participant 35, key informant)

Participant 35 describes an organisation where staff were bullied by their colleagues and management. She links the negative workplace culture to staff who were unable to provide person-centred care for residents. Furthermore, the formerly good reputation of the organisation was suffering. The staff did not pay attention to resident preferences, for example, preferences regarding grooming standards, as described by Participant 28, on the following page.

Nanny used to wear lipstick, why have we not got lipstick on her? Why are we letting people go out into town with their slippers on? Why are they going out into public without their hair being done nicely? Because the staff hadn't been cared for, they then didn't care for the residents, and it was just so wrong. (Participant 28, key informant)

While the care provided by staff met the fundamental physical needs of residents, there was a lack of attention to continuing valued aspects of daily life, such as being appropriately dressed and groomed when leaving the house. Paying attention to the things that matter to residents is a person-centred process, based on staff understanding the aspects of life valued by residents (Brannelly et al., 2019). However, the care environment enables or constrains the delivery of person-centred care.

As explained, previously, the care environment at Whare Aroha CARE had previously acted as a constraint to the provision of person-centred care. The culture of the workplace is an element of the care environment, including accepted work practices and the ways people relate to each other, experienced by staff, residents, family members and others consistent with the definition given by Koren (2010). The work began with demonstrating to the staff that they were valued, in recognition that in productive workplace cultures, person-centredness encompasses staff as well as residents and others, aligned with McCormack et al. (2012).

Management perceived that there was a clear link between the way staff were treated by management and each other and their inability to provide care for residents that respected their personhood. In healthcare settings, bullying behaviour has negative psychological consequences for the person who is being bullied and may be a barrier to them providing quality care (Armstrong, 2018). Therefore, healthcare organisations must address the culture in the workplace to facilitate quality care.

As Participant 28 identifies, while many staff were quickly convinced that a change in the workplace, to a focus on person-centred care, was required, some staff members were resistant to change. Ultimately some staff members were unable to accept the change in focus, and those people left the organisation. However, during the process of changing the culture of the organisation, as stated by Participant 28, on the following page, some people wanted to continue working as they had always done.

Because the staff were really vulnerable, it was relatively easy to convince them that this was a better way of working. Although they were still a little bit wary of people in a management role. Because their experience hadn't been great previously. There were people on the staff who it was extremely difficult to convince that this was the right way forward. Some of the staff who found it very difficult to accept a different way of working. A way that placed the resident at the centre. It was about what was good for them not what was good for staff. It was kind of a little bit like that, you're either on the waka, [canoe], or you're not – if you're not on the waka you have to get off because you create a situation where the waka is going nowhere. There are some people trying to paddle forward, but you are paddling backwards, so everything is staying still, so we had to make some tough decisions, and some unpopular decisions and some people had to go. (Participant 28, key informant)

As exemplified by Participant 28, above, people continuing to work in staff-centred and task-focused ways in an organisation that is transitioning to providing person-centred care is a barrier to progress. Being committed to caring and to participating in a team environment in healthcare are prerequisites for person-centred practice (McCance & McCormack, 2017). During the process of culture change, people who are not committed to delivering person-centred care may need to leave the organisation (Hunnisett, 2011).

The positions left vacant by people exiting the organisation can be filled by people who are committed to caring. Management hired people who were committed to caring to fill vacancies at Whare Aroha CARE, demonstrating the intention of the organisation to employ people with an attribute that is a prerequisite to providing person-centred care as described by McCance and McCormack (2017). The organisation enables care staff to complete the training that allows them to perform their roles, supporting the staff members to provide competent holistic care.

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

Respect for persons is a foundation for caring that underpins person-centred care (Edvardsson et al., 2014). Starting to demonstrate to the staff that they were valued was the first stage of beginning to change to a culture that enables person-centred practice to flourish. The work began with demonstrating to the staff that they were valued, in recognition that in productive workplace cultures, person-centredness encompasses staff as well as residents and others, consistent with the work of Dewing (2008).

5.3.2 Theme: Valuing people

The theme 'valuing people' is operationally defined as containing data about management valuing people at Whare Aroha CARE and The CARE Village. The theme, derived from the study data, aligns with the terminology used by McCance and McCormack (2017), who note that the term 'person' does not just refer to clients or patients in healthcare interactions, but all the other people involved as well. People engaged in healthcare interactions include the person who is the client or, in the case of ARC, the resident, as well as the staff of the facility and the friends and family members of the resident.

While the word 'person' is common, people may have different understandings of its meaning. Relevant to the person-centred practice framework, a person has intrinsic value, regardless of their level of physical or cognitive functioning. Additionally, people, including staff, have individual goals and aspirations, as well as things that are important to them, that persist regardless of their situations (Kadri et al., 2018).

One way of making staff feel valued is to increase their wages. ARC is a challenging environment for managers who want to reward staff financially. As Participant 28 explains, the organisation was not able to offer significant pay increases, due to financial constraints. However, the organisation gradually increased staff pay.

Previously as much money had been saved as possible. Because it was intended that there would be a new build. But it came at a cost. So, it was always about making a fairly substantial profit, and in aged care, there are not many ways you can make substantial profits. Staffing is one, and you don't pay staff very well. We wanted to pay staff more, but we were not able to increase wages hugely, but every year there was an increase. (Participant 28, key informant)

In addition to beginning to pay staff higher wages, management demonstrated that they valued staff by recognising their expertise in their roles. The managers listened to the concerns of staff and acknowledged that staff know the residents well because they worked closely with them. The new management team began listening to the views of Whare Aroha CARE staff.

She's the best nurse manager I have worked with concerning support, understanding, knowledge, that kind of stuff, and if you have got a concern, you don't just get dismissed. (Participant 2, staff member, pre-transition interview)

When management began listening to staff, they were demonstrating they understood the depth of knowledge staff held about residents. Close relationships result in in-depth knowledge about people. The close ties between the people at Whare Aroha CARE and The CARE Village are encompassed in the sub-theme 'like family.'

5.3.3 Theme: Like family

The theme 'like family' is operationally defined as containing data about management, staff, residents and family members at Whare Aroha Care and The CARE Village considering each other as being like their own family. The theme is derived from the data, due to many participants describing each other as being like family members during their interviews. Participant 28 explains her perception that, despite the presence of conflict at times, the regard staff members have for each other is like that of family members. Similarly, residents have described the feeling that the staff and the other residents of Whare Aroha CARE and The CARE Village are like family members to them.

It's like a family when you argue, families argue, but deep down there's still love there, there's a care, care for the residents and care for the staff. It is like a family. And I think it's really important, we talked to the staff in the very early days about the value of touch, and remembering that, asked them to remember that our touch may be the only touch that they have, so can we please make it a loving touch. (Participant 28, key informant)

Participant 28 is discussing the intentionality evident in the creation of the family atmosphere in Whare Aroha CARE and The CARE Village. The atmosphere is experienced differently by staff, residents and family members. Two residents spoke in

their interviews about the feeling of being with family at the facilities. Participant 13 describes her interactions with fellow residents as contributing to a feeling of being with family.

What I like about being here is having conversations with people. All of the people here are like my family. Because I like to help as well, I help to feed people and talk to them. (Participant 13, resident, pre-transition interview)

The value placed on feeling the staff at Whare Aroha Care were like family is explained by one family member in the excerpt below. When she was notified of the impending move to Ngongotahā, she was concerned about the extra distance she would have to travel to visit her husband. She explored the possibility of moving him to another ARC facility closer to where she lives; however, she realised she would miss the staff at Whare Aroha CARE, who were like family members to her and her husband. Participant nine recognised the value of close connections between staff, residents and their family members and decided not to move her husband from Whare Aroha CARE.

Well, 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, he would really miss that. Because everybody to me, they are like family. (Participant 9, family member, pre-transition interview)

Along with the recognition that the people at Whare Aroha CARE and The CARE Village are like a family, people have also described a special feeling. Participants talked about the presence of a special feeling in Whare Aroha CARE. The repetition of that phrase in participant interviews led to the development of a theme of the same name, discussed in the following section of the chapter.

5.3.4 Theme: Special feeling

The theme 'special feeling' is derived from the data and is operationally defined as containing data about participant descriptions of a special feeling in Whare Aroha CARE. Several participants mentioned the presence of a special feeling. Participant 28 recognises the link between the special feeling noticed by people at Whare Aroha CARE and the work done to change the culture of the workplace.

There is a special feeling. What creates it, well 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)

Participant four interpreted the feeling in Whare Aroha CARE through the lens of her Māori worldview. Māori are not a homogenous group, and not all Māori share the same beliefs about matters such as health and spirituality. However, many Māori see health as a holistic concept, hauora, encompassing physical, mental, spiritual and whānau (extended family) wellbeing (Wilson, Heaslip, & Jackson, 2018).

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

In Whare Aroha CARE, a process of changing the workplace culture manifested as a special feeling experienced by people in the facility. While health service users expect to take technical competence for granted, the humanistic aspects of the experiences people have in healthcare settings matter to them and influence their perceptions of the quality of the care they have received (McCance & McCormack, 2017). The organisation supports the staff to be technically competent and provide care based on humanistic values.

5.3.5 Theme: The organisation

The theme 'the organisation' is derived from the Hogeweyk care concept. It is one of the six pillars of De Hogeweyk, as described by van Amerongen- Heijer (2015) and van Hal (2014), described in chapter two, beginning on page 37. The operational definition of the theme is that it contains data about the ways the organisation supports the vision of people living normal lives. The aspect of the data from this theme that is relevant to changing the culture of the workplace relates to organisational support for staff that enables them to deliver person-centred care.

In the care context, the sharing of decision-making and effective staff relationships is interconnected. Historically, disempowered staff in care settings may have developed dysfunctional relationships, including relationships involving horizontal violence, commonly called bullying, towards peers in response (McCance & McCormack, 2017).

Interview data indicate the presence of dysfunctional relationships at Whare Aroha CARE at the time the new management team commenced working there in 2012.

Unfortunately, bullying does happen in health workplaces. When we started at Whare Aroha, there was a real bullying culture. People were ruled by fear. We brought in changes, and if people couldn't change, they had to go. There was very little tolerance so quite a few of the bullies left. (Participant 35, key informant)

Supporting person-centred care in the workplace includes efforts to enhance the sharing of decision-making in an environment where positive relationships between staff members are fostered. Involvement in decision-making contributes to staff empowerment (Bowers, Roberts, et al., 2016). Staff members at Whare Aroha CARE were actively involved in planning towards the transition to The CARE Village, contributing to their empowerment. Management utilised a variety of formal and informal ways to engage staff in the planning of the change.

A transition group of staff and management met weekly to discuss and organise the practical details involved in the transition. The transition group discussed matters such as equipment and furniture, as well as the details of physically moving residents from Whare Aroha CARE to The CARE Village. Staff who were not part of the transition group were kept informed of the discussion via a newsletter. Additionally, there were conversations at the change of shift meetings (handover), and there were many informal talks with staff as questions arose.

It was not all formal meetings, often you would be walking around, and someone would say, "How is this going to work out at Ngongotahā?" So, you would grab a group of people and talk about it. Or you might say, "Actually, we don't know, we haven't really thought about it, what do you think? How do you think it might work?" So, lots of informal conversation went on. (Participant 28, key informant)

Participating in discussions about how things might work in The CARE Village contributed to empowerment for staff and began to prepare them for their new roles after the transition. As the culture change process evolved at Whare Aroha CARE, the management team began to question whether the way care was delivered needed a more fundamental change. Management felt that further opportunity for improving care delivery still existed.

Questioning is how we got to this point. We were asking why aged care is delivered that way. We don't like it, why does it have to be that way? Because that's the way it's always been, but that is very old-fashioned. It came from caring for people who had no money. It was the poor house, a place to house older people. It was accommodation for people who were too old to live in a boarding house. (Participant 35, key informant)

Management at Whare Aroha CARE recognised the roots of the classic model of care in ARC while questioning its continued relevance. Despite the presence of experienced nurses on the management team, none had extensive ARC experience, enabling the team to draw on a range of perspectives from outside ARC to inform their questioning. They understood that having begun to some progress in changing the culture of the workplace, they remained dissatisfied with the model of care in the organisation.

Once we had started to embed that culture in the staff and the residents could start to feel that things were different, then we knew that we could start looking at some models of how people could live differently. It still didn't feel right, it began to feel a bit better, but it still didn't feel right, the way that care was being delivered. (Participant 28, key informant)

The management team felt that they had not yet achieved the change that they were looking for in resident care. The feeling that there was an opportunity for further improvement in resident care led to the exploration of different models of care by the management team. The temporal narrative documenting the process of the transition continues below.

5.4 The process of the transition continues as management identify a new model of care

Models of care are ways of conceptualising care (Ostaszkievicz et al., 2018). In the biomedical model of care, prominence is given to the physical deficits a person is experiencing as a result of disease processes, and the focus is on addressing these deficits; in contrast, the attention of the social model of care is on the impact of social context on health (Germov, 2014). In addition to the social context, as noted in the review of the literature, for people who have dementia, the physical environment can support them to make maximum use of their abilities (Marquardt et al., 2011).

Currently, in NZ ARC is primarily organised in accordance with the biomedical model, meaning people are mostly accommodated according to their assessed level of care needs (EY, 2019; Ministry of Health, 2016). In the current, or ‘classic’ model of care, the levels of care are hospital-level care (high-level care), rest-home-level care (low-level care), psychogeriatric care (a subset of high-level care) and specialist dementia services (a subset of low-level care). Both psychogeriatric care and specialist dementia services are secure environments, meaning, for their safety, the residents in that area of the home are not free to leave the care setting (Ministry of Health, 2016).

Needs Assessment and Service Coordinators (NASCs), employed by DHBs, assess the level of care required by each resident or potential resident, enabling people to be placed in an appropriate ARC setting (Ministry of Health, 2016). As indicated previously, the management team at Whare Aroha CARE did not accept housing people together with peers requiring the same level of care as being the only way to conceptualise the ARC environment. The management team at Whare Aroha CARE began the process of changing the culture of the organisation using the Eden Alternative; however, as noted by Participant 28, they felt the need to continue to search for other models of care that were a better fit with their values.

We wanted to create a home-like environment, to fit with the Eden model that we were planning to use at the time. And we thought, how can you live in a home-like way when you're still living in an institution? You can make some home-like changes, but it's still not home. Even though we would say this is your home, and sure that's where they were living, but it didn't really feel like home. We started to learn a bit more and started to do a little bit more research about what felt right for us or what fitted in with the values that we had.
(Participant 28, key informant)

As part of the search for a model of care that aligned with their idea that ARC services had the potential to be delivered differently, two members of the management team travelled to Sydney, Australia, in 2014, to attend a dementia design school.

HammondCare, an organisation that has a long history of providing ARC based on the small-scale living model, facilitated the design school. At the design school, one of the facilitators introduced the team to the Hogeweyk lifestyle concept of care.

We didn't like the way care was delivered, so we thought we needed to do it differently. Because we were building from scratch, it was really easy to explore different ideas. We didn't have that aged care background where we had tunnel vision about what aged care would look like so we thought if we were really serious, we should go to the Hammond design school. Through the Hammond dementia design school, there were other models we were exposed to, and De Hogeweyk resonated with us. So that is the one we started pursuing.
(Participant 35, key informant)

The management team liked the Hogeweyk concept and decided to learn more about it. Two members of the group heard the founders of De Hogeweyk speak at a conference, and the Chief Executive of Whare Aroha CARE visited De Hogeweyk village. The information gathered at the conference and during the visit to De Hogeweyk enabled the managers to decide to build a village inspired by De Hogeweyk, transforming the need to vacate their premises into an opportunity to consider a new way of enacting ARC in NZ.

There was an opportunity because Whare Aroha was closing down. They had to get off that site. They could have put the old standard classic model on it, or there was an opportunity to look for a different way. (Participant 41, key informant)

Deciding to build a new home for Whare Aroha CARE residents inspired by De Hogeweyk meant the physical environment of the new build needed to be conceptualised differently from a traditional ARC environment. 'They created a physical environment to support the vision of people living normal lives' is the second generative mechanism, identified using retroduction (Danermark et al., 2019), acting in the layer of the real, to enable a change in the way residents can live their lives in The CARE Village, explained in chapter six, beginning on page 156. The next step in the process was purchasing land and working with architects to design The CARE Village.

The management team at Whare Aroha CARE began searching for a suitable block of land for the new village. Options within the Rotorua CDB were limited and expensive. Therefore, after discussion between the management team and the Board of RCCT, it was decided to buy a block of land at Ngongotahā, 8 kilometres from the existing site.

The Board members were concerned about purchasing a site outside the CBD because locating the village outside the CBD would limit accessibility for family members of existing residents and staff members. However, a suitable block of land at an affordable price was not available in the CBD. Therefore, the board of RCCT and Whare Aroha CARE management decided to purchase three and a half acres of land in Tauhi Street Ngongotahā, on the Western Shore of Lake Rotorua.

So, we needed land, and though the preference would be to stay in the CBD there just isn't that much land in town. We looked at many options and, of course, everything we looked at we had to take the board to, and they would have this whole analysis of how far out of town it was. (Participant 35, key informant)

Alongside the decision about where to purchase land, architects needed to be selected to design the new village. The architects were required to understand the objectives of the design, to provide a recognisable environment for residents to live in that would give them cues to participate in normal daily life as they desired and were able. Architects working with an Auckland-based firm had already attended the Hammond international dementia design school.

The architects had previous experience designing a large ARC facility that used the Eden Alternative model of care. Through the Hammond design school, the management team at Whare Aroha CARE were able to connect with the firm and discuss their proposed build. It was clear to the management team that the architects understood the specific needs of people with dementia and were responsive to the vision of the management team.

We were given the name of an architect who had attended a dementia by design workshop when they'd had it in Auckland the previous year. So [Participant 35] rang him to introduce herself and say we're going to be building a new facility. We understand you went to this workshop, we'd be interested in having a chat to you, and so that's how we met [the architect], and straight away there was a rapport. They were totally, totally on board with what we were doing. (Participant 28, key informant)

As part of the design process, the architects needed to know how to interpret the lifestyles from De Hogeweyk in the Netherlands in Rotorua, NZ. In De Hogeweyk, each home conforms to one of seven different lifestyles,

determining the decoration and the pattern of daily life within the house; therefore the environment is recognisable and supports participation in everyday life for people who have dementia (van Amerongen- Heijer, 2015). The lifestyles that are recognisable for people living in De Hogeweyk would not be recognised by New Zealanders, meaning the team at Whare Aroha CARE needed to develop lifestyles suitable for NZ.

The Whare Aroha CARE management team underwent a process of consultation with their staff and others to identify lifestyles recognisable to New Zealanders. The lifestyles developed from the initial themes were refined and became the seven lifestyles initially represented in The CARE Village. Each of the lifestyles is distinguished by a description of the values, work and leisure activities, and socio-economic status relevant to the lifestyle; symbolised by a fish meal for ease of recognition, and described in Table 7, on the following page.

We asked the staff how they were brought up, what sort of house did they live in, so I started by going and talking to people, and I thought this is taking a very long time. I came up with a questionnaire and sent it out to staff and then ended up giving it to anybody who came in the door, family members and the board, anybody, from that I started to pull together some themes. So, we developed that story early on and used it over and over again, so that's an easy way of explaining the lifestyles. So, in the cultural house, you're going to have boiled fish heads. Yum. In the contemporary house you might have a fish cooked in the oven wrapped in paper, so fish en papillote with a bit of white wine. It is still fish. (Participant 28, key informant)

Table 7. The lifestyles in The CARE Village (Source: Organisational document).

| Lifestyle | Description | Fish meal symbol |
|--------------------|--|---|
| Remote | A self-sufficient lifestyle outside urban areas, living from the local environment. Socio-economic status: Austere. | Self-caught, either filleted or smoked whole. |
| Cultural | Māori cultural lifestyle, the marae (courtyard in front of the meeting house) is essential in this lifestyle. Socio-economic status: Frugal. | Boiled fish heads [a boil-up]. |
| Country | Rural lifestyle. Socio-economic status: Economical. | Pan-fried. |
| Classic | Well-to-do formal lifestyle. Socio-economic status: Higher disposable income. | Fish en papillote or smoked snapper fish pie. |
| Contemporary | Modern, comfortable lifestyle, generally well educated. Socio-economic status: Higher disposable income. | Salmon fillets. |
| Middle New Zealand | A lifestyle focused on family and the community. Little opportunity for higher education, likely to be involved in a trade-related industry. Socio-economic status: Thrifty. | Fish pie made from canned fish. |
| Minimalistic | A simple lifestyle. Limited opportunity for higher education. Socio-economic status: Frugal. | Canned fish in white sauce. |

Although there were initially seven lifestyles in The CARE Village, there were no residents who identified with the remote lifestyle. Therefore, at the time of data collection, there were six lifestyles in The CARE Village, guided by resident needs. The statement by Participant 35, below, indicates the dynamic nature of the lifestyles, enabling the organisation to be responsive to the needs of residents.

What's interesting is that we now only have one who had lived remotely, and nobody's coming along, so maybe it was just a cohort of people that we had at the time. (Participant 35, key informant)

The staff make use of a document filled out at admission to help determine the lifestyle that would be appropriate for each resident. The document, called 'My life,' is similar to a mind map and contains spaces for entering information about aspects of the person's life. These aspects include their interests, past employment, life events, where they have lived and who the significant people in their lives are, assisting staff understanding of what matters to the resident.

Whare Aroha CARE staff used their knowledge of residents of Whare Aroha CARE to determine the lifestyle most suitable for existing residents. The information was gained during caring for them and by consulting with family members. Participant 26 describes the process in the data extract, below.

When we first took her to the other place, they asked us some questions about her lifestyle to get an idea of where she might fit. My sister was there as well, and they talked about her previous homes and upbringing. (Participant 26, family member, post-transition interview)

Interview data indicate that consultation did not take place with some family members regarding resident lifestyle. However, as one participant explained, although she was not involved in selecting a lifestyle for her mother, she trusted the staff, although she felt a different lifestyle could have been chosen. The participant did not object to the choice, and her mother is happy in the house she is living in.

You guys have got it partly right, she is very refined and fits in that house, but you have no idea how my Mum just loved her Māoritanga [Māori way of life], so I thought she would go into the cultural house. But I let it happen, I didn't question it at the time, and I am not going to change anything because she is settled and happy. (Participant 20, family member, post-transition interview)

There are some criticisms of the idea of lifestyle classifications. Some have questioned whether the cultural lifestyle at The CARE Village is, in fact, a lifestyle (T. Jeffs, personal communication, April 19, 2018). However, one participant, a relative of a resident who is Māori but does not live in the cultural lifestyle house in The CARE Village disagrees with that view. She argues that Māori culture is an integral part of the fabric of NZ society.

I don't have an issue with having a Cultural house, because otherwise, we wouldn't have our whare tūpuna [meeting house]. We wouldn't have our marae [courtyard in front of the meeting house], for me, [the cultural lifestyle] is just an extension of that, it's not separate for me it's a part of the fabric of what this country is about. (Participant 20, family member, post-transition interview)

A further criticism draws from the idea that the lifestyles reflect the class system in NZ. However, the lifestyles in The CARE Village do reflect class distinction, albeit unintentionally. The management team at Whare Aroha CARE did not see the lifestyles they were developing as reflective of class, but as enabling people to live with others with similar values.

We were very conscious of that, we did not want it to be a class thing, you know we thought that there was not a class system in NZ, but there is, but you do not talk about it, it is not something you talk about. Yes, so all of this stuff came up all at once. We thought how do you talk about people who live from paycheque to paycheque, who actually find it a real struggle to survive and put food on the table, and there is no money for extra things and luxuries, so you find some positive things. They are thrifty, and they are very careful of the pennies that they spend, and they do things to manage themselves around the house, and they grow vegetables, yeah, and so that was the kind of language that we were trying to use. (Participant 28, key informant)

There are socioeconomic inequalities present in NZ, although these are difficult to describe accurately due to technical issues related to their indicators (Crothers &

Yeung, 2018). Lifestyle is to some extent a reflection of income, with taste being a way of displaying the amount of disposable income one has and of distinguishing people as belonging to particular strata of society (Bourdieu, 1984). The built environment is part of a lifestyle, reflecting taste.

Construction on the village began in June 2016 following a ground-breaking ceremony. The RCCT had access to some financial resources due to frugal management practices over previous years. They were able to purchase the land for the new build and begin building using these funds, as well as a grant from the Rotorua Energy Charitable Trust, which funds community groups in the Rotorua area (Rotorua Energy Charitable Trust, 2018). To enable the village to be completed, further funding was needed.

Because of the way the business had been managed before us, we had a reasonable amount of capital, but it was nowhere near enough. It was enough to buy the land, and it was enough to fund the first part of the development. However, we always knew that we would have to get a mortgage, we would have to do some extra fundraising.
(Participant 28, key informant)

The organisation made efforts to obtain funds via donations from members of the public; however, very little money was able to be raised in this way. Additional applications for grants from charitable organisations were not successful. Unfortunately, the organisation was also unsuccessful in obtaining a mortgage needed to enable the completion of the build.

Management was faced with the need to move, combined with the obligation to build a facility for their existing residents and keep their staff employed. In 2017, they decided to accept an offer from Pukeroa Oruawhata Trust to buy the land and buildings at Ngongotahā and lease them back to the RCCT. The leaseback arrangement enabled the completion of the build.

The management team at The CARE Village were working with architects and builders to design and build a new environment for residents of Whare Aroha CARE and endeavouring to raise funds to complete the project. At the same time, they were also collaborating with officials to support the transition to an innovative model of care for residents. They approached a senior official from the DHB who consulted with a senior official from Central TAS, leading to the formation of a service development group.

We met with a senior official at the DHB because if we did not have her support, we were not going to get very far. She was very supportive and suggested we meet with [a senior official at Central TAS], so we arranged to meet with him. (Participant 35, key informant)

The senior official from Central TAS brought together a group of government and DHB officials to support the development of The CARE Village. The composition and role of the service development group are explained in chapter six, beginning on page 173.

The service development group is a governance network that has supported the transition and continues to support the pilot of an innovative model of care for residents of The CARE Village.

So that way of housing people who require secure environments co-habiting in relatively small house units with six or seven people in each house was untested in this country. There was some discussion about what risks does that present to those who don't require specialist dementia services, and living in the same space, living in the same proximity. We set up that service development group to keep engaged with the care village and monitor and manage those risks throughout the pilot. (Participant 41, key informant)

In September 2017 the residents of Whare Aroha CARE moved to The CARE Village, a process that took three days with the help of the families of residents as well as professional movers. Each house was made ready for occupation before the arrival of the residents. Family members furnished and dressed their relatives' rooms before they arrived in their new homes, assisting them to settle in.

With everybody helping, families and the movers, the whole move took three days. The staff were really good as well; lots of them helped with taking things from the old place to the new one. (Participant 40, staff member, post-transition interview)

When family members were not available, the staff made the residents' rooms ready for occupation. Additional staff were rostered during the period of the move to ensure ongoing resident care at Whare Aroha CARE and The CARE Village. Extra staff cover continued in the weeks after the move, while staff adjusted to their new roles.

We had staff here, and in the old facility, so we had staff coverage in both places, and all the residents were safe, so that was the most significant part. (Participant 34, key informant)

Staff roles had changed considerably, and it took time for staff to learn to manage their new responsibilities. After the move to The CARE Village, some staff roles no longer existed. In consultation with the relevant industrial organisation, all staff who had worked as cleaners, cooks or in the laundry at Whare Aroha CARE were offered roles as care staff at The CARE Village. A small number of people chose not to accept the offer and resigned at the time of the relocation (T. Jeffs, personal communication, September 18, 2019).

The care, cleaning, cooking and laundry staff who chose to move to The CARE Village became universal workers in the 13 homes in the village. The two care roles are home leads, who are responsible for the daily running of the homes they consistently work in; and support staff, who support the home leads. I explain the effect of the transition on the roles of staff in chapter seven, beginning on page 184.

5.5 Conclusion

In chapter five I have begun to answer the research question: How has the transition of Whare Aroha CARE residents to The CARE Village been accomplished? Along with a temporal narrative containing details of the process of the transition from Whare Aroha CARE to The CARE Village the first generative mechanism, 'they changed the culture of the workplace to enable person-centred care,' is presented. I have explained the need to move from Whare Aroha CARE due to the expiry of the lease and the opportunity that presented to explore innovative models of care in ARC.

After undertaking an exploration of models of care, management made a decision to build a village inspired by De Hogeweyk and began working with architects and builders. Additionally, management undertook work to change the culture of the workplace to enable the delivery of person-centred care. In chapter six I continue to answer the research question: How has the transition of Whare Aroha CARE residents to The CARE Village been accomplished? by presenting the second and third mechanisms generating the outcomes of the study.

Chapter 6 The creation of a supportive physical environment and the formation of a governance network

6.1 Introduction

In chapter six I explain the remaining two generative mechanisms that enabled the transition of residents from Whare Aroha CARE to The CARE Village. These generative mechanisms, acting in the domain of the real, in accord with Bhaskar (1975), are ‘they created a physical environment that supports the vision of people living normal lives’ and ‘they formed a governance network to support the transition to an innovative model of care.’ The chapter begins with an explanation of the generative mechanism ‘they created a physical environment that supports the vision of people living normal lives.’

6.2 Generative mechanism: They created a physical environment that supports the vision of people living normal lives

As stated in chapter two, beginning on page 37, in De Hogeweyk village people live in and manage their households with support from staff. The ability to go outside the house easily is a part of normal living (van Hal, 2014). As discussed previously, a new village was built to enable residents of the former Whare Aroha CARE and new residents of The CARE Village to live in households, in accord with what matters to them, with support from staff.

The CARE Village has a contract with Lakes DHB to provide specialist dementia services for those residents who require that level of care, and those residents have access to the entire village. Therefore, the whole village is a secure dementia care facility, albeit one with some residents who do not require specialist dementia services. Accordingly, architects designed The CARE Village to provide an environment that provides comfort, security and cues to engage in valued activities for residents who have dementia. The dementia-friendly environment at The CARE Village aligns with recommendations for secure dementia care environments in NZ (Ministry of Health, 2016).

Recognition of what matters to people is an acknowledgement of their value as people. However, identification of attributes of personhood such as physical or cognitive abilities can be marginalising to people who are physically or cognitively

impaired. Alternatively, enabling people to live their lives in accord with what matters to them, with support to compensate for disabilities, is an example of person-centred practice (McCance & McCormack, 2017).

Additionally, the creation of a supportive physical environment contributes to residents being able to continue with valued activities. The ability to continue pursuing valued activities affirms identity and contributes to subjective wellbeing (Stephens & Breheny, 2018). Valued activities vary depending on individual preferences and lifelong habits.

To enable residents to live normal lives with support, the management team at Whare Aroha CARE decided to build a village inspired by De Hogeweyk. They worked with architects and builders to develop the village. In Whare Aroha CARE, despite the previous enactment of culture change processes, the physical environment constrained the way people were able to live their lives.

The home-like environment of The CARE Village supports residents to participate in valued activities, aligned with the organisational vision of people living normal lives. I identified the generative mechanism 'they created a physical environment that supports the concept of people living normal lives' using the capability approach, a theoretical framework (Stephens & Breheny, 2018) described previously beginning on page 65, and evidence-based design guidelines (Ministry of Health, 2016). The theoretical framework and design guidelines aligned with themes in the study data. Two themes in the data enabled the identification of the generative mechanism 'they created a physical environment that supports the vision of people living normal lives.' The themes are 'working with architects and builders' and 'the favourable surrounding'; displayed in Figure 5, on the following page, and described subsequently.

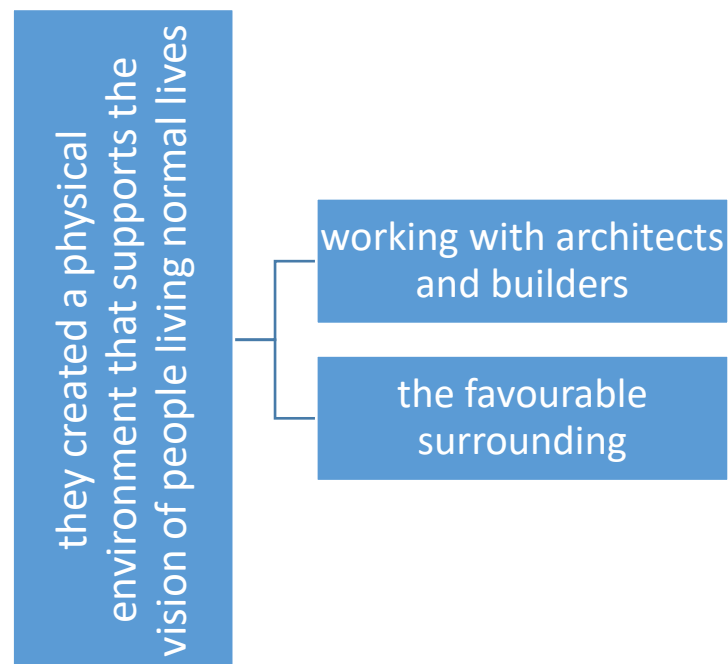


Figure 5. Themes in generative mechanism two.

6.2.1 Theme: Working with architects and builders

The theme ‘working with architects and builders’ is derived from the data. The operational definition of the theme is that it contains data about the management team at Whare Aroha CARE working with architects and builders to ensure the built environment at The CARE Village supports the vision of people living normal lives. As described previously, while they were still investigating models of care, members of the management team of Whare Aroha CARE attended a workshop on the topic of designing for people who have dementia, held at the Hammond International Design School in Sydney, Australia.

At the workshop, the team was introduced to the Hogeweyk concept by one of the facilitators. Also, via the workshop, they learnt the importance of working with architects who understand the purpose of the built environment in ARC, including for residents who have dementia. An architect from NZ had previously attended the same workshop and had the required understanding to design a dementia-friendly environment. One of the convenors of the workshop facilitated an introduction with the architect for the team from Whare Aroha CARE.

When we were at the dementia design school in Sydney, one of the massive things they were talking about when you are going to build a new facility, make sure the architects are people who really understand your story, understanding what it is that you are trying to achieve, and possibly more so with dementia. Because there are certain things that you have to be aware of for people with dementia in the design and the decoration and the way that things work to make it feel OK for them. So, we got given [the architect's] name because he had attended the dementia by design workshop when they had had it in Auckland the previous year. So, the [manager] rang him to introduce herself and say we are going to be building something, and we understand you went to this workshop, we would be interested in having a chat with you. (Participant 28, key informant)

The architect met with the managers at Whare Aroha CARE to discuss the project. As a result of the discussion, the managers realised the architect understood the result they needed to achieve in The CARE Village. The firm the architect worked at was engaged for the design of The CARE Village.

The architects began designing the buildings that would comprise The CARE Village. In the meantime, a member of the management team at Whare Aroha CARE visited De Hogeweyk. After Participant 35's visit to the Netherlands, she and Participant 28 attended a conference where they met the founders of De Hogeweyk. Meeting the founders enabled Participants 28 and 35 to understand how to apply the dementia-friendly village design principles to the village in Ngongotahā, and correct earlier misunderstandings.

That single visit is why we got here. Because I got to see what it was and what it looked like. We were totally heading in the wrong direction because we did not have enough information, and we had joined the dots up wrong. We were very clear now about what it looked like. We built the relationship with [the founders of De Hogeweyk], which meant we could communicate with them. We came back and told the architect he had got the drawings all wrong and had to start again. He took a deep breath and started again. (Participant 35, key informant)

A clear understanding of how the village should look and function informed the revised architectural drawings. Additionally, the design was informed by the lifestyles for the village, reflecting lifestyles typical in NZ. The lifestyles for The CARE Village were developed by the management team at Whare Aroha CARE, in collaboration with staff

members and others, as explained in chapter five, beginning on page 148, the impetus for lifestyle development came from the architects.

They were at the stage where they wanted to design the look of the houses. He rang up one day and said he wanted the description of the lifestyles by the end of the week. (Participant 28, key informant)

Participant 28's comment, above, indicates the architects' understanding of the village concept and the project. Furthermore, architects took the opportunity to meet the founders of De Hogeweyk at a masterclass they were running in Sydney, Australia. The meeting provided them with a chance to discuss and develop their ideas in consultation with the originators of the Hogeweyk design concept.

We went to meet the Hogeweyk founders a couple of years ago in Sydney. They were running a masterclass so [the architects] came as well, so that they could hear what the ladies were talking about and get it. Then they had an opportunity to directly ask questions if they wanted to because everything they'd heard had come from us, apart from their research, so it was really useful that they came as well, it was great. (Participant 28, key informant)

The architects had an understanding of the Hogeweyk concept, and they understood the principles of evidence-based design for people who have dementia, enabling them to design a village inspired by De Hogeweyk incorporating dementia-friendly design principles. In addition to engaging architects who understood and were sympathetic with the aim of the project, Whare Aroha CARE management wanted to engage a construction firm that understood the project.

One of the reasons that we chose [the contractor] to partner with us to be the builders, was when they came to present their proposal when we were looking at all the tenders, they had sat their team down, and they had watched the documentary about De Hogeweyk. They had talked about what that meant. We were really impressed with that. (Participant 28, key informant)

The management team met with several construction firms and hired a contractor that had taken the time to research De Hogeweyk and therefore understood the design concept and the rationale behind it. The management team at Whare Aroha CARE worked with the architects and building contractors to enable the construction of The CARE Village to produce a physical environment supportive of the organisational vision

of people living normal lives. Residents living normal lives in ARC facilities aligns with the theme ‘the favourable surrounding.’

6.2.2 Theme: The favourable surrounding

The theme ‘the favourable surrounding’ is drawn from the Hogeweyk care concept and is one of the so-called ‘six pillars’ supporting the concept. The Hogeweyk care concept is described in chapter two, beginning on page 37. In the current study, the theme ‘the favourable surrounding’ is operationally defined as containing data about residents living in domestic-scale environments, where they can continue valued daily activities, supported by staff.

The physical environments at the two sites for the study, Whare Aroha CARE and The CARE Village, are described, drawing on observational, photographic and interview data and field notes for the study, beginning with a description of the Whare Aroha CARE facility. The site of the original Whare Aroha Care ARC facility is on the edge of the CBD of Rotorua, on the corner of Hinemaru and Whakaue Streets. To the north of the site is Lake Rotorua.



Figure 6. Whare Aroha CARE. Photograph taken by Peter Wood, used with permission.

As can be seen in Figure 6, on the previous page, from the outside, Whare Aroha CARE was a large, white, two-storey hospital-style building. Inside, opposite the main entrance, there was a large sitting room containing comfortable hospital-type chairs and sofas. On the far side of the room was a set of glass doors leading to a garden containing a shaded seating area, established trees, flower beds and a lush green lawn.

Offices for management staff and the reception area were off the main hallway. There were chairs for people to sit on in the reception area and the hall. The hall was attractively painted and decorated with wood panelling topped with a dado rail. Figure 7 shows the main hallway, with the seating area opposite the management offices.



Figure 7. The main hallway in Whare Aroha CARE. Photograph taken by Kay Shannon.

At the end of the hallway, a lift and a staircase provided access to the first floor, where Wairua, the hospital wing, was located. Also, at the end of the ground floor hallway were two corridors going north and south. The corridor to the south led to Manaaki, the rest home area, and the passage to the north led to Manaia, the secure dementia wing.

It's an older two-storey building. The first floor is made up of two departments; one is the rest home area; the other is our safe unit. Upstairs is our hospital wing. (Participant 6, staff member, pre-transition interview)

There was a key-pad entry to Manaia, leading to a long corridor decorated similarly to the main hall. Photographs and other objects that had meaning for the residents decorated the bedroom doors, providing orientation cues for residents, as recommended by Ministry of Health (2016). There were single resident bedrooms on either side of the hall, enabling residents to enjoy privacy and solitude.

I just go into my room, and I shut the door, and I know I've closed the door and I can open it when I'm ready. (Participant 7, resident, pre-transition interview)

The living and dining space in Manaia unit contained sofas and armchairs in various configurations as well as two large dining tables with chairs; residents ate and participated in craft activities at these tables. People in the unit, staff, residents and others often spontaneously sang and danced along with the music that played continuously, commonly popular hits from the 1950s onwards. The garden was accessible from this main living and dining area.

The garden in Manaia was securely enclosed and separate from the central garden. Residents could walk out any of the doors of the unit, walk around the yard and come back inside, safely and securely. The provision of outdoor space for residents requiring specialist dementia services, separate from the outdoor areas used by other residents in the facility, is required under the terms of the contract between the DHB and the care provider (Ministry of Health, 2013a).

I think the garden is fantastic and I see the other residents wandering in and out, and there are different ways they can get around the garden, and there are different exits, and I think that's great for them. And they can open a gate on that one little area and just go further and then come back, doesn't matter whether they shut the gate or not because the whole place is secure anyway. (Participant 8, family member, pre-transition interview)

In the part of the garden outside the main living area, there were raised garden beds containing flowers and vegetables. One of the residents helped maintain the garden

and looked after the chicken that roamed the yard. He was using the outdoor space to continue valued activities, affirming his lifelong identity.

Further along the path was a lawn with a decommissioned red telephone box on it, a familiar item for older New Zealanders. Residents in Manaaki could go into the central garden from the dining room and sitting room. However, residents in Wairua were mostly unable to go outside because Wairua was upstairs, and residents needed staff to take them downstairs to the garden and stay with them while they were there.

Some people in the dementia unit have the freedom to go out into the garden and walk around. In the rest home, some people are independent. They can do what they feel like doing; they can go out. Hospital-level patients, that is a whole different ball game again, because they are restricted in what they can do. (Participant 4, staff member, pre-transition interview)



Figure 8. Participant 14's favourite view from the upstairs dining room in Whare Aroha CARE. Photograph taken by Kay Shannon.

Figure 8, above, shows Participant 14's view of the garden at Whare Aroha CARE. He loved looking down on the garden from the dining room in Wairua but was not able to go outside, in contrast to his experience in The CARE Village, described on page 171. The CARE Village is in Tauī Street, Ngongotaha, on the shore of Lake Rotorua, approximately 8 kilometres from the Rotorua Central Business District; a kaumātua (Māori elder) blessed the site before construction commenced. Including culturally relevant rituals when building accords with evidence-based recommendations for providing culturally respectful dementia care environments for Māori (Ministry of Health, 2016).

At the entrance to The CARE Village, technology unobtrusively keeps residents who require specialist dementia services safe via the use of electronic pendants or wrist bands resembling watches, while enabling those who do not need secure care to enter and leave the complex freely. The outside door opens automatically, people entering or leaving the building step into the area between the doors, the outer door closes. There is a short delay, and the inside door opens, as seen in Figure 9, on the following page. The sensors linked to the door openers detect the presence of the pendants or wristbands worn by residents who require specialist dementia services. The doors are locked if one of them is within a certain radius of the doors, causing occasional inconvenience if a resident wearing one of the devices lingers near the entrance.

[Resident] comes here and the doors lock, it's good for her to have that freedom, but there is a price to pay. We just get the staff from her house to come and get her, but it's a bit inconvenient for people who can't get in and out, whereas in the old place the dementia wing was a closed circuit unless the staff took you out. (Participant 27, staff member, post-transition interview)

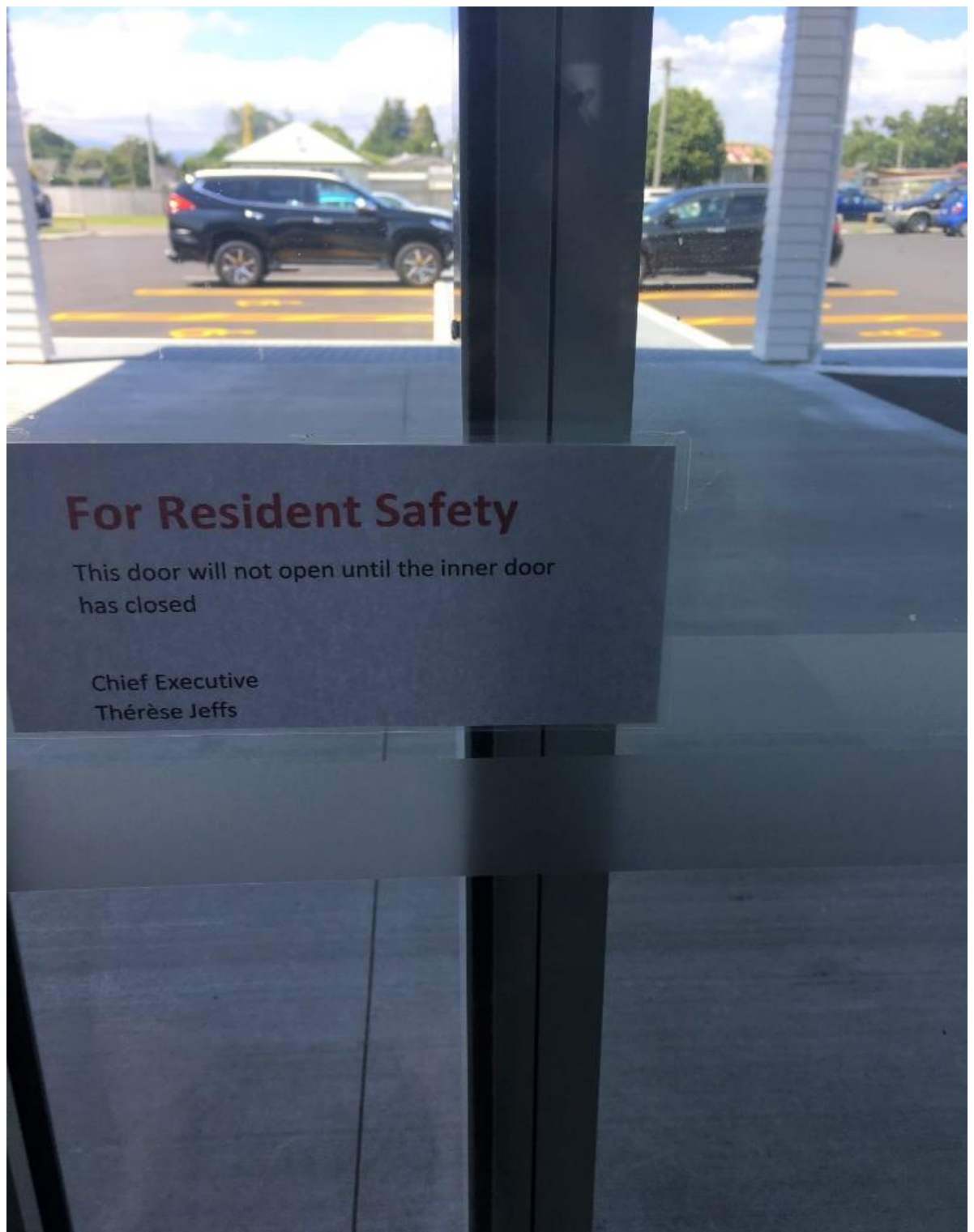


Figure 9. The outer door at The CARE Village. Photograph taken by Kay Shannon.

The building at the entrance to the facility is the administration building, known as 'the hub.' This building contains the reception area, public toilets, administration offices, professional staff office, shop and tearooms, and maintenance workshop. There is a large, grassed area adjacent to the hub, the future site for the town square.

Currently, the space in front of the hub contains the old red phone box from Whare Aroha CARE and some outdoor seating and shade areas. Further development of the town square is on hold since the change in ownership. However, there are tables and chairs in the shop and tea-rooms, and outdoor furniture where people can sit and have a drink or eat ice-creams bought in the shop, as can be seen in Figure 10, below.

You get a very positive vibe when you go in, and I'd like to see the village part of the concept, which is the town square with the retail shop and the hub. That is more of an everyday connection we get in our normal lives (Participant 41, key informant)



Figure 10. The area outside the shop and tea-rooms at The CARE Village. Photograph taken by Kay Shannon.

Facilitated by home lead, Participant 39, children from a local childcare centre engage in craft activities in one of the houses every week and then run and play on the grassy area near the hub. The centre has limited space on its grounds, and The CARE Village management has invited centre staff to treat The CARE Village as an outdoor space for their children to play in. The activity is an example of enabling residents to remain connected with the local neighbourhood. A similar intergenerational community connection has been identified in a facility in Belgium, where children from a local nursery school visit and interact with residents (Van Hecke et al., 2019).

The residents love having the kids here, enjoy watching them do their colouring and craft and hearing their chatter. When the kids have finished their art, they can have a run around outside. (Participant 39, staff member, post-transition interview)

From the hub, pathways lead to the houses, depicted in Figure 11, below. Eleven of the houses were occupied at the time of phase two data collection in January to April 2018. Each home has a central open plan living, dining and kitchen area, and is decorated in a style that corresponds with the lifestyle of the people who live there. There is a corridor leading off each side of the open-plan area; these contain the six or seven bedrooms, bathrooms and a laundry.



Figure 11. Pathways leading to houses in The CARE Village. Photograph taken by Kay Shannon.

Each house has garden beds at the front and a domestic-style letterbox. Because The CARE Village is on lakefront land, two houses have views of the lake from their windows. For people who enjoy walking outside, there is a path along the lakefront, with park bench seating beside it. The provision of a path enabling residents to walk past interesting sights contributes to positive subjective quality of life, as identified by (Fleming et al., 2016). Participant 19 discusses their view of the impact of the freedom

to go outdoors and see interesting sights on the residents in the interview extract below.

They're a lot happier; there's more freedom, they can just get out and wander around when they like, they go and sit by the lake and watch the swans, the ducks come up onto the grass. (Participant 19, staff member, post-transition interview)

The houses are within grounds that resemble a neighbourhood in a small town, with walking paths around the village. Each of the houses is run independently, according to the routine that suits the residents, and residents are supported by staff to participate in the running of the household. Participant five, below, is describing a dementia-friendly environment where residents can experience the benefits of an accessible outdoor environment. Additionally, they are noting a perception of increased awareness of their surroundings in accord with the benefits of light and vitamin D, as recommended by the Ministry of Health (2016).

It is just beautiful. I love how everybody has their own home, especially the residents, where they can come out and just wander around and be free, and nothing is stopping them. The other place was only small, and they couldn't really do much. Especially for us up in the hospital. We could only take them to the lounge and put them in front of the TV. Whereas here, you have the doors wide open, the sun coming in, you have the scenery of the gardens, people walking past. They are more aware than before; the residents are more aware of their surroundings. (Participant 5, staff member, post-transition interview)

Conversely, when living in Whare Aroha CARE, despite the change in workplace culture, residents were constrained by the physical environment there and were not able to live normal lives. The statement by Participant 29, on the following page, demonstrates her perception of the difference between her ability to participate in a valued activity such as making a cup of tea at the two facilities. The physical environment of small homes where daily household activities are occurring supports residents to continue living in ways they value. In addition to cues provided by their surroundings, residents require the support of staff to do the things they value. As explained in chapter seven, depending on desire and ability, participation in household activities ranges from being present when activities take place to actively participating in completing household tasks.

Well, I think it sort of, it's meant to be like your own home and if you want to make a cup of tea you can, whereas in Whare Aroha CARE I never had much show. (Participant 29, resident, post-transition interview)

Living in a single-storey house with easy access to the outdoors enables all residents to go outside if they want to. In contrast, the two-storey layout of Whare Aroha CARE, with the hospital wing upstairs (Wairua) meant that residents who were dependent on staff for mobility did not have access to the outdoors, due to the amount of staff time involved. The statement by Participant six indicates how difficult it was for Whare Aroha CARE staff to take residents from Wairua into the garden.

We have to mobilise them, in a big chair, so one person is taking one person, from upstairs. So, we're going down in the lift taking these big chairs that they're lying in, so it takes a lot of staff. I can't take too many staff off the floor, so we can't have a group of people out there at once, because then they need a group of people to look after them. (Participant 6, staff member, pre-transition interview)



Figure 12. Participant 14's view at The CARE Village. Photograph taken by Kay Shannon.

In contrast, Participant 14's view of the outdoors at The CARE Village, shown in Figure 12, above, is from the ground floor, from the open-plan living area, with direct and

safe access to outside via sliding glass doors onto the patio. He can sit out on the patio and still be safely visible to staff inside the house. Additionally, data from his wife's interview transcript confirms how much he enjoys watching people walk past the house from his bedroom window, facilitated by staff knowing he values that activity.

They must have gone to a lot of trouble to work out the room for [Participant 14]. He can look out and see people all the time, and that's really nice. (Participant 9, family member, post-transition interview)

Interview data confirm staff awareness of the value of being outside for residents, including those who require support with mobility. Outdoor areas are more accessible to all residents, including those with dementia. The physical environment and the person-centred approach of staff enable residents with dementia to safely use the outdoor spaces in the village. The inclusion of usable outdoor spaces in ARC facilities has been found to be valued by residents who have dementia and their families (Innes et al., 2011).

We can wheel them out into the garden we can put the umbrella up, and they can have breakfast outside or lunch outside, weather permitting. We don't have to be inside all of the time, and we can go for a walk and look at the lake, we can look at the ducks, some people like to feed the birds, so we want them to experience everything as much as possible. That's life, and it should not be limited to four walls because that is just depressing. What about getting outside to take your shoes off and walk in the grass. (Participant 6, staff member, post-transition interview)

The fully enclosed site supports residents who have dementia and require specialist dementia services to engage in valued activities, such as walking safely. Innovative use of technology ensures free entry to and exit from The CARE Village for residents who do not require specialist dementia services. However, those who need specialist dementia services are kept safe; they are unable to leave the village, and technology enables staff to know where they are within the village.

There are messages on the phone if one of the residents is walking around. There are 'eyes' on them, keeping them safe. (Participant 5, post-transition interview)

Thus, as it can be seen from the data and processes detailed previously, a supportive environment was created that contributes to the positive quality of life of CARE Village residents, with and without dementia. The environment and the support of the staff enable residents to do the things they value, contributing to the continuation of lifelong identities. The creation of a supportive environment is the second of three generative mechanisms explaining the process of the transition of Whare Aroha CARE residents to The CARE Village. The final generative mechanism relevant to the process of the transition is 'they formed a governance network to support the transition to an innovative model of care.' I explain the generative mechanism 'they formed a governance network to support the transition to an innovative model of care in the following section of the chapter.

6.3 Generative mechanism: They formed a governance network to support the transition to an innovative model of care

Officials from some key organisations were brought together in a service development group to support the transition of Whare Aroha CARE residents to The CARE Village. Members of the service development group collectively and individually supported the success of the transition. They did so by ensuring acceptance of the model by senior clinicians, changing the national contract to support a pilot of the new model, and collaborating to ensure compliance with regulatory requirements to manage risk and maintain resident safety.

The transcripts of interviews with key informants, as well as policy documents from The CARE Village, are the data that support this step of the analysis. The interview transcripts contain the study participants' interpretations of events. Danermark et al. (2019) identify participant interpretations as being an essential part of this stage of explanatory research.

A process of retroduction (Danermark et al., 2019) was used to identify the generative mechanism 'they formed a governance network to support the transition to an innovative model of care.' The generative mechanism was identified using a conceptual framework theorising governance networks (Koliba et al., 2017) and themes in the data. The themes in the data that enabled identification of the generative mechanism 'they formed a governance network to support the transition to

an innovative model of care’ are ‘readiness to consider a new model of care,’ ‘managing risk,’ ‘working together,’ ‘changing the contract’ and ‘regulatory compliance’; these are displayed in Figure 13 and described subsequently.

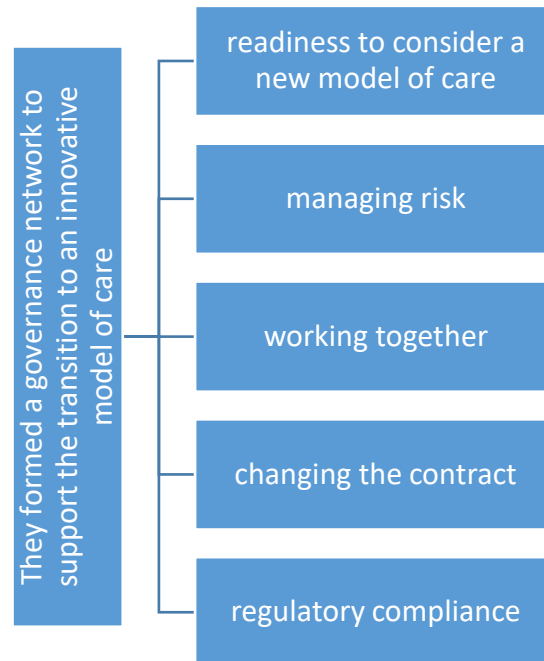


Figure 13. Themes in generative mechanism three.

6.3.1 Theme: Readiness to consider a new model of care

The theme ‘readiness to consider a new model of care’ is inductively derived and is operationally defined as containing data about the willingness of senior officials to consider supporting an innovative model of care in ARC. As described earlier, the senior officials at Central TAS, HealthCert and Lakes DHB who had the power to enable the new model of care to be certified were receptive to considering innovative ways of delivering ARC services. Around the time the decision was made at Whare Aroha CARE to move to a different model of care, the Ministry of Health had collaborated with The University of Auckland to produce guidelines for secure dementia care environments in ARC homes (Ministry of Health, 2016).

These guidelines emphasise the dignity and human rights of people with dementia who are living in secure dementia units, and advocate that care be person-centred and culturally sensitive (Ministry of Health, 2016). Nationally, several ARC providers had been exploring alternative models of care (Edeninoz&nz, 2018; The Selwyn

Foundation, 2018). As Participant 37 explains, small-scale living facilities in ARC are gaining acceptance, however mixing people who require specialist dementia services with those who do not has not been undertaken previously in NZ.

Absolutely the smaller environments, no problem at all, and we are well researched on that. I do agree with no problem with the smaller environment; I think what we're really test-casing here is mixing specialist dementia services with other models. We need to see whether that works for everybody. (Participant 37, key informant)

Exploration of alternative models of care coincided with disquiet among clinicians, regulators and funders about the growing number of people with dementia living in multi-storey complexes in ARC settings. Both these factors contributed to the readiness of senior officials in influential positions to consider alternative models for delivering ARC services. This context of willingness to consider change coincided with the need to move from the original Whare Aroha CARE site in Rotorua.

It also fits into an area where in NZ a lot of the new developments were based on multi-storey buildings, with the thought that people with dementia could be on the second or third floor with no external access, and those units could be bigger than 21 people. So that was an environment when, again, the clinicians were saying they didn't see that that was the appropriate living environment for people with cognitive impairment. They thought it was important that people could go outside and so there were also challenges at that time to say it is probably time to all think about what is a good living environment. (Participant 38, key informant)

The formation of a governance network occurred in the context of openness to considering new ways of enacting ARC. The senior official who initiated the formation of the governance network provided an opportunity for the management at Whare Aroha CARE to present an innovative model of care to a group of senior officials. The group deliberated and were able to be supportive of the project.

Dementia care, in particular, is a really growing industry in NZ, and we have to find different ways of doing things, and we have to have a permissive model or commissioning framework that allows new ways to be explored and developed in a safe environment, and that is what this is about. (Participant 41, key informant)

Initially, the Chief Executive of Whare Aroha CARE had discussed the transition to the new model of care with a senior official at Lakes DHB. The DHB is the first point of

government contact for ARC providers. The DHB contracts with the provider, in this case RCCT, to provide services for older people who require residential care services.

Under the terms of the national ARC contract, funding is provided by the Ministry of Health to the DHBs, who contract with local ARC service providers (Ministry of Health, 2013a). After discussion between senior officials at Lakes DHB and Central TAS, a senior official at Central TAS brought a governance network together. One of the purposes of the governance network, known as the service development group, is to manage risks associated with the transition to an innovative model of care.

6.3.2 Theme: Managing risk

The theme 'managing risk' is inductively derived and is operationally defined as containing data about risk management relevant to the process of the transition from Whare Aroha CARE to The CARE Village. The senior official from Central TAS encountered some resistance to The CARE Village concept from some parts of the ARC sector. In support of the aim of managing risk, the senior official from Central TAS arranged for a team of clinical experts to meet with the management team from Whare Aroha CARE to discuss the proposed new model of care with a view to ensuring the continuation of safe and appropriate care of all residents after the transition. The expert clinicians were of the view that the model would be safe for residents, providing reassurance that it was safe to proceed with the transition from Whare Aroha CARE to The CARE Village.

My role was to drive the change to the national agreement and sell that through the DHBs and the joint ARC steering group, which is made up of sector representatives and DHBs and ministry folk. To get that change accepted and agreed through that process. Some resistance for the sector, the sector was quite questioning about aspects that we had to surrender as a part of changes to the national agreement, particularly around secure dementia care. Some people were classical providers of secure dementia services that were quite questioning of the concept. To help sort of giving some comfort and background around that I pulled together a group of clinicians from around the country, psycho-geriatricians, geriatricians, ministry folk and others, to have the opportunity to meet with [Whare Aroha CARE management] and have the concept explained. Then we had a big session, pretty much a whole-day session around challenging and understanding the risks that might be inherent within that type of model because it was new for NZ. So, getting the clinical view that said, yes, some risks will be there ongoing. However, if it's done

correctly, if it's done well, the model should actually produce a good outcome for all concerned, so it was going through all of those sorts of pathways to get the people on board to accept it. (Participant 41, key informant)

Additionally, the senior official from Central TAS established the service development group, a governance network comprised of himself, another senior official from Central TAS, a manager from Whare Aroha CARE, a senior official from HealthCert and a senior official from Lakes DHB. This group collaborated to identify and manage any risks associated with the transition. The collaboration between members of the governance network supported the transition to the new model of care.

6.3.3 Theme: Working together

The theme 'working together' is inductively derived and is operationally defined as containing data about the collaboration between members of the service development group. The exercise of the power held by one key individual, the senior official from Central TAS, facilitated the bringing together of the service development group. The members of the group were all known to each other because of previous working relationships, as described by Provan and Lemaire (2012). Each of the members of the service development group had a different role to play and was able to support the transition differently.

Health is like this. I had worked with him in a previous life in the DHBs. (Participant 35, key informant)

Members of the network each had a slightly different perspective to bring to the group due to their differing roles, consistent with Behagel and Arts (2014). Participants from organisations outside Whare Aroha CARE saw the role of the service development group differently, depending on their substantive positions. The difference in the perspectives of members of the service development group is apparent in the quotes from Participant 35, who viewed the purpose of the group as being supportive and proactive in the management of problems, while participant 41 focused on engagement and risk management.

He put together the service development group work with me and made sure that it was going the way we thought it would and if there were any problems they would be quickly identified. (Participant 35, key informant)

We set up that service development group to keep engaged with the care village throughout the pilot to ensure that those risks were monitored and understood. (Participant 41, key informant)

The differing perspectives illustrate the representation of relevant governance expertise in the group, similar to the findings of Behagel and Arts (2014). Despite differing perspectives, what is clear is the atmosphere of open communication and collaboration that characterises the governance network, similar to that noted by Ferlie et al. (2011). Open and respectful communication between the network actors, all of whom were known to each other due to current or previous working relationships, was the basis of the governance network that supported the transition.

I think what is important to say is that communication is very open and very transparent. I think regular contact and meeting are helpful, well I certainly hope they are helpful. (Participant 37, key informant)

It is this governance network, facilitated by the exercise of power embodied in the substantive position of the instigator of the group that has enabled The CARE Village to be contracted and certified as a pilot site for a mixed services model of care in ARC. The group met, and continues to meet regularly, to ensure the transition progressed as smoothly as possible, and any risks identified continue to be managed appropriately. Additionally, members of the group have supported the Board of RCCT and the management team at The CARE Village in governance matters to ensure all those people had a clear understanding of the purpose of the transition.

I went up and had a brief visit when people were of course living in their homes, which was great. I also met with the Board and [the manager] and the team to talk about some of the matters as we see it just in supporting the governance. I wanted to ensure the management structure were all over understanding what the care village was trying to achieve. I talked about our role in supporting and ensuring that we are all keeping transparent about this. So, we can understand how well it is working and what might be the learnings and what we might need to do in the future to change any policy or other settings for other providers if things go well. (Participant 37, key informant)

As can be seen in the participant quote above, another aspect of closely engaging with The CARE Village is to gain understandings that will be useful to other providers in the future who may want to develop facilities using a similar model of care. Additionally,

an essential aspect of ensuring a smooth transition from Whare Aroha CARE to The CARE Village was the development of a variation of the existing standard contract for the provision of ARC services. I discuss the theme ‘changing the contract’ in the following chapter section.

6.3.4 Theme: Changing the contract

The theme ‘changing the contract’ is inductively derived and is operationally defined as containing data related to the changing of the contract to enable the pilot of a mixed services model of care at The CARE Village. The Ministry of Health is the government department responsible for the health and disability system in NZ. At a local level, health services are provided by DHBs, with a majority of elected members (Laugesen & Gauld, 2012). The Ministry of Health devolves responsibility to the DHBs for hospital and other health services, including ARC services, provided under contract by service providers (Laugesen & Gauld, 2012).

The Age-related Residential Care Services Agreement, the contract (“the contract” hereafter) between the DHBs and the ARC service providers does not vary nationally. Under the contract, residents are accommodated together based on their assessed level of care needs (Ministry of Health, 2013a). To ensure the care provided for residents is safe and of an appropriate standard, services are audited against the contract and the standards contained in the Health and Disability Services (Safety) Act 2001 (Ministry of Health, 2013b).

The model of care at The CARE Village, housing residents with others who have lived similar lifestyles rather than with others who require the same level of care, does not comply with the national standard contract between Lakes DHB and the RCCT, the trust responsible for operating Whare Aroha CARE and The CARE Village. A contract variance was needed to enable The CARE Village to comply with the terms of the contract. Collaboration between Central TAS and management of The CARE Village has resulted in a contract for a three-year pilot of the new model of care, a mixed services model, being signed between Lakes DHB and the RCCT

The senior official at Central TAS initiated this process after recognising the need for it. A legal firm was engaged to work on varying the contract to align with the proposed

new model of care. The legal services were paid for by Central TAS, who led the governance network.

So Aged Residential Care contracts with residential care providers is a national contract. I mean it is the only real national contract that exists within health, there is no variation from it at all. When you have this model proposed that does not fit within the national contracting framework, you need to find a way to make adjustments to that to allow it to be supported. The journey of moving from a national contract to a special arrangement for this particular facility, we have managed all the work and costs that have gone into that.
(Participant 41, key informant)

The services provided under the contract between RCCT and Lakes DHB were required to meet the same criteria as any other health service provided under contract to a DHB. The DHB and the RCCT agreed on a three-year pilot of the new mixed services contract. As can be seen in the quote from Participant 41, below, if, at the end of the three-year pilot, the model is not seen as being successful, the pilot will be terminated.

It is on a three-year pilot, it can then be established as a successful model, it can be extended beyond the three years if there is still insufficient confidence in the model requires a little bit more testing or changes, or it can be terminated and returned to the classic model where specialist dementia is not co-habiting. (Participant 41, key informant)

Termination of the pilot will result in the contract reverting to the national one. A consideration impacting the success of the pilot is around regulatory compliance. I discuss the theme 'regulatory compliance' in the following chapter section.

6.3.5 Theme: Regulatory compliance

The theme 'regulatory compliance' is inductively derived and is operationally defined as containing data about matters to do with auditing and certification of the two facilities that are sites for the study. Since 2002 NZ ARC services have undergone a certification auditing process; in 2009, following a report by the Auditor General, some changes to the process were made, including a shift to an outcomes-focused approach and "the introduction of 'spot' or unannounced audits" (Neville, Wright St-Clair, Healee, & Davey, 2018, p. 5). Certification is administered by HealthCert, a business unit in the Ministry of Health, with audits being carried out by independent accredited auditors (Ministry of Health, 2018).

The service provider engages the auditor of their choice and is responsible for the audit costs. Facilities are audited against their service contract with the DHB and the standards set out in the Health and Disability Services (Safety) Act 2001 (Ministry of Health, 2017). Audit reports are publicly accessible on the Ministry of Health website.

We have an integrated model in NZ, where the audit framework for certifying and monitoring services is against the contract and the standards. (Participant 37, key informant)

Services are audited and certified every one to four years, depending on the results of the previous audit. Identification of non-compliance issues at the audit leads to providers reporting to the DHB on their progress addressing these. Additionally, an unannounced 'spot' audit is carried out during the period of certification.

If a new operator purchases a certified service, a new audit must be carried out; this is known as a provisional audit. If an existing provider adds new services or reconfigures a service, a partial, provisional audit is carried out (Ministry of Health, 2017). Because The CARE Village is a reconfigured service provided by an already certified organisation, a partial, provisional audit was required.

The required partial, provisional audit was conducted in August 2017, before the transition of residents to The CARE Village, and resulted in the identification of some non-compliance issues. These were mainly related to policies that had not been updated to reflect the changed model of care and other yet-to-be developed documentation. Subsequently, a 'spot' audit was carried out in January 2018, after residents had moved into The CARE Village, identifying some unresolved issues. After each of these audits, the team at The CARE Village, including management and other staff, worked with a senior official at Lakes DHB to ensure the issues identified were resolved satisfactorily, providing accurate documentation of safe and compliant care in The CARE Village.

Those corrective actions, I sat down with [the manager] and we went right the way through all of those, and we signed those off as being either there or in progress. (Participant 38, key informant)

Both the senior official at Lakes DHB and Whare Aroha CARE management identified the partial, provisional audit as challenging. Management and staff completed the

corrective actions required, and an audit carried out in June 2018 resulted in a three-year certification for The CARE Village. The auditing and certification framework can assist services to ensure their documentation reflects their care, and the service provided meets all the required standards and contractual obligations.

Your provisional audits are done before your building sites are finished. Therefore, a lot of what is in the provisional audits is likely to tell you that you haven't got this, and this and this. You are six weeks away from the build. All the things that ought to be in place, actually the residents are living in, or they are sitting on. So, the provisional audit is always a challenge. However, the systems and processes and documentation of those sort of things for the new site, and the staff training and the idea of selling the model, was always on the expectations that everybody was ready to move on the transition and would automatically know what they were going to do on day one.
(Participant 38, key informant)

The auditing and certification process can be seen by service staff as challenging, particularly at busy times, such as during the process of a transition to a different model of care. As indicated by Participant 37, ensuring all the relevant documentation required for certification is in place will facilitate sharing with other organisations interested in developing facilities using a similar model of care. Throughout the process, HealthCert and the senior official at Lakes DHB have worked collaboratively with the team at Whare Aroha CARE, and later The CARE Village, to ensure management of any issues identified, similar to the findings of Bailey and Wood (2017).

I would certainly hope the team at The CARE Village would say we were always responsive and always tried to provide flexible options. I know they've got frustrations around some of the corrective actions, the findings from the audit. However, I do believe there is an opportunity for them to tell a bit more of their story in writing and for everybody to know what that is and how it looks for consumers.
(Participant 37, key informant)

A senior official from Central TAS formed a governance network to support the transition from Whare Aroha CARE to The CARE Village. The network worked collaboratively to seek reassurance regarding clinical risks, to manage risk, to vary the contract between RCCT and Lakes DHB for the provision of ARC services and to

facilitate certification of The CARE Village. The network continues to support The CARE Village during the three-year pilot of the mixed services model of care.

6.4 Conclusion

In chapter six I have explained two generative mechanisms that supported the transition of residents from Whare Aroha CARE to The CARE Village. A process of retroduction enabled the identification of the two generative mechanisms, using study data and theory. The generative mechanisms “they created a physical environment to support the vision of people living normal lives” and “they formed a governance network to support the transition to an innovative model of care” explain two aspects of the transition from Whare Aroha CARE to The CARE Village.

Whare Aroha CARE management created the physical environment at The CARE Village by working with architects and builders to ensure the built environment supported their vision of people living normal lives. Residents in The CARE Village live in a domestic scale setting within a secure perimeter, enabling them to safely participate in valued activities and providing cues for residents with memory loss. RCCT provides ARC services for residents under the terms of its contract with Lakes DHB.

A governance network facilitated by a senior official at Central TAS worked together to ensure the national contract was varied to allow for the pilot of a mixed services model of care at THE CARE Village. The generative mechanism “they formed a governance network to support the transition to an innovative model of care” explains the role of the governance network. Members of the governance network, known to each other, worked collaboratively to support the transition from Whare Aroha CARE to The CARE Village.

The governance network will continue to support The CARE Village during the pilot of the innovative mixed services model of care. The model of care enables residents to live with peers who have lived similar lifestyles rather than peers with the same level of care need. Chapter seven explains the effects of the transition on the lives of residents and their families and the staff of The CARE Village.

Chapter 7 The outcomes of the transition from Whare Aroha CARE to The CARE Village

7.1 Introduction

In chapters five and six I explained the process of the transition of residents from Whare Aroha CARE to The CARE Village. The explanations of the process of the transition answered the research question: How has the transition of Whare Aroha CARE residents to The CARE Village been accomplished? In the current chapter the outcomes of the transition will be explained, including the answer to the research question: What is the effect of the transition of Whare Aroha CARE residents to The CARE Village on the lives of the residents?

The study is a single case study with three embedded units of analysis (Yin, 2014): the first embedded unit of analysis is the staff of both facilities, the second is the residents of both facilities and the third is the family members of those residents. The outcomes related to all three units of analysis are relevant to the way residents of The CARE Village can live their lives.

The domestic-scale environment and the person-centred practice of the staff intersect to support resident quality of life in The CARE Village. That support enables residents to choose to live in ways they prefer, aligned with their previous lives outside of ARC. Staff support compensates for disability, enabling residents to engage in valued activities that contribute to continuation of sense of self. The chapter begins with an explanation of the effects of the transition on the way staff perform their roles.

7.2 The effects of the transition on the way staff perform their roles in The CARE Village

The roles of staff have evolved to support the provision of health and social care for residents. The process of changing staff roles has been continuous and remains ongoing. The new model of care requires a shift from providing healthcare and support with ADL to delivering care that aligns with the vision of residents living normal lives. In turn, staff have been required to change the way they conceptualise care.

Despite the work of management to change the focus at Whare Aroha CARE from staff- and task-focused to person-centred, there is some evidence of the persistence of

a task focus at The CARE Village. The evidence indicates the importance of management continuing to work with staff to promote person-centredness in practice. Working with staff includes formal and informal conversations about the application of the model of care and mentoring of new staff by experienced staff who understand how to support resident choice.

At Whare Aroha CARE, admission paperwork included capturing the resident's life history and preference for participation in valued activities. The information collected informed staff efforts to provide valued activities for residents, an example of person-centredness in practice. For example, one resident at Whare Aroha CARE spent almost all day in the garden outside the specialist dementia services unit, while others used the garden sometimes or not at all.

We give them a purpose, we try and make gardens, so they can participate in gardening if they like gardening. We try and find out what they like. We do that through the 'my life' form in their admission pack when they come in. We try and give them a meaningful purpose in life. (Participant 16, staff member, pre-transition interview)

Staff at Whare Aroha CARE had the freedom to adapt daily routines to accommodate resident preference. Accommodating resident choice is an example of shared decision-making, a person-centred process. In the excerpt from her pre-transition interview, below, Participant one describes how she adapts the daily routine to accommodate resident preferences.

Everything is worked out around the person's needs, if someone doesn't want to get out of bed until nine o'clock in the morning, that's fine, if they're going to go outside and eat their meal, that's OK. (Participant 1, staff member, pre-transition interview)

Shared decision-making includes supporting residents in ARC to decide their daily routine, indicating respect for their beliefs, values and autonomy. However, there are contradictory statements within the interview data, with some participants reporting the staff-centredness of the daily routines at Whare Aroha CARE. Participant six's description of the morning routine in Wairua (the hospital-level care wing) at Whare Aroha CARE aligns with a typical hospital-based routine of early-morning personal hygiene, regardless of resident preference.

Some people need to be hoisted; some have showers, we have a roster for showers, we get all of that out of the way and all our residents up into the lounge in their blue chairs. (Participant 6, staff member, pre-transition interview)

Additionally, at times, staff routinely taking over resident ADL persisted despite efforts to move towards encouraging residents to maximise their remaining abilities by doing as much as they could for themselves. Workloads and staff beliefs about efficiency accounted for the continuation of staff **‘doing for’** rather than **‘doing with’** residents. Participant one, below, explains the need to continually reinforce the message with care staff about encouraging residents to do as much as possible for themselves.

Sometimes people are in a hurry to get their work done, so it’s easier to dress someone and do their buttons up than it is to take the time to let them do it, so we chat about it, and some days it works and some days it doesn’t. (Participant 1, staff member, pre-transition interview)

The data extract above is evidence of inconsistent delivery of person-centred care at Whare Aroha CARE, exemplified by falling back into task-focused routines when the workload was heavy. They indicate the need to keep supporting care staff to develop an understanding of the underlying philosophy of resident choice and maximisation of remaining abilities. Ongoing conversations about person-centred care prepared the team for their roles at The CARE Village; however, continuous education is required to ensure old ways of working do not re-emerge.

Data from five themes intersect to explain staff roles at Whare Aroha CARE and The CARE Village. The themes containing data relevant to the staff role are ‘the organisation,’ ‘living with people who share the same lifestyle in a small group,’ ‘health,’ ‘employees and volunteers’ and ‘life’s pleasures and meaning of life.’ The chapter section relevant to the impact of the transition from Whare Aroha CARE to The CARE Village on staff roles begins with the theme ‘the organisation.’

7.2.1 Theme: The organisation

The theme ‘the organisation’ is theoretically derived and draws from the Hogeweyk care concept, described by van Hal (2014). The operational definition of the theme is that it contains data about the collaboration of staff to support resident life, supported by policies, procedures, the structure of the organisation and finance. The organisation

supports staff to support residents living normal lives, in alignment with the vision driving the transition to The CARE Village.

The basis of the staffing model in The CARE Village is that each house has a consistently assigned universal care worker. This person is called the home lead and is responsible for the day-to-day running of the house and care of the six or seven residents. Support workers, commonly shared between two houses, support the home lead to care for residents and to manage household tasks.

As explained in chapter five, beginning on page 134, the work undertaken to change the culture of the organisation has contributed to the empowerment of staff. Staff empowerment, in turn, enables staff members to engage in the semi-autonomous work required for the role of home lead in The CARE Village. For empowered staff to work semi-autonomously, ongoing management support is required, both informal and formal.

You have to give them credit that they can manage their own house. Micromanaging does not work well in this environment, or if you really want to value people. (Participant 35, key informant)

Informal support consists of activities such as managers being out and about in The CARE Village, visiting the houses and having ongoing conversations with care staff about the model of care. While reinforcing the important aspects of the model of care, managers also avoid being overly prescriptive about the day-to-day running of the houses. Ongoing discussion between staff and management supports the staff role in the enactment of the model of care. Formal support for home leads occurs at regular home lead meetings.

I keep stressing all the time what is important and just allowing them the freedom to run their house the way they want. (Participant 35, key informant)

Regular home lead meetings are an element of management support for the home lead role. At these meetings, issues are discussed with management and among the team of home leads. In turn, home leads and management provide support staff with guidance to enable them to work with residents to maximise their remaining abilities by doing tasks with them rather than for them where possible.

We meet three times a week, Monday, Wednesday and Friday, and we discuss any issues we have. (Participant 19, staff member, post-transition interview)

Aligned with the recommendations of the World Health Organization (2015), staff support reablement by doing activities of daily living and other tasks **with** residents rather than **for** residents. However, not all support staff demonstrate an understanding of the new model of care. Observational data indicate the persistence of taking over tasks from residents by some well-meaning staff, telling residents they do not need to worry about doing any household tasks, reinforcing dependence and disablement.

Consequently, the process of changing the way staff work with residents to support normal living is ongoing. For the model of care to be consistently enacted, effective and sustainable, all staff must understand it and work in ways that support it. Sustainability of the model of care is addressed in chapter eight, beginning on page 238. In the excerpt below, Participant 32 discusses the ongoing effort to refocus the way staff and residents conceptualise care at The CARE Village.

*One of my roles there, when we are talking about care, is trying to retrain our carers and some of our residents that the new model of care is more of a **do with** model than a **do for** model. Where we have come from you could not participate in making your breakfast, making a cup of tea or doing your own washing, the list is endless. In this setting, the carers need to be encouraging their residents to be doing it if they are capable of doing it, and if they are not they need assistance, or if they are more advanced on their health journey, it's doing it for them. But that should be the end stage. Where it has been hard for some of our staff because often it is easier and quicker to do things for the residents, but this whole model is about enabling normal everyday activities, everyday life. That means there needs to be a change in the carers' focus and way of doing things. They need to be focused on doing with instead of doing for. As the residents have become more settled and are becoming more aware of what is happening on a daily basis, and they're becoming more familiar with the home lead and how things work in their home. I think residents are taking on more if they are interested and if they want to. But there will always be residents who want things done for them and so will never want to do something for themselves. (Participant 32, staff member, post-transition interview)*

In addition to the need for all staff to understand the model of care, they must have the required training to fulfil their roles. The organisation has ensured that appropriate training has been provided for all staff to enable them to perform their expanded roles. As indicated by Participant 16, below, staff training is provided by an external private education provider, contributing to staff competence for their roles. The training provider utilises facility RNs to work with staff on the assessments of their knowledge and skills, relevant to the training.

That is a good thing about this organisation; they give you good training opportunities. They have put me through dementia, Eden; now they are putting me through health and wellbeing, they give you chances. (Participant 16, staff member, post-transition interview)

Ensuring staff competence in their new roles, an aspect of person-centredness, required additional training for some people. The additional training included certification in dementia care for all care staff, because residents requiring specialist dementia services are not segregated from other residents in The CARE Village. The organisation worked with an external education provider to ensure all staff were adequately prepared to competently perform all aspects of their roles in The CARE Village. Appropriate certification for care staff, together with their practice experience, enables them to provide holistic person-centred care for residents in The CARE Village.

7.2.2 Theme: Employees and volunteers

The theme ‘employees and volunteers’ is theoretically derived and draws from the Hogeweyk care concept, as described by van Hal (2014). The operational definition of the theme is that it contains data about the way staff work to support the vision of people living normal lives, and the contribution volunteers make to supporting that. There have been significant changes in staff roles post-transition to The CARE Village.

At Whare Aroha CARE, before the transition to The CARE Village, staff roles were discrete. Resident needs for health and other care were met by RNs and HCAs, while other staff managed resident activities, food preparation and service, housekeeping and maintenance services. Following the transition, there was a radical transformation of most staff roles. I explain the role of the RN in the chapter section ‘Theme: Health,’ beginning on page 196, while I now continue the explanation the roles of the home lead and support staff.

As noted previously, in The CARE Village, a consistently assigned home lead supports residents in each house. The home lead works a morning shift from Monday to Friday and has responsibility for all resident care as well as the day-to-day running of the house. The home lead role represents a significant increase in scope and responsibility for those staff members, who semi-autonomously provide health and social care for residents, supported by RNs.

Before the transition, staff were invited to express their interest in the home lead role. Subsequently, discussions about the enactment of care in The CARE Village included staff who had been selected to be home leads, empowering them to contribute to decision-making. The role of the home lead is semi-autonomous and encompasses many skills and competencies to manage the daily running of the home and care of the residents who live there.

One of the critical things was selecting the people who were going to be home leads early and start talking to them, giving them the feeling of responsibility. Taking them out to Ngongotahā, and saying, “OK, this is going to be your home, have a look and think about how you are going to run things.” (Participant 28, key informant)

In addition to caring for the six or seven residents in the house, the home lead is responsible for all the tasks involved in running the household, including resident activities. The role is complex, and home leads require a high level of organisation. While HCAs are accustomed to a busy workday, the home lead role requires them have an overview of all aspects of the health and social care of the residents in the house.

Although home leads contributed to the development of their roles, the role was outside of their current experience. There were initially some adjustment difficulties as home leads adapted to their new responsibilities. In the immediate aftermath of the move, many of the home leads struggled with prioritising their workload, as well as with aspects of their new environments such as unfamiliar domestic appliances.

I didn't even know how to work the stove. I'm not used to the latest appliances like we have here. (Participant 16, staff member, post-transition interview)

Juggling the competing demands of caring for residents as well as preparing food, laundering clothes and linen and keeping the houses clean was challenging and

exhausting for home leads. However, the groundwork that was done by management in empowering staff during the period before the transition enabled them to use their resourcefulness and team focus to identify creative solutions to many challenges. While additional meals and snacks had been made in advance of the move and frozen, cooking was the major challenge for many.

We prepared enough freezer meals for 2-3 weeks, [the cook] used to cook double recipes. So that gave people food to pull out for lunch, a frozen casserole that had already been made or some muffins that had already been done, we had all of that to take that pressure off cooking. (Participant 35, key informant)

Empowered staff, supported by each other and by management, have overcome the initial challenges of working in changing roles in a new environment. The team have developed person-centred ways of working, drawing on their embodied knowledge of the lifestyle and their understanding of the preferences of the residents in the houses they run. While the homes each have a routine, it is a routine based on the needs of the people who reside in the house, rather than the needs of the staff.

Every morning I used to see who was up, and now, after studying them, I know who is up first and who needs to go where. I will try and catch them there [continence], one's had an operation and needs attending to, and I know how to catch that one, you watch them and study them. (Participant 33, staff member, post-transition interview)

The needs of residents encompass the need for physical care, social and other activity, cultural and spiritual needs. Before the move to The CARE Village, lifestyle co-ordinators managed many of the resident needs for social and other activities, the chaplain visited, and many volunteers visited. After the move, management disestablished the lifestyle co-ordinator role, and home leads took over that function in their houses.

Disestablishing the lifestyle co-ordinator role aligns with the philosophy of residents living normal lives. Participation in the running of the household is part of normal living. It represents a continuation of activities that would have been part of life for residents in their own homes, reflecting person-centred practice. However, leisure and social activities are also part of life, and initially in the new model of care these were organised by home leads.

The shifting of responsibility for resident activities to home leads has not been successful. The home lead role is busy and complicated, enacted in an environment where resident needs for physical or emotional care can escalate unpredictably. Managing the care of residents as well as the running of the houses has led to many home leads being unable to plan regular activities for residents.

I don't really think they have the capacity to organise activities, especially in busy homes. (Participant 3, staff member, post-transition interview)

During the planning of the transition, management hoped that the innovative model of care would attract a lot of interest from volunteers. It was envisaged that these volunteers would assist with organising activities for residents. However, despite initial interest, only a small number of volunteers have been able to be recruited to assist at The CARE Village.

There were quite a number of people who expressed an interest in volunteering when we moved out to Ngongotahā. We talked about the model, and we took them through the village, and that was November, everyone has really good intentions, it is a busy time of year, life is busy if you are retired, so we haven't seen them as much as we would have liked to. (Participant 32, staff member, post-transition interview)

As noted by Participant 32, volunteers are not as numerous as had been hoped, adding difficulty to the provision of activities for residents. Despite the small number of volunteers, they run two popular activities; a cultural group and a knitting group. The contributions made by volunteers are further discussed in the chapter section 'Theme: Life's pleasures and meaning of life,' below.

7.2.3 Theme: Life's pleasures and meaning of life

The theme 'life's pleasures and meaning of life' is theoretically derived, drawing from the Hogeweyk care concept. The theme is operationally defined as containing data about social activities, day trips, walking outside, shopping for groceries and being free to walk around the village, aligned with the Hogeweyk care concept described by van Hal (2014). Staff contributions to resident enjoyment of life include organising formal and impromptu activities and working with volunteers.

The choice of enjoyable activities reflects individual interests and preferences, contributing to quality of life. When people live in ARC, they need support to organise social events and other pleasurable activities. However, large artificial activities, such as those common in ARC facilities, while alleviating boredom and offering an opportunity for social engagement, do not usually reflect individual preferences.

In The CARE Village residents participate in daily activities according to their ability and desire. Many residents enjoy engaging in household tasks that represent a continuation of their daily lives before living in ARC. Residents participate in cleaning and gardening and walks within the village, both organised and impromptu. The most common household tasks performed by residents are cooking and laundry, which comprise physical activity and mental stimulation, as discussed by Participant 33, below, demonstrating her understanding of the holistic benefits of doing activities **with** rather than **for** residents.

They look at the names on the clothes, and they go this is yours, one of them will do the towels, once they've finished folding, I tell them to put them away, and it keeps them motivated, it keeps their minds thinking because they know who's who, they sort the clothes and go, that's yours, that's mine. (Participant 33, staff member, post-transition interview)

Home leads organise residents to go for a walk as a group. Additionally, residents often accompany the home leads going to the on-site shop to pick up the daily food supplies for the home. Many residents walk around the village on their own, free to take part in solitary activity safely within the secure perimeter.

They are a lot happier, there is more freedom for them compared with the other building. They can get out and wander around when they like, and they go and sit by the lake. (Participant 19, staff member, post-transition interview)

Home leads collaborate to organise activities involving residents of more than one house. The Māori culture group and the knitting group are two particularly successful activities, run by volunteers and co-ordinated by home leads. Participants 16 and 33 have organised an activity that enables older Māori residents to hear and speak their language, and continue to participate in cultural activities, contributing to wellbeing.

[Participant 33, staff member] and I organised it. 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, all the little things like that.
(Participant 16, staff member, post-transition interview)

Participant 16 illustrates the richness encountered when home leads collaborate and organise an activity that enables residents to connect authentically with valued activities. Valued activities may be part of people's lives in their recent past or the distant past. Home leads also work together to organise shared morning teas and barbecues for residents, enabling them to interact with people from other houses.

However, it became apparent that the home leads had full days caring for residents and running the houses. Therefore, there was often no time to organise social and other activities. Unfortunately, residents felt they had nothing to do, compared with when they were at Whare Aroha CARE, where there were many organised activities.

At the other place they had bus rides twice a week, now they only have them once in a blue moon. (Participant 24, resident, post-transition interview)

The organisation recognised the gap in their service and have appointed a co-ordinator to manage the on-site shop and tea-rooms and organise village-wide and smaller group activities. Examples of village-wide activities include a visiting ice-cream truck and a market day, while small group activities include van outings and group fitness. These activities have an appeal to a wide range of residents from the different lifestyles within the village. I discuss the theme 'living with people who share the same lifestyle in a small group' in the following chapter section.

7.2.4 Theme: Living with people who share the same lifestyle in a small group

The theme 'living with people who share the same lifestyle in a small group' is derived from the literature about the Hogeweyk care concept. The operational definition of the theme is that it contains data about the lifestyles in The CARE Village. Data comprising the theme draw from responses to the interview questions about the

process of developing lifestyles, allocating people to lifestyles and whether people have things in common with other residents and staff.

In allocating residents to some houses, their care needs were considered alongside their previous lifestyle. In most houses, residents live with peers, who have shared a similar lifestyle in the past, and their assessed care needs may differ within each house. However, in some houses, residents with the same care needs, particularly those with high needs, are grouped together. In recognition of the high health needs of some residents, ENs have been selected for the home lead role in some houses.

The running of each house in The CARE Village is in accord with the lifestyle of the people who live there. Therefore, the home lead for the house should ideally have lived a similar lifestyle and have an embodied understanding of the subtle distinctions between the lifestyle of the house they are running and the other lifestyles in the village. The home lead's understanding of the social norms of their lifestyle, for example, standards of behaviour, contributes to an authentic atmosphere within the home.

Identification of their previous lifestyle was part of the process of selecting home leads for each of the 13 houses in The CARE Village. Home leads were involved in staff discussions that contributed to the development of the seven lifestyles for The CARE Village. Staff familiarity with the lifestyles enabled them to identify their lifestyle from among the seven, assisting management in assigning them to one of the homes.

We selected two lifestyles that we thought were a good fit for us. We let management know what they were, and they took it from there and allocated us to houses based on that. (Participant 16, staff member, post-transition interview)

Home leads remained in the homes they were initially assigned to, indicating the effectiveness of the process in selecting the right staff for each house. Attention to matching home leads to homes run according to lifestyle contributes to a feeling of ownership for them. Participant 16, above, was discussing whether the home leads, including herself, fitted well with the lifestyles of the homes where they are working.

I think it has worked quite well, [staff member] is in the Classic house, she suits that house, whereas I am suited to the Minimalistic house. It's my turf, and I get quite protective. (Participant 16, staff member, post-transition interview)

The feelings of ownership home leads have about the houses they run is indicative of the work undertaken by management to develop empowered staff, capable of moving into an extended role in The CARE Village. Staff development work began during the planning of the transition, supporting staff to start their new roles. The transition to an innovative model of care, foregrounding normal living rather than disability, has resulted in changes in all staff roles, including the role of the RN.

The RN role was enacted traditionally before the move to The CARE Village, with RNs providing care within their scope of practice, as well as supervising care staff providing care under RN delegation. After the move to The CARE Village, there have been some subtle but significant changes in the role of the RN. RNs employed at The CARE Village continue to have oversight and responsibility for resident health. The role has some similarities to and some differences from the RN role at Whare Aroha CARE. I explain the work of the RN at The CARE Village in the theme 'health,' below.

7.2.5 Theme: Health

The theme 'health' is theoretically derived, drawing from the Hogeweyk care concept described by van Hal (2014). The theme is operationally defined as containing data about the care of resident health. This chapter section explains the theme 'health' as it relates to staff management of resident health, while resident health outcomes are explained, beginning on page 213. Resident health was managed in a way that conformed with hospital routine before the transition to The CARE Village; HCAs would report concerns to RNs, who would assess the resident and manage the problem or refer the resident to the General Practitioner (GP) who visited three times a week, as well as being available by telephone.

Similarly, in The CARE Village, home leads and support workers report health changes to the RN on duty, who responds and assesses the resident, consulting with the visiting GP if required. Staff collaborate to provide quality healthcare for residents that complies with contractual and legal requirements, meaning there is no loss of health management under the new model of care. The daily work of RNs in The CARE Village

is enacted differently from their daily work in Whare Aroha CARE while retaining all the essential elements of the RN role in ARC.

The significant difference in the roles of RNs and HCAs at The CARE Village lies in the step back taken by RNs, aligned with the focus on normal living in The CARE Village. The RNs retain responsibility for care planning and oversee care delivery; resident health is monitored unobtrusively by the HCAs, while supporting residents to live normal lives. The RNs work hard to establish and maintain excellent communication, facilitating reporting of the subtle health changes noticed by HCAs, who are very familiar with residents they care for every time they come to work.

In Whare Aroha CARE the RNs were based in the nurse's station in Wairua (the private hospital unit), whereas in The CARE Village the RNs are found in the hub, the building at the entrance to the village that houses the administration offices, and their role aligns with that of a visiting professional. All the RNs who participated in the study indicated they endeavour to see every resident every day when they are on duty in the village, aligned with care in any inpatient setting. Participant two describes the holistic care provided by RNs, integrating physical and emotional care while at the same time observing every resident every day.

It is a routine for all RNs; we need to see everyone. Because as an RN, I feel like I need to see my residents, I want to go and see the residents. So then of course if we need to record the temperature or the obs, we need to do that. But I think communication is the most crucial aspect of care. If we communicate with them, half of their problems would be gone. So, I spend some time, depending on my other priorities. That does not mean that I will spend less time in houses which have less priority, but I spend a greater amount of time in the houses with greater priority, for example, if someone is sick or having treatments in that house. Now [early afternoon] I have just finished my wound dressings. This morning around 7.30, after handover, I went to every house. (Participant 2, staff member, post-transition interview)

The RNs at The CARE Village who participated in the study confirmed the significant role of the home leads in enabling early identification of changes in resident health. RNs and home leads collaborate to identify and manage resident health changes. The collaboration is facilitated by excellent communication between them and by the close relationships between home leads and residents.

I think because they've got the 1:1 every day that they are on they get to know the residents quite well. So, if there is some change that they've noticed, say in someone losing appetite or fluid intake, they know, and they can report to us, and we can put them on a fluid log just to monitor it for a few days. I reckon they do quite well with a smaller household. (Participant 3, staff member, post-transition interview)

Home leads are crucial to the management of resident health changes. In response to being asked about the management of resident health in The CARE Village, Participant 16 notes the importance of the home lead role. Additionally, Participant 16 emphasises the importance of home leads consistently caring for the same small number of residents.

[Resident health is managed] by the home leads, we keep an eye out for changes and things in their skin, skin integrity, their behaviour, basically anything, any little bumps and bruises, we report to the RN immediately. We notice changes immediately especially behaviour and moods, I don't know, being a home lead you tend to notice if something's not quite right so we report it to the RN to have a look, or you say I feel somethings not right, could you have a look. (Participant 16, staff member, post-transition interview)

Consistent staff assignment enables home leads to identify changes in residents they know well. Open communication between home leads and RNs, consciously facilitated by RNs, has resulted in both RNs and home leads noting improved management of subtle changes in resident health in The CARE Village. The RNs at The CARE Village are enabling residents to live normal lives with improved healthcare by balancing support of the autonomy of home leads and continued monitoring of resident health.

7.3 The effects of the transition on the lives of residents of The CARE Village

The building of a village containing small homes has enabled households to be created for residents, supporting person-centred care. Within the households, spaces with a recognisable purpose, such as a kitchen, dining room, laundry and garden enable residents to choose how they spend their time. The environment supports ongoing connections with personal identity and facilitates meaningful occupation.

The CARE Village is a dementia-friendly environment because there is no segregation between those who require specialist dementia services and those who do not,

enabling all residents to participate in life in the village. Furthermore, desegregation has contributed to the de-stigmatisation of dementia within the village. Additionally, positive connections with the community outside The CARE village are promoted via a relationship with a local child-care centre and the inclusion of a shop and tea-rooms within the village, encouraging visitors to stay for longer.

Five themes comprise the study data relevant to the effects of the transition of the lives of the residents. These themes are 'living a normal life,' 'living with people who share the same lifestyle in a small group,' 'like family,' 'life's pleasures and meaning of life,' and 'health.' In the following section of the chapter, I present the results of the study relevant to the theme 'living a normal life.'

7.3.1 Theme: Living a normal life

The physical environment has a role in supporting people's ability to go about the activities that comprise their daily lives. When people are experiencing disabling conditions such as dementia, a supportive physical environment can promote the continuation of daily activities, whereas an unsupportive environment can contribute to disability (Calkins, 2018). The physical environment at Whare Aroha CARE was disabling, forcing residents to be dependent on staff. On the other hand, at The CARE Village, the environment is reabling; it encourages residents to continue living normal lives, with staff support.

The theme 'living a normal life' is derived from the data and the Hogeweyk care concept, as described by van Hal (2014). Inspired by the Hogeweyk care concept, the vision that guided the transition from Whare Aroha CARE to The CARE Village was 'people living normal lives.' The theme is operationally defined as being about people living in households, in accord with what matters to them, with support from staff. In contrast to traditional ARC facilities, where residents become accustomed to staff members going into their rooms to do things like putting their clothes away, data indicate that residents in The CARE Village feel at home, exemplified by them not wanting other people touching their possessions.

I think they think they are living a normal life again because they get a bit upset if people come in and touch their belongings or go through the cupboards. After all, it is their house; I think they think they're all just flatmates. (Participant 36, staff member, post-transition interview)

The aspects of daily living that matter to people are individual. Accordingly, residents at The CARE Village participate in a variety of activities, either by doing them or by being present during the event. The aspects of daily living participated in by residents and captured in the data included activities related to food, shopping, laundering clothes, cleaning, outdoor activities, the arts, craft activities, caring for others, cultural and religious activities and social events.

Mum loves going to Ngongotahā shopping, which to her is the little shop they have on-site. She will tell me "I went and looked around that shop at Ngongotahā." She loves going there and having a coffee because she's always been a coffee shop lady. (Participant 26, family member, post-transition interview)

In contrast to Whare Aroha CARE, where the kitchen and laundry were in separate places in the building, meal preparation, laundry and other household activities take place in the homes. Residents have the opportunity to participate in the running of the household in ways they value, enabling them to reciprocate for the care they receive. Being able to reciprocate, even in seemingly small ways, matters to people who receive care. Participant 18's statement indicates that she values her contribution to the aesthetic environment, made possible with the support of staff in a domestic-scale setting.

I don't want just to sit here. I want to contribute, like [arranging] the flowers. (Participant 18, resident, post-transition interview)

Residents contribute to their households, with the support of staff. They can perform a variety of tasks in domestic-scale environments. Continuing with activities that help in their home is valued by residents as an opportunity to give as well as receive care.

Each house has a small garden around it. Residents who value gardening can continue this activity. A resident has planted vegetables among the other plants near his home. Gardens, where food is grown, provide a connection to culture for Māori residents. Participant 26's mother, Participant 23, has planted herbs and other plants in a

decorative wheelbarrow and planters outside her house. The garden is shown in Figure 14, below.

Some of our family gave her a voucher for the garden centre at Christmas. We went and got some things for the wheelbarrow and some of the other planters that she has taken over. (Participant 26, family member, post-transition interview)



Figure 14. The garden planted by Participant 23. Photograph taken by Kay Shannon.

The change in the physical environment and the staff focus on resident choice enables residents in The CARE Village to participate in valued activities in their homes. The domestic environment fosters a continuation of self-identity supported by person-centred care enabling choice. Additionally, the small houses are peaceful because they only have six or seven residents each.

We are giving them their life before. It is the setting of their life how they grew up. They can smell the food cooking, and they can hear the washing machine, they can hear the television, there is music, it's not crowded, because they are living in a big house with five or six others, they have peace. (Participant 10, staff member, post-transition interview)

In contrast, the physical environment at Whare Aroha CARE did not support resident participation in food preparation. Residents were physically separated from the sight and smell of cooking because the food was prepared in a central kitchen. It was delivered to the three units in trolleys, before being served to residents. However, despite the institutional setting in Wairua unit (hospital-level care) in Whare Aroha CARE, Participants 12, 13 and 15 were observed taking meals and drinks to other residents. They helped with feeding other residents or encouraging them to eat, clearing away dishes at the end of the meal, or returning trays to the tray trolley.

Eat your kai [food, meal], or you will get sick. (Participant 13, resident, to Participant 14, resident, pre-transition observation data)

In the Manaaki unit (rest-home level care) in Whare Aroha CARE, residents also participated in activities related to mealtimes, as confirmed by interview data. Both observation and interview data indicate the participation of residents in household activities before the transition to The CARE Village. Despite the limitations of the physical environment, residents enjoyed helping staff at mealtimes, a continuation of usual daily activities.

Some of our residents help in dishing up; some like to dish, some like to collect the trays and take them for washing. In the rest home, they know those people and encourage them to participate in those activities, that is normal for them. (Participant 2, staff member, pre-transition interview)

The physical environment at The CARE Village, with an open-plan kitchen, dining and living area in each house, encourages residents to participate in food preparation and related activities. Residents participate either physically or by seeing and smelling the food preparation. The familiar sounds and smells of food preparation and the proximity of the dining room to the living room provide cues for residents, prompting them to participate in a home-like dining experience.

You are still participating to a point even if you are not able to help with the food preparation; you can hear the crash and bang of the pots, you can smell the food being prepared. You can hear the vacuum cleaner going through. You are participating in a way even if you are not physically or cognitively able to do it and I think that is really exciting. (Participant 32, staff member, post-transition interview)

Participant 17 was observed at lunchtime, appearing to be dozing in his chair. However, he became aware that his fellow residents were at the dining table, having lunch, so he went and joined them. After lunch, he left the table and picked up a banana from the fruit bowl on the island bench, taking it to eat in the living room, free to choose to do so. Participant 17 has memory loss; however, the household environment at The CARE Village, together with the staff approach to care, enables him to continue to make choices such as choosing to go to the table and eat lunch and choosing to eat a banana after lunch.

People who can live independently take these simple daily activities and the ability to exercise choice for granted. Supporting resident autonomy and choice is an example of shared decision-making, a person-centred process related to working with the resident's beliefs and values. Depending on their ability and preference, residents may participate in preparing food.

Mum has her involvement in prepping food, nothing big, just like prepping potatoes. Just like having a normal lifestyle rather than having everything done for you. They are a little bit more independent, and I think that's healthy. (Participant 31, family member, post-transition interview)



Figure 15. Participant 25 preparing vegetables. Photograph taken by Kay Shannon.

There was less opportunity for residents to engage in normal household activities in Whare Aroha CARE than in The CARE Village. Participant 23 reflects on her lack of ability to live a normal life in Whare Aroha CARE. She notes the few ways residents have to occupy their time in the data excerpt on the following page.

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

Participant 23's daughter, Participant 26 confirms her mother's observation.

In the quote below, Participant 26 describes a life with nothing to do.

Participant 23 has been a busy and active woman all her life, and it distressed her daughter to see her with no purpose.

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 just 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)

Supported by staff and the physical environment in The CARE Village, Participant 23 is once again able to participate in the daily activities that reinforce her sense of self. She washes laundry for herself and other residents and hangs it on the outside clothesline, bringing it in when it is dry. Because of her memory loss, initially, Participant 23 brought in washing belonging to other houses; however, the creativity of the home lead in her home has overcome that problem, as described below.

The pegs now have the house number written on them in permanent marker, and she only brings in the washing hung with pegs marked with the appropriate number. She also folds and sorts the laundry after bringing it in, making a pile of clothes for each of her housemates, and a pile of household linen. Participant 23 enjoys the sense of purpose provided by having a role to play in the running of her house. Figure 16, on the following page, shows Participant 23 bringing laundry back to the house from the clothesline.

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)



Figure 16. Participant 23 bringing laundry back from the clothesline. Photograph taken by Kay Shannon.

Other activities undertaken by residents at The CARE Village include delivering mail, ironing and cleaning. Staff, guided at times by the in-house Occupational Therapist, encourage a wide range of activities. Living in an environment that supports normal living enables residents to change their role in the home from that of a passive recipient of care, to a participant in the daily life of their home.

She does the ironing, she loves cleaning, give her a cloth and the window cleaner, and she will go and clean the windows. (Participant 19, staff member, post-transition interview)

When people who live in ARC facilities are encouraged to contribute to the ARC community, reciprocity is enabled. Reciprocity is a moral imperative to give as well as receive, enabling wellbeing for those who value it. Barriers such as poor health and the social construction of older people as having no valuable expertise exclude some older people from contributing (Stephens & Breheny, 2018). In The CARE Village, staff

overcome those barriers by enabling residents to participate in community life in ways that are valuable to them, supporting wellbeing.

Residents have a large amount of space outside their own homes, but it is within a secure perimeter, where they can safely enjoy being outside. Participant 31, below, describes the difference living in The CARE Village has made for her father. The freedom her father experiences in The CARE Village contrasts with his experience of walking around the corridors in Whare Aroha CARE.

They have got more freedom to choose what they want to do. For example, Dad going out for a walk. He didn't have that opportunity before. He would pace the corridors. He was like a caged lion in some ways. (Participant 31, family member, post-transition interview)

The amount of participation in household activities has evolved spontaneously in some houses, and while in other houses it was planned. One home lead asked the residents who would be moving from Whare Aroha CARE into her house what they would like to do, before the move. Participant 25 enjoys arts and crafts, belongs to the knitting group, and was observed knitting a large scarf during the early part of phase two of data collection.

A lady from the knitting group has knitted me a scarf. (Participant 11, staff member, post-transition interview)

In addition to valuing the opportunity to contribute to their households, participants also value the opportunity to reciprocate, demonstrated by Participant 25's gift of a hand-knitted scarf to Participant 11, a staff member who spends time with her. Support from staff enables residents to participate in their chosen activities. Participant 29 is depicted making cupcakes in Figure 17, on the following page. Participant 29 describes how staff support residents, below.

[Staff member] passes me all the ingredients and I sit in the chair and do it, I do the baking. (Participant 29, resident, post-transition interview)



Figure 17. Participant 29 making cupcakes. Photograph taken by Kay Shannon.

While being involved in the day-to-day running of their houses suits some residents, others who have moved from Whare Aroha CARE to The CARE Village prefer not to participate. Residents who do not choose to participate in household tasks had become accustomed to having these done for them in Whare Aroha CARE and believed staff should continue to be responsible for them. When new residents move into The CARE Village it is likely they will choose to continue living in ways that are normal for them, within their levels of ability.

I know she helps with setting the table and doing those sorts of things and she quite enjoys that. She had another lady that was helping her going, I don't know why we need to be doing this, we're paying, but she was going, no it's lovely, I enjoy it, so she enjoys any little jobs that she can do that makes her feel that she's a part of it. (Participant 26, family member, post-transition interview)

Lifestyle is part of usual daily life. The CARE Village residents live with peers who have shared a similar lifestyle in the past. I discuss the results of the study relevant to the theme 'living with people who share the same lifestyle in a small group' for residents in the following chapter section.

7.3.2 Theme: Living with people who share the same lifestyle in a small group

The theme 'living with people who share the same lifestyle in a small group' is derived from the literature about the Hogeweyk care concept, as described by van Hal (2014). I provide the operational definition of the theme on page 194. Data comprising the

theme draw from responses to the interview question about whether people share common interests with other residents and staff.

Housing people with peers who have similar backgrounds potentially fosters friendships based on common interests. For example, a new resident has developed a friendship with Participant 24 based on a shared love of walking. In addition to previous background and interests, personality has a role in determining interpersonal compatibility.

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

Although most people have settled into the households chosen for them based on their previous lifestyles, staff needed to move some residents from the houses where they were initially placed. The change from housing residents in three units in Whare Aroha CARE to 13 houses in The CARE Village has made it easier for staff to move people around when they do not get on with each other. Being able to move people who are unhappy due to personality conflicts benefits the individual and others; the move results in the person being happier in their new house and the previous house being more harmonious than before the move.

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)

Another reason for moving people between houses relates to the initial choice of lifestyle for that person not being correct. As described previously, resident lifestyles are selected based on information about their previous life collected on admission, as well as consultation with the resident and their family. Both the examples spoken about by participants indicate the need for further discussions with family and friends if the chosen lifestyle does not seem to suit the resident.

[Staff member] usually goes through the process of asking about the particular person's background when they come in, and that's when they get placed in different houses. Usually, they are OK, it takes a while for them to settle in, but all in all, it works well. (Participant 3, staff member, post-transition interview)

Choosing an appropriate lifestyle for residents involves considering past modes of living as well as the mix of personalities in each house. When people who live together are compatible, close relationships develop, described by participants and being 'like family.' I discuss the theme 'like family' in the following chapter section.

7.3.3 Theme: Like family

The theme, 'like family,' derived from the data, has been operationally defined in chapter five, on page 141. In addition to the data from the theme that appears in chapter five, an aspect of the theme is relevant to resident outcomes following the transition to The CARE Village. The element of the theme pertinent to resident outcomes post-transition is that of residents caring for and about each other.

Participant 13 prepares meals and bakes for morning and afternoon teas. Observational and interview data confirm while she is dependent on staff for some of her needs, she is also busy working alongside staff assisting in feeding dependent residents and participating in the running of the house. Participant 13 chose her house based on the other residents who were going to be living there because she wanted to participate in their care.

Well, Participant 13 is not really a good fit with the Cultural house. She's a better fit with the Minimalistic lifestyle. But she's in the Cultural house because she wanted to look after the Nans.
(Participant 35, key informant)

Participating in normal household activities, as well as the care of others, is a source of pride and purpose for Participant 13. Additionally, being busy during the day helps her to sleep well at night. Therefore, having the opportunity to care for others enables her to contribute to her household and demonstrate reciprocity for the care she receives, supporting her emotional, mental and physical wellbeing.

I like it because it keeps my mind going, keeps the brain going. I'll have good sleeps, and I'll feel good because I have done something.
(Participant 13, resident, post-transition interview)

Small-group living seems to facilitate closeness among the residents of the houses, leading to caring relationships, as described by Davis et al. (2009). Participant 29

describes the effect of peer efforts to include a socially withdrawn resident in household conversations. The members of the household had recognised the need to include one member and made an effort to change the situation.

We are starting to include [resident] more, and she is getting more outgoing, she brought out a photo of herself and her husband the other day. (Participant 29, resident, post-transition interview)

The combination of open-plan shared spaces and private bedrooms enables residents to be with others when they choose to, and retreat to their rooms when they want to be alone. When residents are in the shared open plan living, dining and kitchen area, there is a family atmosphere. The atmosphere is fostered by familiar domestic-style spaces and the small number of people present.

Well, you have sort of got your privacy. I've got my television, and if they are all watching something that I don't want to watch, I will come down here and watch my own. I like to watch the news, and not everybody does, things like that. (Participant 29, resident, post-transition interview)

The shared spaces are the location of many of the activities organised by the home leads, based on the interests of residents. The events are relevant to the theme 'life's pleasures and meaning of life.' I discuss the theme 'life's pleasures and meaning of life' in the following chapter section.

7.3.4 Theme: Life's pleasures and meaning of life

All people, including older people, value the ability to engage in enjoyable activities. For older people, who are conscious of their mortality, it is particularly important to be able to spend time doing things purely for pleasure. These pleasurable activities are unique to individuals and represent a continuation of lifelong pursuits. Although the health and policy literature foregrounds the health benefits of pleasurable activities, pleasure has an intrinsic value to individuals regardless of other benefits (Stephens & Breheny, 2018). Many residents of ARC facilities are dependent on staff to be able to continue to enjoy the pleasurable activities they value.

The theme 'life's pleasures and meaning of life' is operationally defined on page 195. Before the transition to The CARE Village, lifestyle co-ordinators organised social activities for residents. ARC providers are contractually obliged to provide activities for

residents, appropriate to their clinical needs, abilities, previous routines when living independently and preferences (TAS, 2019a).

Residents in Whare Aroha CARE had a busy schedule comprising regular weekday activities such as discussing the news in the local paper, guided reminiscence and trips in a minivan to get ice cream or go to a pub or restaurant. Residents who were unable to participate in organised activities were given one-to-one attention by the lifestyle coordinators who would talk with them or 'pamper' them with, for example, hand massages. Photographs taken at events were pinned on a noticeboard in the main hallway for family members to take home.

They have photos of the residents doing activities on a notice board in the hallway. If you see your family member in the photos, you can take them. I really like that. (Participant 21, family member, pre-transition interview)

However, the lifestyle coordinators worked Monday to Friday, leaving residents who did not have family visitors at the weekend with nothing to do. Participant 12 describes having nothing to do on weekends. Her frustration is evident in the data extract below.

They just let us doodle doodle do and nothing to do on weekends.
(Participant 12, resident, pre-transition interview)

In contrast, in The CARE Village many residents are actively participating in household activities and spontaneous social events such as family visits. The result is that many residents are spending less time with nothing to do. Participant 29 describes how she is able to continue with activities that confirm her self-identity in the following data extract.

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)

The physical environment within The CARE Village enables residents to continue with activities similar to those they pursued before living in ARC. In the excerpt above,

Participant 29 describes her activities, encompassing craft, the arts, cooking, exercise and spontaneous social interactions. The activities, made possible in the environment of The CARE Village, contribute to resident wellbeing and health. I discuss the theme 'health' in the following chapter section.

7.3.5 Theme: Health

The theme 'health' has been operationally defined on page 196. Since the transition of Whare Aroha CARE residents to The CARE Village, staff have noted several changes in resident holistic health. Because home leads spend all day with the same residents, staff and residents get to know each other very well.

She knows her residents well, they know her. It's all familiar, and she knows their likes and dislikes. Where they have come from there could have been someone different assisting with feeding every day, whereas she is with the residents every day, helping with feeding and she has got an excellent handle on how they are doing. (Participant 32, staff member, post-transition interview)

As noted in the explanation of the management of resident health, previously, staff, particularly home leads, notice subtle changes in residents, including changes in appetite. Other resident health changes noted by staff include reductions in behavioural symptoms. An effect of a reduction in behavioural symptoms is the reduced need for antipsychotic medication to manage behavioural symptoms.

Lowering their risperidone, because they're not as anxious as they used to be, they've got more room to move, they haven't got people in their face all the time, you haven't got a ward where you've got 20 people, and you're trying to find your space to have your cuppa, you haven't got someone with dementia walking past with their walker and banging your leg, and we don't have that here, there's more space, and there's more 1:1 time, it's a bonus. (Participant 6, staff member, post-transition interview)

In addition to reported reduced antipsychotic medication use, there are reported positive effects on the moods of residents following the transition to The CARE Village. The crowded environment at Whare Aroha CARE had an adverse impact on resident moods. However, staff had practical solutions such as seating people away from incompatible peers.

He gets upset with the number of people and noise. If you get a day when there's a lot of visitors as well as the residents, he finds it really difficult. There are a few people there that he doesn't get on with and they aggravate each other. The staff are excellent, and they just separate the ones that they know can't sit at the same table.

(Participant 22, family member, pre-transition interview)

Living in a small environment with peers who share common assumptions about the way life is lived has removed many potentially aggravating situations. For example, Participant seven, a quiet and private woman, visibly jumped in her seat when a peer played loud and surprising intermittent notes on her harmonica in Manaia unit (specialist dementia services), in Whare Aroha CARE. The small-scale environment in The CARE Village enables people who are not compatible to be moved so they do not have to live in the same house.

In Whare Aroha CARE, observational data indicate many residents appearing to sleep for long periods during the day. Those residents did not seem to be engaged with their environment, in contrast with the alert appearance of residents at The CARE Village. Fellow residents and staff members have noted changes in resident levels of alertness following the move to living in a home-like environment.

I have never seen them so happy and so chirpy and talkative, not like before, Nanny X, she will be asleep, and the next minute she will say something. When she was over there [Whare Aroha CARE] I never heard her say anything like that. All the nannies have all woken up now, all the koros [older men], everybody is awake. (Participant 13, resident, post-transition interview)

The transition to living with five or six peers from a similar background has resulted in a peaceful atmosphere. In a serene atmosphere, residents can live in their way, without being overstimulated by the environment. The data indicate the environment at The CARE Village provides an appropriate level of stimulation, enabling residents to be aware of their surroundings while avoiding the harmful effects of overstimulation.

The provision of an environment free from noxious stimuli has reportedly reduced the need to restrain residents physically. The need for physical restraint occurs when residents may place themselves in danger by getting up and independently walking when assistance is required. Additionally, staff can easily observe residents in the small calm environment, a possible reason for the reported reduction in restraint use.

There was a decline in the use of restraints. (Participant 3, staff member, post-transition interview)

The ability of staff to easily observe residents has also resulted in anecdotal reports of a reduction in the number of residents falling since the transition. However, despite the proximity of staff to residents in the household environment, residents in ARC are an ageing population with complex and evolving health needs, making the elimination of falls impossible. The changed environment facilitates improved staff monitoring of resident health; however, resident health continues to decline as a result of ongoing chronic conditions.

We still are having falls, and I can't remember off the top of my head how many we had last month. However, there are people who have deteriorated, not the environment, not them having more space, just a deterioration in their health. (Participant 34, key informant, post-transition interview)

Family members often spend a significant amount of time with residents, noting health changes. Participant nine indicates that Participant 14's memory loss has progressed over time. However, his mood has improved since he moved from Whare Aroha CARE to The CARE Village.

I think being in this environment has helped him a lot. Interviewer: With his memory? Participant: No, his memory has actually got worse, but just feeling happy in himself. (Participant 9, family member, post-transition interview)

Family members who visit frequently know their relatives very well and are aware of small changes in their health. The physical and social environments in ARC facilities influence the experience of families visiting their relatives. I explain family perceptions of the effect of the transition to The CARE Village in the following chapter section.

7.4 The effects of the transition on the families of residents

Social connections, including family connections, contribute to the health and wellbeing of older people. There is strong evidence that the maintenance of valued social contacts has positive health benefits, while loneliness and social isolation have negative impacts on the health of older people (Stephens & Breheny, 2018). The results of the current study indicate the positive effect of the physical and social

environments at The CARE Village in enabling residents to maintain valued social connections with family, supporting wellbeing.

The current section of the chapter focuses on the effects of the transition from Whare Aroha CARE on the families of residents. Family members of residents are study participants. However, friends also visit people living in The CARE Village.

I have had no end of friends come down here to see me. I can say I've had visitors every day. Participant 29, resident, post-transition interview)

Observational data confirms the presence of many visitors at The CARE Village on most days I was present. The smaller domestic-scale environment where people are often sitting in pleasant communal areas of the houses facilitates group conversations. Visiting families and friends have been observed sharing a conversation in the common areas of the houses, replicating a visit to a person's home in the community.

Four themes capture the results of the study that are relevant to the experiences of family members of residents of The CARE Village. The four themes relevant to the experiences of the families of residents are 'the favourable surrounding,' 'living a normal life,' 'employees and volunteers' and 'life's pleasures and meaning of life.' The physical environment in The CARE Village affects the experience of family members visiting their relative.

7.4.1 Theme: The favourable surrounding

The theme 'the favourable surrounding' has been operationally defined on page 161. Family connections are easier to maintain in the home-like environment of The CARE Village. This ease of maintaining relationships is because visiting their relative is more enjoyable than it had been at Whare Aroha CARE.

I feel that the families are spending longer with their family members, where we've come from they have to sit in a poky little room, they don't want to sit with them in the lounge because it's really unsettling seeing all those other people, but in the home, you've got a lounge, not all the residents will be in the lounge at the same time, the families can make a cup of tea, the grandchildren can have a biscuit out of the pantry. (Participant 32, staff member, post-transition interview)

The home-like environment is welcoming to families. People have a range of places to gather that replicate visiting someone in their home rather than visiting an institution. I discuss the theme 'living a normal life' in the following chapter section.

7.4.2 Theme: Living a normal life

The theme 'living a normal life' has been operationally defined in a previous chapter section, on page 199. Families have been positively affected by the focus on normal living in The CARE Village. The physical environment of the houses encourages relatives to feel at home. Staff are welcoming to visitors, encouraging them to treat the homes as their relative's home, described by Participant five, below.

You get the visitors coming in, and I say go and make a cup of tea and something to eat or if you want to bring some kai [food] in. The visitors are their family, and I encourage them to make this the home for their family as well because at the end of the day this is their last place. I know for a fact that all of them would have offered their visitors or whomever something to eat and drink and to have a seat and to make them feel comfortable and at home. (Participant 5, staff member, post-transition interview)

As indicated in the quote from Participant five, above, visitors are encouraged to feel at home in The CARE Village. Staff members facilitate the welcoming atmosphere, enabling residents of The CARE Village to live a normal life, as far as possible. I discuss the theme 'employees and volunteers' in the following chapter section.

7.4.3 Theme: Employees and volunteers

The operational definition of the theme 'employees and volunteers' is given previously, on page 189. Employees and volunteers support residents of The CARE Village to maximise their remaining abilities and to live in ways that align with their previous lifestyles. Family members who frequently visit, such as Participant 31, are aware of the level of support provided to their family member.

Participant 31 has noticed a positive difference in the availability of help for the staff caring for her parents when they need it. The shift to a household model of care has resulted in staff being more available to assist each other to care for residents than they were in Whare Aroha CARE. The staffing model of a home lead, with support staff available when needed, contributes to the team being able to support residents.

I have no problem with the availability of help, and if they need help, they just call someone. So now I don't have any issues related to their care, whereas previously I might have. (Participant 31, family member, post-transition interview)

The staff of The CARE Village provide support for residents who need physical care, emotional care and help to participate in household activities. Staff also support residents with social and leisure activities. Social and leisure activities are included in the theme 'life's pleasures and meaning of life,' discussed in the following chapter section.

7.4.4 Theme: Life's pleasures and meaning of life

The theme 'life's pleasures and meaning of life' has been operationally defined previously on page 192. Staff working in a changing culture, with a focus on the vision of people living normal lives, support resident social lives and leisure activities, such as family outings. A change in focus enables families to take residents to events and return them as if they were going home rather than to an institution.

We took her over to Hamilton to watch the balloons. We feel we can do more of that because at the other place the doors were locked at certain times and we had to get her back by that time, so going to Hamilton and back wouldn't have worked, whereas in this place you feel like you can get her back later, just communicating. (Participant 26, family member, post-transition interview)

Additionally, increases in resident contentment are reassuring to their family members. Participant nine cared for her husband, Participant 14, at home for a long time before he moved to Whare Aroha CARE. Knowing he is contented enables her to be happier with the fact that he needs to live in residential care, contributing to improved quality of life for her.

I do feel more contented that he is here. I'm not so worried when I go home because he is more contented than he was at the other place. Also, it is much nicer to visit than the other place. (Participant 9, family member, post-transition interview)

The change in culture, enabling delivery of person-centred care in small domestic-scale environments, has enabled the normalisation of daily living for residents. The change is reflected in the ease of taking residents out into the community for family members.

When family members can see that their relative is happy, they are relieved of the burden of worrying about their loved one who is living in ARC.

7.5 Conclusion

Chapter seven has presented the outcomes of the transition for the residents, their families and the staff of The CARE Village. These three groups are the embedded units of analysis for the single case study; the transition of Whare Aroha CARE residents to The CARE Village. The transition has resulted in significant changes for all three groups; most importantly, there have been small but significant changes in how residents can live their lives.

The changes in resident daily life may seem to be small. However, they represent a meaningful change in the way residents can live in ARC. The change is the difference between continuing to live a normal daily life, supported by the physical environment and the staff, in ARC and living in an institution.

Resident daily life, including participating in valued activities that enable the continuation of a sense of self, is supported by staff and volunteers. Staff roles have changed considerably, with the home lead role requiring the ability to work autonomously within a team and adapt to the needs of residents rather than adhering to a staff-centred routine. The consistent assignment of staff to the same small group of residents has resulted in some positive changes in the management of resident health needs.

Family members report being satisfied with the availability of staff to support their relatives in The CARE Village. The domestic-scale environments with accessible outdoor areas and the welcoming attitude of the staff contribute to family members feeling welcome and comfortable when they visit residents. Welcoming family members into the facility and encouraging them to stay for longer visits facilitates family connections, contributing to wellbeing for residents and their families. In chapter eight I discuss the results of the study with previous research findings.

Chapter 8 Discussion of the study results, conclusions and recommendations

8.1 Chapter introduction

In this chapter I discuss the results of the study relevant to the literature informing the research. I begin the discussion with the process of the transition of residents from Whare Aroha CARE to The CARE Village, including the three generative mechanisms enabling the transition to occur. The generative mechanisms that enabled Whare Aroha CARE residents to move to The CARE Village are ‘they changed the culture of the workplace to enable person-centred care,’ ‘they formed a governance network to support the transition to an innovative model of care’ and ‘they created a physical environment to support the vision of people living normal lives.’ Following a critical discussion of the three generative mechanisms, I then discuss the outcomes of the transition, the effects on the way staff enact their roles in The CARE Village, the impact on resident daily life and the way members of resident’s families experience The CARE Village. The results of the study address the aim of the research: to explain the resettlement of Whare Aroha CARE residents into The CARE Village, and the effects of the resettlement on the lives of the residents.

Following the discussion of the results, I make recommendations to inform potential changes in practice in ARC and policy relevant to ARC facilities. The recommendations enable the results of the study to inform the work of practitioners caring for older people living in ARC facilities and providers of those facilities. Additionally, the evidence provided by the study will assist policymakers in ARC by providing an example of a successful transition from a traditional ARC facility to a dementia-friendly village model of care. Specifically, the evidence the study provides about the outcomes of the transition will offer reassurance that a supportive physical environment and person-centred care practices enable residents who previously required specialist dementia services to be successfully integrated into the village.

The study results highlight the need for further research, and I make recommendations for further studies. These recommendations relate to ensuring the sustainability of the model of care in The CARE Village and investigating measurable outcomes of care in NZ facilities using a clustered domestic model of care compared with those using a classic

model of care. Every study has limitations and strengths; therefore, I continue with a discussion of the limitations and strengths of the current study. In the final sections of the chapter, I summarise and draw conclusions from the thesis. The discussion begins with the process of the transition from Whare Aroha CARE to The CARE Village.

8.2 Discussion of the results of the study

The results of the study have answered the research questions, which were:

- How has the transition of Whare Aroha CARE residents to The CARE Village been accomplished?
- What is the effect of the transition of Whare Aroha CARE residents to The CARE Village on the lives of the residents?

In the current chapter I critically discuss the results of the study in relation to extant literature relevant to those results. I begin with a discussion of the study results relevant to the three generative mechanisms identified in the research as contributing to the process of transitioning to an innovative dementia-friendly community in ARC. I continue with a discussion of the study results concerning the outcomes of the transition, the effects on the lives of the residents of The CARE Village. In addition, I discuss the effects on the roles of facility staff and the experiences of family members. I begin the discussion with the first generative mechanism I identified as contributing to the process of the transition: ‘They changed the culture of the workplace to enable person-centred care.’

The first stage of the process of moving residents from Whare Aroha CARE to The CARE Village began with the arrival of a new management team and subsequent efforts to change the workplace culture at Whare Aroha CARE. The study identified a prior combination of neglect of the physical environment and a workplace culture in which management did not value the contributions of staff or enable respect for the choices of residents. Recognition of these factors caused the new management team to take action to change the culture of the workplace. Without a shift in workplace culture, the transition to The CARE Village would have resulted in a change in the care environment, but no change in the way care was enacted. The first generative mechanism identified in the study is ‘they changed the culture of the workplace to enable person-centred care,’ critically discussed below.

8.2.1 Changing the culture of the workplace to enable person-centred care

There is extensive literature about culture change in ARC, which aims to improve care and daily life for residents by enabling person-centred or resident-centred care. The aims of culture change have intuitive appeal, although changing the culture of ARC workplaces is challenging. However, the move to enable person-centred care in ARC is enshrined in NZ policy (Associate Minister of Health, 2016).

Despite widespread acceptance of person-centred care as being the most appropriate way to care for older people in ARC, in reality it may be difficult to achieve. Person-centredness is implicit in the philosophies of many ARC providers. However, in practice, unless the culture of the organisation supports person-centredness, care delivery may be focused on the needs of staff and the organisation (Killett et al., 2016). In alignment with Killett et al. (2016), the study identified the presence of a staff and organisational focus and an absence of person-centredness at Whare Aroha CARE before a new management team was appointed. The results of the current study explain how the new managers recognised the need to change the workplace culture in a busy ARC setting, to enable care to become person-centred.

The appointment of a new management team, who developed a vision for how care should be enacted, was a significant milestone in the transition from Whare Aroha CARE to The CARE Village. The new team did not share the taken-for-granted assumptions about ARC that were evident in the organisation when they arrived. Within organisations, shared ideas, attitudes, policies and practices, developed in response to problems, become embedded as organisational culture. The culture is accepted by members of the organisation as being the way things are done, and is taught to new members (Killett et al., 2016). Similarly, at Whare Aroha CARE there had been an acceptance of a standard that did not demonstrate respect for the people providing or receiving care. It required the introduction of a group of people from outside the organisation to envision a different way of enacting care.

The new leadership group was driven by a vision of improving care for the people who lived at Whare Aroha CARE. Correspondingly, at De Hogeweyk, influential and visionary leaders have enabled the evolution of a dementia-friendly village from a traditional ARC facility (Schumacher-Jones, 2014). Improving care required a change in workplace

culture, to allow all people in the organisation to be valued. Strong, visionary leadership is required for the difficult process of helping staff whose attitudes and behaviours are a barrier to person-centred care to adapt or exit the organisation (Kotter, 1995). Similarly, the results of the study demonstrate how new staff who understood and supported the organisational vision were hired to replace those people who left because their attitudes were barriers to person-centredness.

The process of changing the culture of the workplace began after management knew they would have to move from their existing facility, but before they had decided on a model of care for the new facility. Although the result was resident care that was more person-centred than it had been before, the managers felt dissatisfied with the way residents were able to live their lives. Consequently, they began investigating alternatives to the classic model of care in ARC.

The end of the lease at Whare Aroha CARE was an opportunity for management to consider creative solutions to the problem presented by the need to create a new home for residents. Consistent with the contract between RCCT and Lakes DHB, residents requiring specialist dementia services were segregated from residents requiring private hospital- or rest home-level care. Additionally, the physical environment was institutional rather than home-like and acted as a barrier to residents participating in daily activities such as cooking and going outside.

Members of the management team attended a dementia design school, which exposed them to a solution to both of these problems. Whare Aroha CARE had a secure dementia unit, and some residents who required rest home- or private hospital-level care were also experiencing cognitive impairment. The finding aligns with evidence indicating a high proportion of residents of ARC facilities may be living with dementia, as noted by Dyer et al. (2018).

Not all residents in Whare Aroha CARE were living with dementia. However, the presence of residents who required specialist dementia services, as well as residents in other areas of the facility who were cognitively impaired, indicates the need to consider dementia-enabling environments when planning a new facility. The organisation hosting the dementia design school has experience in the clustered domestic model of ARC facilities for people with dementia (Smith et al., 2010). While

participating in the design school, managers of Whare Aroha CARE learned about the Hogeweyk care concept. The concept extends the clustered domestic model of care for people with dementia to include the idea of residents living with peers who have lived similarly in the past (van Hal, 2014).

I introduced the Hogeweyk care concept in chapter two, on page 37. De Hogeweyk provides a supportive physical environment that promotes normalisation for residents who have dementia. The recognisable, home-like physical surroundings support resident ability to accomplish desired activities. Additionally, there are features of a small town such as a town square and a restaurant, aligned with normalisation (Chrysikou et al., 2018). The care concept is innovative and has received considerable media attention. Most of the media reports have been positive, focusing on the ability of the facility to support normal living for people who have dementia.

One criticism of De Hogeweyk is that the village reflects a lack of truthfulness. De Hogeweyk has been described as an artificially created village, controlled by invisible outsiders, where inhabitants mistakenly believe they are living a real life (Verderber, 2018). The ideas that the residents are not being told the truth about the fact that they are living in an ARC facility, and that the lack of truth-telling is unethical are implicit in the criticism. As noted in chapter two, on page 38, considerations about truth-telling in dementia pose an ethical dilemma, requiring a balance between the risk of destroying trust inherent in untruthfulness and the need to minimise distress for the person with dementia. While it can be argued that not telling the truth harms the moral integrity of care staff and family members, the truth may cause distress to the person with dementia (Nuffield Council on Bioethics, 2009). The tensions evident in the truth-telling dilemma may not be resolvable; however, in dementia-care environments, the wellbeing of the person with dementia must be prioritised.

As noted previously, on page 37, there is scant empirical research about De Hogeweyk. In response to an interview question about how the care outcomes were measured, a senior official from the organisation answered that “common sense” was the measure used, rather than objective measures (Widen & Haseltine, 2016, p. 5). Most of the published anecdotal reports have been written after visits and are positive. Authors have noted the freedom residents experience within the secure grounds (Fagan, 2014),

the normality of the environment (Milner & Milner, 2016), the rarity of behavioural and psychological symptoms of dementia (Schumacher-Jones, 2014) and the use of technology to unobtrusively keep residents safe (Carryer, 2016). Therefore, it is difficult to understand the organisation's reluctance to enable the use of empirical measures to evaluate the outcomes of the Hogeweyk care concept.

The one empirical study I was able to locate focused on the influence of architecture on the use of space. The authors do not mention whether they had the approval of facility management to conduct the study, and all the data were gathered in the publicly accessible areas of the village. The authors were critical of the remote geographical location as a barrier to connecting with the local community, including family members. Positive results of the study indicate that the physical environment at De Hogeweyk minimises resident anxiety while supporting remaining functions (Chrysikou et al., 2018). However, the effect on residents who live with others with similar values was not able to be studied.

The lifestyle groups that are part of the Hogeweyk care concept are unique to The Netherlands, and international organisations seeking to build similar facilities should identify household groups suitable for their contexts. A senior official at De Hogeweyk recommends organisations use the "six pillars of De Hogeweyk philosophy" to develop facilities that are appropriate for their location (Widen & Haseltine, 2016, p. 6). The concept of lifestyle groups will not fit with the national psyche in some countries, for example in Germany, where post-World War Two sensitivities preclude segregating people in groups according to their background (Haeusermann, 2018). Whare Aroha CARE management identified a group of lifestyles recognisable to New Zealanders, to enable the development of a facility inspired by the Hogeweyk care concept.

I have previously discussed criticism of the concept of lifestyle groups on the grounds they reflect inequalities in NZ, on page 152. However, the managers at Whare Aroha CARE identified the Hogeweyk care concept as the preferred concept to inspire their proposed facility, with lifestyles adapted for NZ. The results of the study indicate the willingness of senior officials at Central TAS, HealthCert and Lakes DHB to consider supporting the adoption of innovative care concepts in ARC. The care concept aligns

with a current NZ evidence-based design guide for secure dementia care environments, including the creation of domestic-scale environments.

8.2.2 The creation of a physical environment to support the vision of people living normal lives

The second generative mechanism identified in the study, contributing to the transition of residents from Whare Aroha CARE to The CARE Village is ‘they created a physical environment that supported their vision of people living normal lives.’ The vision inspired the transition of Whare Aroha CARE residents to The CARE Village. The institutional environment at Whare Aroha CARE had been a barrier to residents participating in the activities that constitute normal living for most people, such as being able to prepare food or go outside easily. Therefore, an environment that supported normalisation was required.

The results of the study indicate that the perimeter fence with external electronic access keeps residents who need specialist dementia services safe while giving them access to the entire village within the perimeter. Residents who do not require specialist dementia services may come and go from the complex freely. Therefore, the environment balances the need for some residents to be safe within a secure environment with the rights of others to have freedom of movement between the village and the outside community. The need to accommodate the needs of people who do and do not require secure care is unique and contrasts with De Hogeweyk, where, according to van Hal (2014), all residents require a secure care environment.

The work of Wigg (2010) compared the effects of living in a secure dementia care unit, with locked doors, including the doors to the garden, with the impact of living in an environment where technology enabled residents to go outside and walk around freely. She noted the residents of the latter facility seemed to exhibit less anxiety and frustration than those in the locked unit. Similarly, in The CARE Village there are no locked units, and all residents have free access to the grounds; staff at The CARE Village have noted a reduction in distressing symptoms of dementia in the new environment, discussed beginning on page 213.

Aspects of the physical environment can be therapeutic for people who have dementia and experience distressing neuropsychiatric symptoms. Although evidence about the

effect of small-scale living facilities on dementia symptoms is mixed, there are indications that smaller care environments with fewer people present are associated with fewer behavioural symptoms of dementia. While small-scale living facilities in ARC minimise the overstimulation found in traditional ARC settings, they may provide limited opportunities for social contact and activities (Marquardt et al., 2014). Similarly, the current study noted that, while the smaller environments are therapeutic, staff must take care to ensure residents are supported to participate in social and other activities such as going outside.

The study found that while all residents of Whare AROHA Care had access to a garden, the specialist dementia services area segregated some residents. They were not able to go into the central garden and were only able to use the yard attached to the secure dementia unit. Specialist dementia services is a subset of rest home care in NZ and is accepted in NZ and internationally as a legitimate aspect of safely caring for people with dementia. Criticism of secure and segregated care environments for people with dementia within ARC is part of a recent discourse occurring internationally, drawing from the recognition of the rights of people living with dementia as people with disabilities. Critics of secure and segregated care use a human rights perspective to question its continuing relevance (Steele, Swaffer, Phillipson, & Fleming, 2019). The results of the current study contribute to the discourse about the relevance of segregated care by explaining the process and outcomes of the transition to a physical environment where people who require specialist dementia care are not segregated from their peers within The CARE Village.

Dementia Alliance International is an organisation comprising only people who have a diagnosis of dementia, formed to eliminate stigma and discrimination against people with dementia. Advocacy work by the organisation led to the United Nations including people with dementia in the Convention on the Rights of Persons with Disabilities (CRPD). NZ has ratified the CRPD and is, therefore, obliged to ensure the rights of New Zealanders with disabilities are protected (White, 2018). According to the CRPD, people should not be deprived of their liberty because they have a disability; however, in some instances, people may need to be detained for their protection (Crowther, 2016).

Additionally, according to the CRPD, people with disabilities have the right to live independently and to be part of their communities (Crowther, 2016). The results of this study indicate that, while residents who require specialist dementia services are not free to leave and do not live independently, they are integrated into the dementia-friendly community within The CARE Village. Accordingly, their right not to be segregated from their fellow ARC residents is respected, and they are provided with a safe place to live.

Significantly, not segregating residents who require specialist dementia services in a separate locked area contributes to the destigmatisation of dementia within The CARE Village. This aspect of The CARE Village aligns with the aim of dementia-friendly communities to decrease social stigma around dementia (Alzheimer's Disease International, 2016). However, because the village perimeter confines residents who require specialist dementia services, they are segregated from the wider community.

Although some residents cannot leave the facility to go out into the community, the results of the study show that management invited a childcare centre in the neighbourhood to use the grounds and the communal area in one of the houses in The CARE Village. This activity promotes social inclusion for residents, in alignment with the results of the study by Van Hecke et al. (2019), who noted the benefits of interactions with children from a local nursery school for ARC residents.

In addition to being a dementia-friendly environment in ARC, The CARE Village is a domestic-scale, normalised environment. There is evidence that similar environments in ARC contribute to greater contentment, happiness and social engagement with peers for residents with dementia, compared with traditional environments in ARC (Lee et al., 2015). Similarly, residents of small-scale living facilities have been found to have slightly more enjoyment of their surroundings, need slightly less help with ADL, were slightly more socially engaged and were physically restrained less often than their peers in traditional ARC facilities (te Boekhorst, Depla, de Lange, Pot, & Eefsting, 2009). The evidence from the current study suggests that living in a normalised environment is beneficial for resident wellbeing.

The study showed that residents of Whare Aroha CARE who lived on the upstairs level of the facility rarely went outside. The intersection of the physical environment and

staffing constraints meant it was difficult for staff to take physically dependent residents' downstairs so they could go out. If staff did take residents outside, they had to stay with them to ensure their safety; this was difficult due to the number of staff required. The finding aligns with those of previous researchers, who noted the influence of physical and organisational barriers to dependent ARC residents being able to go outside (Fisher et al., 2018; Van Hecke et al., 2019). In contrast, residents in The CARE Village can go outside their houses easily, either independently or with the assistance of staff.

The transition of residents from Whare Aroha CARE to The CARE Village has affected the way they can live their lives. The enactment of staff roles has also been affected, as have the experiences of the families of residents. I discuss the results concerning the outcome of the transition for these three groups of people, who are the embedded units of analysis for the case study, beginning on page 235.

According to the Hogeweyk care concept, residents live in domestic-scale environments with peers who share the same assumptions about lifestyle. The aspect of the concept housing residents in lifestyle groups rather than according to assessed care is innovative. It does not conform with the terms of the contract between DHBs and ARC service providers in NZ. Specifically, the contract stipulates the segregation of residents who require specialist dementia services from those who do not.

It is clear the intent of the contract is to provide a safe and supportive environment in specialist dementia services environments. For example, there is a specification regarding the maximum number of people to be present, thereby minimising the risk of overstimulation. Additionally, residents must be able to freely go outside to a secure garden (Ministry of Health, 2013a). Unfortunately, the requirements for segregation stigmatise the affected residents and exclude them from the social life of the wider facility. Therefore, a variation of the contract was required before the transition to a dementia-friendly community in ARC could proceed.

The contract is a service agreement under the terms of the NZ Public Health and Disability Act 2000. It is recognised that regulations, an aspect of legislation, can be a barrier to innovation in dementia care. Some organisations manage regulatory barriers adaptively by working within regulatory requirements in dementia units while

promoting innovation aimed at improving care (Biggs & Carr, 2019). However, in the current study, the legislation was a barrier to innovation in ARC services, unable to be mitigated by adaptive working within the organisation; therefore, the contract needed to be varied.

The variation in the contract was accomplished as part of the work done after the formation of a governance network to support the transition. Governance networks, groups of actors from the public and private or not-for-profit sectors, have arisen in part in response to the need for innovation in public policy (Koliba et al., 2017). The third generative mechanism, identified in the study, supporting the transition of residents from Whare Aroha CARE to The CARE Village is 'they formed a governance network to support the transition to an innovative model of care,' discussed in the following chapter section.

8.2.3 The formation of a governance network to support the transition of residents from Whare Aroha CARE to The CARE Village

The study's findings indicate that the intention of the managers of Whare Aroha CARE to build a village inspired by the Hogeweyk care concept led to the formation of a governance network to support the transition of Whare Aroha CARE to The CARE Village. The network, known as the service development group, is led by a senior official from Central TAS and comprises of senior officials from Central TAS, HealthCert, Lakes DHB and Whare Aroha CARE/The CARE Village. The power held by the senior official from Central TAS enabled this person to bring together and lead the group.

The possession of power and authority within governance networks depends on the types of relationships between the members of the network. In hierarchical networks, controlled by the most senior person, power moves vertically from the top down, with the person at the head of the network having power over the other members. A mixed-authority structure is one alternative to a hierarchical structure; in this structure possession of power is negotiated between members (Koliba et al., 2017). The results of the study indicate that, despite the presence of collaborative processes within the group, the possession of power in the governance group was primarily hierarchical because the senior official from Central TAS had the ultimate authority over whether or not to support the transition to an innovative model of care. In this respect the

results of the current study align with those of Martin (2011) and Eberhard et al. (2017).

The senior official from Central TAS was aware of the international trend towards the adoption of models of care in ARC that promote normalisation for residents, intending to improve quality of life. Recent design guidelines for specialist dementia services are aligned with that trend (Ministry of Health, 2016). Additionally, there has been a series of reports highlighting the need for changes in ARC service delivery in NZ. Governance networks in public policy can be a means of supporting innovative changes in response to political pressure (Eberhard et al., 2017). Accordingly, the decision to support the transition from Whare Aroha CARE to The CARE Village was an opportunity to pilot an innovative model of care aligned with the publicly reported need for change in the sector, international trends and evidence-based design guidelines.

The results of the current study show that the service development group was collaborative and was brought together and led by the most powerful individual in the group, who represented an organisation providing services to the central government. Similarly, previous studies have found influential individuals, often representing central government, assume the leadership roles in collaborative governance networks (Eberhard et al., 2017; Martin, 2011; McGuire & Agranoff, 2011). The members of the group represented different organisations in the ARC, health and government sectors.

The results of the study show that the senior official from Central TAS was concerned with managing any risks associated with transitioning to a model of care that was untested in NZ. The senior officials sought the views of senior clinicians in the sector about possible risks arising from the implementation of a model of care in which there is no segregation between residents who require specialist dementia services and those who do not. Risk management in ARC focuses on the balance between acceptable risk and resident autonomy (Evans et al., 2018). Accordingly, the current study found potential risks inherent in a pilot of a mixed-services model of care were managed in two ways, beginning with a consultation with representatives from the ARC sector.

The sector representatives expressed concerns about potential risks arising from residents who require specialist dementia services cohabiting in small houses with

peers who have different care needs. Caring for residents who have differing needs can mean that, for example, if a person who has dementia is experiencing behavioural symptoms, their needs may be prioritised over others. However, there is evidence that environmental stimulation may cause some people with dementia to experience behavioural symptoms (Evans et al., 2018). Therefore, living in a low-stimulus, familiar, domestic-scale environment may eliminate the risk of people who do not require specialist dementia services being negatively impacted by those who do.

Additionally, the study found, managing any potential risks of the model of care was one of the purposes of bringing together representatives of all the relevant sectors to form the service development group. Similarly, previous studies have found that governance networks comprise members from different areas, brought together because of their expertise and prior ties between the members (Beyers & Braun, 2014). The inclusion of differing perspective in governance networks has the potential to result in novel approaches to complex problems (Sørensen & Torfing, 2017). Therefore, the service development group was well placed to collaboratively manage the risks inherent in changing the way care is delivered to a vulnerable population in ARC.

The service development group is a governance network that was brought together with a particular purpose, and some members have contractual relationships with each other. As described previously, on page 19, in NZ, the Ministry of Health devolves funding and responsibility for ARC services to the 20 DHBs. Local providers contract with the DHB to provide services; HealthCERT is responsible for making certain services, including ARC facilities, meet the required standards for safety and level of service (Ministry of Health, 2013b). The service development group purposefully includes representatives of all the organisations with an interest in ensuring a safe and viable pilot of a new model of ARC.

The study results show that there is a high level of trust between the members of the service development group. While senior officials at the national and DHB level were willing to consider innovative models of care in ARC, they needed to trust the provider organisation proposing the innovative model of care. An example from a creative activity for ARC residents in Denmark illustrates the positive impact of a trusting

relationship within a governance network (Sørensen & Torfing, 2017). Similarly, in the current study, supporting a trusted provider was considered an appropriate way to explore innovation in service delivery in ARC.

Despite the mutual acknowledgement of challenges around the auditing process, the results of the study indicate the collaborative working between the DHB official and management. After the identification of areas of non-compliance in audits of The CARE Village, and management worked with the DHB official to correct these. It is common for ARC providers to view compliance audits as stressful, despite acknowledgement that the process is necessary to ensure services are accountable for meeting the appropriate standards for resident care (Biggs & Carr, 2019). Contractual relationships between network actors are a powerful motivator in ensuring accountability within a governance network (Cristofoli et al., 2014). Similarly, in the current study, the contractual relationship between RCCT and Lakes DHB underpinned the working relationship required to ensure regulatory compliance.

In addition to the existence of a contractual relationship, the members of the service development group all knew each other due to their current or previous employment roles. The existence of those prior working relationships contributed to positive relationships within the service development group. Similarly, evidence from previous research indicates the social capital of network actors, built by spending time making connections with each other, enables their inclusion in networks and contributes to trust within those networks (Jordana, Mota, & Noferini, 2012).

Governance networks, comprised of actors from central government and the public, private or not-for-profit sectors, are a way of supporting innovation in public policy (Sørensen & Torfing, 2017). The current study found that the service development group, a governance network, enabled a variance of the contract for the provision of ARC services between Lakes DHB and RCCT. The contract is for a three-year pilot of the innovative model of care, where residents live with peers who have shared a similar lifestyle rather than those who require the same level of care. The model of care promotes the normalisation of resident daily life within The CARE Village.

The terms of the national contract for the provision of ARC services stipulates residents who require specialist dementia services must be segregated from those who do not.

In The CARE Village, residents have desegregated within the secure environment of the village. The study found that the pilot of an innovative care environment allowing the integration of residents requiring specialist dementia services within the secure environment of The CARE Village is made possible by the variation in the contract, enabled by the instigator of the service development group. However, the process of changing the contract was challenging, accomplished via consultation, collaboration and the exercise of authority by an individual who recognised an opportunity to support an NZ response to international trends in ARC services.

Furthermore, the study found the pilot, if successful, may inform changes in policy regarding ARC. Governance networks have supported innovation in sectors such as resident experience of new activities in ARC (Sørensen & Torfing, 2017) and library services (Scupola & Zanfei, 2016). However, I have been unable to identify previous research evidence about the role of governance networks in supporting innovative models of care in ARC. The current study makes an original contribution to knowledge about the role of a governance network in innovation in models of care for ARC residents. I have identified the formation of the governance network as a generative mechanism and explained its role in the process of developing The CARE Village.

A further aspect of the originality of the findings lies in the detailed explanation of the development of an innovative model of care in ARC. I have identified three generative mechanisms that have enabled the residents of Whare Aroha CARE to transition to The CARE Village. The management team changed the culture of the workplace to enable person-centred care practices in both facilities, and they created a physical environment that supports the vision of people living normal lives. Finally, a governance network was formed to support the transition to an innovative model of care, promoting the integration of residents requiring specialist dementia services within the facility.

The innovative model of care at The CARE Village has positively impacted the lives of residents and the experiences of their family members and altered the enactment of staff roles. Staff have been supported to develop ways of working that support normalisation of daily life for residents, contributing to greater family satisfaction with care. These groups of research participants form the embedded units of analysis for

the case study. The results of the study relevant to the outcomes for these participants are discussed in the following chapter section.

8.2.4 The impact of the transition on the staff, residents and family members

The vision guiding the transition of Whare Aroha CARE residents to The CARE Village is 'people living normal lives.' The development of The CARE Village is consistent with an international trend, driven in part by consumer demand, towards small-scale physical environments in ARC. Small-scale physical environments may promote improved health and quality of life for residents compared with traditional ARC facilities (Dyer et al., 2018). In The CARE Village staff support residents to continue to engage in valued daily activities in a recognisable domestic-scale environment.

In Whare Aroha CARE there were some limited opportunities for residents to help with serving or cleaning up after meals, and some residents assisted others in the dining room. However, some residents were bored. Contrastingly, in The CARE Village, staff support residents to participate in running their households, as they choose and are able, enabling the continuation of lifelong routines and identities.

The study found that participation ranges from being present when food preparation and other household activities are taking place and, for example, smelling, hearing and seeing the cooking of food, to being responsible for the household washing. Staff compensate for resident disabilities with supportive actions such as assembling cooking ingredients and mitigating errors. The home-like physical environment provides support for the work of staff in enabling resident participation in these activities.

While the physical environment provides activity cues for residents, staff support is needed to enable residents to engage in daily activities. Previous researchers have found similarly (Richards et al., 2015; Van Steenwinkel, de Casterlé, et al., 2017). After shifting from a classic model ARC facility to a home-like environment where staff flexibly adapted routines to align with resident needs, residents with dementia were found to spontaneously engage in more activities, both independently and with others, and interacted socially more than they had before the move (Morgan-Brown et al., 2013). The results of the current study indicate that it is the intersection of the physical

environment and the supportive social environment provided by staff that enables residents of The CARE Village to participate in activities that they value.

The results of the study indicate that, while a process of changing the culture of the workplace at Whare Aroha CARE prepared staff to deliver person-centred care, there was some persistence of a staff-centred focus in care delivery. A staff-centred focus was most notable when caring for residents with high-level physical care needs. Although staff were encouraged to facilitate residents' independence in activities of daily living such as showering and dressing, at busy times staff continued to find it quicker to do these tasks *for* rather than *with* residents.

In contrast to doing tasks *for* residents, doing tasks *with* them while encouraging them to do as much as they can for themselves enables participation in valued activities. The approach is similar to reablement, a relatively recent development in home care practice, aimed at fostering independence in daily tasks (Aspinal, Glasby, Rostgaard, Tuntland, & Westendorp, 2016). Reablement is a person-centred, time-limited intervention; home care workers support older people to retain abilities or regain abilities they have lost, for example, after hospitalisation.

When the staff at The CARE Village accomplish tasks *with* rather than *for* residents, they have adapted the purpose of reablement to fit the ARC context. Reablement is inclusive and person-centred, focusing on the daily activities that are important to the person (Aspinal et al., 2016). In an aligned example from the current study, a home lead, Participant 36, has supported and encouraged Participant 23 to do the laundry for her home, using creativity to overcome a problem stemming from Participant 23's memory loss. Despite disability related to memory loss, Participant 23 can continue with an activity that is important to her and forms part of her identity.

Staff at The CARE Village support residents to continue with activities they value and that are part of their identity. The opportunity to contribute to the community, regardless of declining health, is important to many older people (Stephens & Breheny, 2018). The current study identified that residents at The CARE Village have a variety of opportunities to contribute to community life by working inside and outside the house and by caring for their peers. Those who want to contribute are supported to do so, enhancing wellbeing.

Following the move to The CARE Village, an environment that supports residents to engage in usual daily tasks, some staff-centred practice endured. The finding is not unique; previous studies have found similarly. Where staff feel constrained by their workload, they may perceive that facilitating resident preference and choice is too time-consuming (Corazzini et al., 2014; Roberts & Pulay, 2018). However, staff adaptation to the challenge of incorporating person-centredness into their practice enables the prioritisation of resident preference and choice (Corazzini et al., 2014).

While acknowledging the challenges of the HCA role, I question the claim that workload is a valid reason for reverting to staff-centred practice. The staff workplace is the home of vulnerable residents who are depending on the organisation and staff for their health and wellbeing. Strong leadership is required to ensure staff have a clear understanding of the values underpinning the model of care in the organisation (McCance & McCormack, 2017). Staff who clearly understand the importance of working in person-centred ways may be more able to sustain person-centred practice in times of stress, including those working in small-scale living facilities.

Within small-scale living facilities, practicalities such as budgetary or space restrictions often determine the number of residents in each house, which ranges from five to 15 (Verbeek et al., 2009). The small-scale domestic model of care at The CARE Village was identified as contributing to a peaceful and harmonious atmosphere within the households, each comprising of six or seven residents who have previously lived similar lifestyles. Family members and admission documents provided the information needed to allocate residents to an appropriate lifestyle group, and these allocations remain mostly stable. A small number of residents have moved within the houses due to either personal incompatibility or initial incorrect lifestyle choice, and the presence of 13 homes within The CARE Village, rather than three units within Whare Aroha CARE, facilitates those shifts.

However, I have not been able to identify any previous research specifically about the role of housing people in ARC with peers who share expectations about how to live within one's home and make a recommendation for further research about this topic on page 245. The creation of a harmonious atmosphere in a small home-like ARC facility is complex, and the study found personality, as well as previous lifestyle, was

relevant. One international study of a facility where residents had different care needs noted that some residents were unhappy about living with people they considered very different from themselves, such as those with cognitive impairment. Those residents did not share assumptions about daily life based on previous lifestyle (Van Steenwinkel, de Casterlé, et al., 2017). While shared understandings about social norms within households provide the foundation for harmonious living, the ability to move residents between houses contributes to compatibility within lifestyles in The CARE Village.

Residents are caring for and about each other in the houses, and there is evidence of new friendships developing. This finding supports the findings of Roberts (2016), who noted the clustered domestic model of care facilitated resident relationships with fellow residents and staff. In contrast, Van Steenwinkel, de Casterlé, et al. (2017) found despite living in a small-scale living facility, many residents chose not to socialise with their peers. The CARE Village, where six or seven residents have single bedrooms and share a communal living, dining and kitchen area, has further promoted the family atmosphere that was evident at Whare Aroha CARE. It is likely the care that has gone into ensuring the compatibility of housemates is responsible for that atmosphere.

The study found that management and professional staff continually discuss the model of care and how it applies in practice with frontline care staff at THE CARE Village. The discussions aim to develop an understanding of the operationalisation of the model of care among the staff. The finding aligns with the results of a previous study, indicating the need for staff at all levels of the organisation to understand the principles of person-centred practice and how to apply them (Roberts & Pulay, 2018). Ensuring all staff understand the philosophy underpinning the model of care and how it is used in practice contributes to the sustainability of the model.

The organisation supports staff to perform their new roles in The CARE Village by ensuring they have the appropriate training. The role of home lead in particular is significantly evolved from the HCA role at Whare Aroha CARE. Those staff members have multiple responsibilities and manage the homes semi-autonomously with support.

The study results show that management supports staff in the semi-autonomous home lead role with regular meetings and by respecting their ability to decide on day-to-day operational matters within the homes they run. Research in facilities based on a clustered domestic model of care with a similar staffing model using consistently assigned universal workers found similarly, that frontline care staff felt empowered when their day-to-day decision-making ability was respected (Bowers & Nolet, 2011). Involving staff in organisational decision-making contributes to empowerment, as identified by Bowers, Nolet, et al. (2016). The process of selecting staff for the home lead roles occurred during the transition planning, and once chosen, those staffs were involved in the plan.

The role of an activities officer was not part of the original plan for The CARE Village. The rationale for the decision not to include the role was that daily life in the homes provide activity for residents, and organised activities do not align with that idea. Initially, home leads in The CARE Village organised activities within their houses, or between several houses. However, residents of De Hogeweyk participate in organised activities by belonging to clubs, organised around areas of interest.

While not specified in the literature about De Hogeweyk, it is likely these clubs have a dedicated organiser or organisers, possibly volunteers. De Hogeweyk has a large number of volunteers who work with staff to support residents (van Hal, 2014). The home lead role at The CARE Village is complex and includes supporting residents to participate in household activities. However, management of The CARE Village has now recognised that social activities and hobbies need to be organised by others. A 'hospitality team' now organises resident activities at The CARE Village, including the running of the on-site shop and tea-rooms.

The study identified that while RNs at The CARE Village retain overall responsibility for the clinical aspects of resident care, empowered home leads, in collaborative relationships intentionally facilitated by RNs, proactively identify subtle changes in the health of residents they know well. Previous research has found similarly, indicating the impact of the quality of communication between RNs and home leads in clustered domestic model ARC facilities on resident health outcomes (Bowers & Nolet, 2011; Bowers, Roberts, et al., 2016). The RNs at The CARE Village work with home leads to

enable the early assessment of changes in resident health and, if needed, management by RNs.

The current study found the transition process, involving a representative group of staff, including RNs and direct care staff, has resulted in an embodied understanding of the model of care in the RNs and home leads particularly. Empowered home leads are confident in their ability to communicate with RNs about resident health changes and RNs respect the judgement of the home leads, whom they know and trust. This outcome aligns with the findings of Bowers and Nolet (2014), who noted the positive influence of the two groups working alongside each other on the development of collaborative working.

People who have dementia and live in ARC have complex and individual care needs. Staff at The CARE Village report residents with dementia exhibit less agitation than was evident before moving from Whare Aroha CARE, reduced use of antipsychotic medications as well as a reduction in restraint use. In contrast, previous research was unable to identify any statistically significant differences in neuropsychiatric symptoms of dementia between residents of facilities utilising a clustered domestic model of care and those using a classic model of care (Verbeek et al., 2010). A recent review found mixed results in studies comparing health and quality of life outcomes in residents of small home-like facilities and traditional ARC facilities, with minimal conclusive evidence of better outcomes in the small facilities (Ausserhofer et al., 2016). Research in ARC facilities in NZ identified a relationship between person-centred organisational culture and reduced antipsychotic prescription for residents (Peri et al., 2015). Similarly, the results of the current study indicate that the physical environment and the person-centred care practices of staff of The CARE Village may have led to benefits for the health of residents who have dementia.

The use of restraints in NZ health services is regulated under New Zealand Standard 8141:2001, Restraint Minimisation and Safe Practice. A restraint is a device that restricts the mobility of the person who is restrained; its use must be clinically indicated for the safety of the person restrained or others, after exploration of alternative options (Standards New Zealand, 2008). The use of restraint has negative physical and psychological consequences for the person restrained (Maker &

McSherry, 2019). Therefore, it is preferable to avoid restraining people if they can be kept safe by other means. Staff report their proximity to residents in The CARE Village minimises the need for restraint, a positive outcome for residents.

Staff perception is that the small domestic-scale environment at The CARE Village enables greater oversight of residents with a consequent reduction in falls, consistent with previous research conducted by Cohen et al. (2016). The results of previous studies related to the health of residents in clustered domestic model ARC facilities are inconclusive. Some research indicates there are definite health benefits associated with the model (Afendulis, Caudry, O'Malley, Kemper, & Grabowski, 2016), while others note no difference compared with classic model facilities (Verbeek et al., 2010). Previous researchers have observed a decrease in health costs for residents of clustered domestic model ARC facilities compared with those in classic model facilities, indicating a possible positive effect on resident health (Dyer et al., 2018; Grabowski et al., 2016).

Family members of ARC residents experience distress at the time of admission and subsequently. At the time of admission, families report negative emotions related to the need to place the person in ARC. Family distress subsequent to admission often relates to anxiety about care quality and generalised worry about their family member with dementia in ARC (Afram, Verbeek, Bleijlevens, & Hamers, 2015). Family members are more satisfied with the care and feel less burdened with caring for their relative in facilities utilising clustered domestic models of care than those using classic models of care (Verbeek et al., 2010). In alignment with those previous studies, significantly, a family member who had cared for her husband at home before his admission to Whare Aroha CARE is now confident that he is well cared for when she is not there, aligned with the findings of Verbeek et al. (2010).

Families found the domestic-scale environments in the houses were more pleasant to visit than Whare Aroha CARE. Previous researchers have identified that families are more comfortable visiting their relatives in clustered domestic facilities (Bowers & Nolet, 2014), although they do not necessarily visit for longer (Verbeek et al., 2010). In The CARE Village the creation of an environment where families feel comfortable

visiting their relative has facilitated social inclusion for residents in ARC, an aspect of dementia-friendly communities.

8.3 The creation of a dementia-friendly community within Aged Residential Care

The results of the study indicate that the three generative mechanisms identified during data analysis intersected to support the transition of residents from Whare Aroha CARE to The CARE Village. These mechanisms, identified using retroduction, are ‘they changed the culture of the workplace to enable person-centred care,’ ‘they formed a governance network to support the transition to an innovative model of care,’ and ‘they created a physical environment to support the vision of people living normal lives.’ These three elements of the process of the transition have all contributed to the creation of a dementia-friendly community within ARC, beginning with workplace culture change.

The change from a staff-centred and task-focused way of delivering care to person-centred care was the first step in moving to a model of care where residents can live normal lives. If that change had not been accomplished and the ongoing work had not continued, enabling staff to understand the model of care, focused on residents being able to do the things that are important to them, the model would not have been successful. Changing the physical environment without changing the focus of care to what matters to residents would have resulted in staff-centred and task-focused care being delivered in a domestic-scale physical environment.

The creation of a physical environment that is familiar to residents, decorated in recognisable styles and providing cues to normal living, for example, the smell, sight and sounds of food being cooked, along with the opportunity to assist with food preparation, encourages residents to eat and drink. Additionally, living with peers who share similar ideas about lifestyle contributes to the feeling of living a normal life and encourages friendships among residents. The shift to an innovative model of care at The CARE Village, where residents live with peers who have lived a similar lifestyle in the past rather than those requiring the same level of care, needed support from senior government officials to enable compliance with regulatory and contractual obligations.

The support of senior government officials, via a governance network, the service development group, has been a vital aspect of the development of The CARE Village. The service development group managed risks associated with the transition, ensured the model of care was acceptable to industry leaders, and facilitated the variation in the contract between Lakes DHB and RCCT to enable the pilot of a mixed services model of care. The thesis makes a significant original contribution to theory on governance networks in public policy, in the context of person-centred care delivery in Aged Residential Care, and the national contract between aged care providers and DHBs. Drawing from the results of the study, I make recommendations for practice and policy in the following chapter section.

8.4 Recommendations for practice and policy

There are five recommendations for practice and two recommendations for policy. The recommendations support the development of further ARC facilities utilising a similar model of care as The CARE Village. First, the recommendations will assist providers seeking to develop facilities using the same model of care as The CARE Village. Second, the recommendations will assist senior government officials seeking guidance about managing risk in clustered domestic model ARC facilities where there is no segregation between people requiring specialist dementia services and peers requiring rest home- or private hospital-level care.

There is a growing interest in alternatives to the classic model of care in ARC. As awareness of the possibility of continuing to live in valued ways increases in consumers and potential consumers of ARC services, the demand for services that meet consumer expectations is likely to increase. The study provides some guidance for providers looking to develop services inspired by The CARE Village.

I recommend that providers pay attention to the three elements of the process of transitioning to a village model of care inspired by The CARE Village. First, the delivery of person-centred care is essential to support The CARE Village model of care. Therefore, organisations may identify the need for a culture-change process in the workplace.

Second, collaboration with senior government officials is required to support the new service, to comply with contractual and regulatory requirements. At the time of

writing, a variation in the contract between the DHB and RCCT for services provided at The CARE Village enables residents to live with peers with different assessed levels of care. Senior staff at Lakes DHB have worked with management at The CARE Village to ensure regulatory compliance. Accordingly, I recommend the first point of contact in collaboration with the central government is the local health authority official responsible for services relevant to the health of older people.

Third, the creation of an environment that is of domestic scale supports people with dementia to be as independent as possible while remaining safe and helps residents to engage in valued activities is an integral part of The CARE Village model of care. I recommend that providers work with architects who understand the principles of dementia-friendly design and builders who comprehend the outcome the organisation is aiming to achieve. Additionally, providers, architects and builders should consult the Ministry of Health (2016) recommendations for the design of person-centred and culturally appropriate environments for people who require secure dementia care if they plan to house those residents.

The findings of this study demonstrate the need for training and support for staff to ensure the sustainability of The CARE Village model of care. Currently, an experienced team who understand the model of care mentor less experienced and new team members to ensure the model is understood and applied by them. I recommend the organisation formalises the process by working collaboratively with the current mentors to develop a training package for new staff and an annual refresher for existing staff, ensuring the knowledge held by mentors is not lost if they leave the organisation and can be accessed consistently by other staff.

The leadership demonstrated by RNs is an integral part of the model of care at The CARE Village. The RNs at The CARE Village have moved beyond providing healthcare to providing health and social services. These RNs have established positive and collegial relationships with care staff and consciously maintain those relationships. The support enables care staff to consult them about subtle changes in resident health while acknowledging the primary role of home leads in maintaining resident health and social wellbeing. I recommend RNs at other ARC facilities follow the example provided by the RNs at The CARE Village. Fostering teamwork and facilitating excellent resident

care and supporting health and wellbeing can guide other RNs working in ARC facilities to improve resident care by developing and maintaining collegial relationships within the care team.

One of the goals of the service development group, the governance network formed to support the transition to The CARE Village, was to manage any risks associated with the transition. Potential risks identified included any risks arising from integrating those residents who require specialist dementia services with those who do not. The study has not identified any harms resulting from the desegregation of residents who require specialist dementia services: people who have severe behavioural and psychiatric problems and need psychogeriatric-level care do not live at The CARE Village.

The variation in the contract between Lakes DHB and RCCT for the provision of ARC services at The CARE Village is a three-year pilot. If the pilot is not successful, the contract will revert to the standard contract, requiring segregation of residents who need specialist dementia services. The recommendation arising from the results of the study is for the continuation of the contract between Lakes DHB and RCCT, enabling continued desegregation of residents who require specialist dementia services.

Further, the support provided to the management of The CARE Village by the service development group has ensured the continuation of contractual and regulatory compliance by the service, enabling safe and compliant care for residents. I recommend extending similar support to organisations seeking to develop ARC facilities inspired by The CARE Village, enabling those facilities to provide safe and compliant care to residents by managing any risks associated with the development of innovative ARC services. I make recommendations for further research arising from the results of the study in the following chapter section.

8.5 Recommendations for further research

The study has explained the process and outcomes of the transition of residents from a classic model ARC facility to a facility utilising an innovative model of care. The use of a critical realist methodology and case study research methods has revealed the three generative mechanisms enabling this transition to occur. The use of case study

research methods has enabled an explanation of the outcomes of the transition for facility staff, residents and their families.

Consistent with one of the recommendations for practice, further research at The CARE Village could enable formalisation of knowledge of the model of care and its application in daily practice. A study using a participatory model, working with facility staff, would be useful for identifying the critical elements of the model of care and how staff apply them in practice. Such a study could help ensure the sustainability of the model and assist other organisations wanting to utilise the model.

The research has revealed a willingness among senior government officials in NZ to consider innovative models of care in ARC. That finding leads to the recommendation that providers considering transitioning to an innovative model of care partner with researchers to build on the knowledge about the process of transitioning to an innovative model of care developed in the current study. Building an evidence base on innovative models of care in ARC in NZ will guide policymakers and providers regarding innovation in ARC.

Providers who are considering developing a facility inspired by The CARE Village model of care will be interested in financial viability. The financial aspects of the transition from Whare Aroha CARE to The CARE Village were not part of the current study. However, future research could include a comparison of the overall costs with facilities using a classic model of care.

The study used qualitative research methods to explain the outcomes of the transition to The CARE Village for the three groups who form the embedded units of analysis for the case study, including residents. International studies have used large national datasets to compare resident outcomes of care in facilities utilising classic and clustered domestic models of care. A NZ study using interRAI data collected during ARC resident assessment would produce quantitative evidence comparing outcomes of care in both models of care that would provide reliable and useful information for providers and policymakers.

The research has been a unique opportunity to explain the outcomes of housing ARC residents in small lifestyle groups with peers. I was not able to identify any other

studies specifically about this topic. Further research could identify the influence of elements of the model of care, such as small groups, a familiar domestic environment and shared understandings about lifestyle on care outcomes for ARC residents.

Data collection for the current study took place at two time points, before and after the transition to The CARE Village. The study has explained the process of the transition to an innovative model of care in ARC, and the effects of the transition on staff, residents and their family members. However, the model continues to evolve as new residents move in, and the organisation adapts to their needs. In particular, when residents are admitted from their own homes, they may request support for a broader range of household activities than is currently provided. A longitudinal study would provide information about the evolution of the service that would be helpful for other providers seeking to utilise a similar model of care.

The study includes the perspective of residents of Whare Aroha CARE and The CARE Village, including those who have dementia. Advocates for the human rights of people who have dementia suggest that research about those individuals must include their participation. Therefore, I recommend that research about people with dementia enables their inclusion as participants, following the procedures described in this thesis beginning on page 111, or other inclusive data collection methods. The study by Moalem (2019), who used photo-elicitation methods, is a recent example of research using inclusive data collection methods to enable people with dementia to participate.

8.6 Limitations and strengths of the study

Every study has limitations and strengths; I have identified five limitations and seven strengths of the study. These relate to the methodology, methods and scope of the study. The first limitation relates to the recruitment of study participants.

The first limitation is that the participants were key informants, facility staff, residents and their families who volunteered to be part of the study. The sample may not be fully representative of those groups because it does not include potential participants who did not volunteer to be involved. The second limitation relates to the timing of data collection.

Data collection mainly took place at the two study sites in Rotorua. The inclusion of observation of resident daily life as a method of data collection resulted in total time in the field of approximately four days a week for ten weeks. Time constraints as a result of my full-time employment in Auckland resulted in the commencement of phase two of data collection four months after residents and staff had moved into The CARE Village.

The second phase of data collection began in January 2018, four to five months after residents had moved into The CARE Village. While staff and management indicated that residents settled into their new environment rapidly, the timing of the second phase of data collection may have impacted the results of the study, a potential limitation. The third limitation of the study relates to the operationalisation of the chosen methodology.

The study methodology was critical realism, chosen because it is a useful approach for studies seeking to explain events by revealing mechanisms acting below the surface of events, causing outcomes to occur. A process of retroduction is used to reveal these generative mechanisms. The process described by Danermark et al. (2019) has been used to retroduce the data.

The authors explain the process thoroughly and provide an example of a study using the process. However, the study has not been published in English. I contacted the author, and there is no English publication available describing the process they followed. Although I used another example, there is a possibility I have misinterpreted the steps of the process of retroduction, a potential weakness of the study.

The fourth limitation of the study relates to the transferability of the study findings to other contexts. The results of the study refer to the process and outcomes of the transition from a classic to an innovative model of care by one ARC provider in regional NZ. The study aimed to explain the resettlement of Whare Aroha CARE residents into The CARE Village, and the effects of the resettlement on the lives of the residents. I have achieved that aim; however, the results of the study may not be generalisable to other providers. The potential lack of generalisability is a limitation of the study. The final limitation of the study is an aspect of the transition that not included in the scope of the research.

The financial aspects of the transition were not part of the study. The lack of focus on finance is a limitation of the study. For that reason, the recommendations for further research include the potential for a cost comparison between classic and clustered domestic models of care in ARC.

The study has limitations; however, it also has many strengths. The strengths of the study are the use of theory to guide the study, the selection of an appropriate study methodology, the triangulation of data sources, the inclusion of different perspectives among study participants, the inclusion of the perspectives of facility residents in the study data, the use of robust processes to analyse the data and analytical triangulation by checking the results of the study with participants. I begin the discussion of the strengths of the study with a reiteration of the use of theory in the study.

The use of theory to guide the study enabled me to focus on the purpose of the study during the design phase. The investigation began with theoretical propositions, guiding initial data collection and analysis (Yin, 2017). Additionally, theory guided data analysis in two ways; at the beginning of coding and during retrodution.

Second, the use of case study research methodology was selected as appropriate for the study, aiming to develop an explanation of a phenomenon in context. Single case study methodology was the logical choice because the topic of investigation was a unique case. Additionally, the logical choice of three embedded units of analysis in the case were the three groups of people affected by the outcomes of the transition.

Third, the study includes data from several sources. Study data comprised transcripts of semi-structured interviews with participants, records of focused observation of resident daily life, and organisational and publicly available documents. Triangulation of data sources enables, as in the current study, confirmation of findings in differing sources, or identification of differences allowing the opportunity to investigate the reason for the difference (Patton, 2014).

Fourth, the inclusion of different perspectives of the phenomena under investigation is a strength of the study. Study participants were key informants including managers at Whare Aroha CARE and The CARE Village, and senior officials from organisations

involved in the service development group that supported the transition, facility staff, residents, including those who have dementia, and their family members. The inclusion of the different perspectives brought by the participants has contributed to the development of a complete explanation of the process and outcomes of the transition of residents from Whare Aroha CARE to The CARE Village (Patton, 2014).

The fifth strength of the study is the inclusion of the perspectives of facility residents, with and without dementia, in the data. Data were collected with participants via semi-structured interviews, either in a standard or go-along format, and by observation of daily life, before and after the transition. The study has offered facility residents the opportunity to contribute to research about a change in their environment, consistent with respecting the demand of people who have disabilities, including dementia, to be consulted about issues that affect them (Dementia Alliance International, 2015).

Sixth, I used robust processes to analyse the study data. At the beginning of the analysis, codes were developed from the beginning theoretical propositions for the study, data were analysed using constant comparison, and inductively derived codes were added to the code book (Miles et al., 2014). Constant comparison of the data and the use of inductively derived codes enabled me to investigate rival explanations for the phenomena (Patton, 2014).

Using constant comparison during data analysis includes keeping an open mind and enabled me to begin to develop the generative mechanism 'they changed the culture of the workplace to enable person-centred care.' I identified the three generative mechanisms that contributed to the transition of Whare Aroha CARE residents to The CARE Village using theory and the data in the process of retroduction. The retroductive process of using study data and extant theory to identify underlying mechanisms causing phenomena of interest to occur is a strength of the study.

Finally, I used analytical triangulation by checking the results of the study with study participants. The process of verifying that my understanding of the process and outcomes of the transition resonated with the study participants is a type of analytic triangulation, contributing to the strength of the study (Patton, 2014). I summarise the research in the following chapter section.

8.7 Summary of the research

The study aim was to explain the resettlement of Whare Aroha CARE residents into The CARE Village, and the effects of the resettlement on the lives of the residents. A critical realist theoretical perspective guided the study, using case study research methodology and methods. Critical realism proposes a stratified reality comprising three distinct but overlapping layers, and enables the identification of generative mechanisms, acting below the surface in the layer of the real, causing events to occur in the layers of the real and the actual, experienced by actors in the layers of the real, the actual and the empirical.

The study identified the formation of a governance network to support the transition, an example of a generative mechanism, acting in the domain of the real. An example of events occurring in the domain of the real is the facilitation of a variation in the contract between Lakes DHB and RCCT, enabling desegregation of residents requiring specialist dementia services within The CARE Village. The experiences of key informants, facility residents, their families and the staff, of life in The CARE Village, comprise the layer of the empirical.

As one aspect of gathering data about the layer of the empirical, I observed the daily lives of 11 resident participants in Whare Aroha CARE and eight resident participants in The CARE Village. A total of 48 hours was spent conducting a structured observation of resident daily life at both facilities and in the neighbourhood of The CARE Village. During my observations, I did not participate in the daily life of residents; however, I engaged in conversation with participants and other people present.

Participant interviews and photographs of the environments at both facilities were also used to gather data about the layer of the empirical. A total of 42 participants agreed to one or two interviews, with questions derived from the beginning theoretical propositions for the study, and the data as data collection progressed. Interviews were conducted with facility staff, residents and family members before and after the transition, except for two residents who had moved out of the district and therefore did not move into The CARE Village, and one resident who died before the transition took place. One resident declined an interview before the transition and subsequently agreed after the transition. One family member and five staff members

were not interviewed at Whare Aroha CARE because they were recruited after the transition; key informants were interviewed once.

Interviews were electronically recorded, and I transcribed them. Data gathered via observation and interviews were triangulated with data collected from organisational documents and photographs of the physical environments at Whare Aroha CARE and The CARE Village. Data from all sources contributed to answering the two research questions for the study:

- How has the transition of Whare Aroha CARE residents to The CARE Village been accomplished?
- What is the effect of the transition of Whare Aroha CARE residents to The CARE Village on the lives of the residents?

The data from interview transcripts, organisational documents, observation of resident daily life and photographs of the physical environment at Whare Aroha CARE were triangulated to answer the first research question. An event-listing matrix was used to develop a narrative of the significant events in the process of the transition. Additionally, the data were retroduced using relevant theory to identify the three generative mechanisms enabling the transition of Whare Aroha CARE residents to The CARE Village.

The study has identified three intersecting generative mechanisms. The first generative mechanism is 'they changed the culture of the workplace to enable person-centred care,' comprising of four elements. These are the organisation, the work that was done to change the culture of the workplace, beginning with management demonstrating that they valued facility staff, and the 'special feeling' identified at Whare Aroha CARE and The CARE Village. Changing the culture of the workplace was the first step in the process of developing The CARE Village.

The second generative mechanism, 'they created a physical environment that supports the vision of people living normal lives,' encompasses the second step in developing The CARE Village. The two elements, working with architects and builders and the favourable surrounding, and a physical environment that supports residents to engage in valued activities, supported by staff, are encompassed in the generative mechanism.

The first and second generative mechanisms intersect to contribute to the creation of supportive social and physical environments at The CARE Village.

The third generative mechanism, 'they formed a governance network to support the transition to an innovative model of care,' enables any risks associated with the innovative model of care at The CARE Village to be managed and ensures the regulatory and contractual compliance of the new facility. The third generative mechanism incorporates five elements.

The five elements the generative mechanism comprises are a readiness to consider a new model of care, managing risk, working together, changing the contract and regulatory compliance. The revised contract facilitated via the governance network enables desegregation of residents requiring specialist dementia services within the village. The finding is unique in the literature about ARC in NZ and makes an original contribution to theory about governance networks in public policy, person-centred care in ARC and the current national contract between providers and DHBs.

The first aspect of the aim of the study to explain the resettlement of Whare Aroha CARE residents into The CARE Village, has been met by the identification of the three intersecting generative mechanisms. The second aspect of the aim of the study is to explain explain the effects of the resettlement on the lives of the residents. The second research question is: What is the effect of the transition of Whare Aroha CARE residents to The CARE Village on the lives of the residents? The study results relevant to the answers to the second research question have met the second aspect of the aim of the study, to explain the effects of the resettlement on the lives of the residents.

The outcomes of the transition for each of the three groups of people who form the embedded units of analysis for the case study provide the answers to the second research question. Staff roles have changed considerably, particularly the role of HCAs who are home leads in the new facility. Home leads are empowered to manage the day-to-day running of the households and the person-centred care of the six or seven residents who live there.

RNs facilitate positive relationships with frontline care staff, enabling excellent communication about resident health and care. The physical environment and

supportive staff providing person-centred care combine to enable residents to participate in the running of their households and engage in activities they value. Staff report positive health effects for residents as a result of the new model of care.

Positive health effects for residents include greater awareness of their surroundings, reduced BPSD such as agitation and reduced antipsychotic medication use. Family members can visit their relative in a small-home-like atmosphere. Family members are more satisfied with the care their relative is receiving compared with the care they received in Whare Aroha CARE.

The research has enabled me to explain the process and outcomes of the development of an innovative dementia-friendly community in ARC. The CARE Village represents a reconceptualisation of ARC as a place where the social and physical environments intersect to support residents to continue to live their lives, with support. Residents who previously conformed to institutional routines and passively received care are now able to contribute to the life of their community, in ways that are personally significant to them. Additionally, the community is inclusive of people who require specialist dementia services, contributing to the destigmatisation of dementia within the facility.

The originality of the study lies in three aspects of the research process and outcomes. First, the results of the study explain the development of a facility where ARC is reconceptualised. The study has provided a detailed explanation of the process of developing an ARC facility where residents can continue with lifelong occupations, affirming their identities. Three generative mechanisms intersect to support a process encompassing workplace culture change, a change in the physical environment and a regulatory change. To my knowledge, no previous work has explained how these three processes intersect to support innovation in ARC service delivery. Enabling other providers to understand that all three processes were required to ensure a successful transition will contribute to the development of similar endeavours in the future.

I have identified the pivotal role played by a governance network in supporting innovation in ARC. Previous researchers have identified the role of governance networks in supporting innovation in many sectors, including ARC. However, to my knowledge, the current study is the first explaining the role of a governance network in

supporting the development of an ARC facility using an innovative, person-centred and dementia-friendly model of care. That aspect of the results of the study demonstrates the power of a governance network to safely support innovation in ARC in response to international trends towards normalisation, evidence-based design guidelines and political pressure.

Finally, the study finding regarding the desegregation of residents who previously required specialist dementia services is, I believe, unique in the literature. The study has identified that, within the facility, there is a balance between the need to safely care for people who require a secure environment and enabling them to be free within the village community. The result is a dementia-friendly community in ARC, where people who have dementia are not stigmatised and people who require secure care are kept safe while being integrated into the entire village.

8.8 Conclusion

The transition from Whare Aroha CARE to The CARE Village was driven by the vision of people living normal lives. The management team at Whare Aroha CARE did not accept housing people together with peers requiring the same level of care as being the only way to conceptualise the ARC environment. Enabling residents to live with peers who share similar understandings of how life is lived gives primacy to what matters to people, rather than focusing on deficit and disability.

In The CARE Village, residents are people living their lives with support, instead of having the rhythm of their lives dictated by their need for help with health and activities of daily living. While assistance for health and activities of daily living is provided, as in any ARC facility, the focus is on reablement, by encouraging residents to engage in occupations that reflect valued lifelong identities. The primary focus is now on the enduring personhood of residents rather than their disabilities, such as those related to dementia.

Within the secure environment of The CARE Village, people who require specialist dementia services are integrated into the community. Integration has resulted in the destigmatisation of residents who previously lived in a separate secure unit. The study has demonstrated that the supportive physical and social environments in The CARE Village have enabled residents who require specialist dementia services to be

integrated into a dementia-friendly community in ARC. The transition was facilitated by the formation of a governance network, supporting innovation. The most significant original contribution to knowledge that the thesis makes is the contribution to theory on governance networks in public policy, in the context of person-centred care delivery in Aged Residential Care, and the national contract between aged care providers and DHBs.

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Appendices

Appendix A. Dementia-friendly community initiatives: An integrative review

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REVIEW

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Dementia-friendly community initiatives: An integrative review

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Abstract

Aim: To synthesise international research conducted on dementia-friendly community initiatives.

Background: The number of people living with dementia is increasing as a result of population ageing. Impairments related to neurological changes, together with environmental challenges, result in disability for people who have dementia. Led by the World Health Organization and Alzheimer's Disease International, initiatives have been undertaken internationally to promote social inclusion for people who have dementia. Communities where people with dementia are able to remain socially included are known as dementia-friendly communities.

Design: An integrative review of the literature.

Methods: Scopus, MEDLINE, Web of Science and CINAHL Plus via Ebsco databases were searched for relevant articles. The PRISMA framework guided the article search and screening; reporting is in accordance with the PRISMA guideline. Eight eligible studies were identified. The methodological quality of the eligible studies was evaluated using the MMAT checklist. The matrix method was used to extract, abstract and analyse the data.

Results: Of the eight studies reviewed, five were from the UK and one each from Australia, New Zealand and Canada. Four major concepts were identified in the literature, and these are characteristics of dementia-friendly communities, facilitators and barriers to community engagement for people with dementia, strategies for developing dementia-friendly communities and challenges encountered when developing dementia-friendly communities.

Conclusion: People with dementia are at the centre of dementia-friendly initiatives, and these foster social inclusion. Collaborations and partnerships enhance development of dementia-friendly communities; however, lack of resources and difficulty ensuring representation of marginalised groups provide challenges.

Relevance to clinical practice: An understanding of the impact of marginalisation and inequality on community participation for people with dementia is important for practitioners, enabling them to support those people. Senior nurses with this understanding can ensure services are able to meet the needs of a growing population with dementia.

Globally, the number of people who are living with dementia is increasing as a result of population ageing, and this is associated with increased financial and social costs, including reduced quality of life for people with dementia and their care partners (World Health Organisation & Alzheimer's Disease International, 2012). Most people who have dementia reside in the community (Alzheimer's Disease International, 2015; World Health Organisation & Alzheimer's Disease International, 2012). Neurological changes that occur with dementia cause the individual to experience impairments; however, it is increasingly recognised that it is the intersection of these impairments with the physical and social environments encountered that creates the experience of disability for the person with dementia (Dementia Alliance International, 2016).

Recognising the impairments experienced by people living with dementia leads to disability; Alzheimer's Disease International has adopted 'a rights-based approach, including access to the United Nations Convention on the Rights of Persons with Disabilities' (Dementia Alliance International, 2016, p. 2). One of the general principles of the United Nations Convention on the Rights of Persons with Disabilities is ongoing participation in society (United Nations, 2006). In May 2017, the World Health Organization adopted the global action plan on the public health response to dementia (World Health Organisation, 2017). A key proposal from the plan is member states working towards improving the physical and social environments to promote social inclusion. Social inclusion is specified to encompass both age-friendliness and dementia-friendliness (World Health Organisation, 2016). Based on the leadership from Alzheimer's Disease International, and other leadership opportunities such as the United Kingdom Prime Minister's challenge on dementia (Department of Health, 2015), many national Alzheimer's organisations have developed their own guidelines to support communities in endeavours to become more inclusive for people who are living with dementia, with many local initiatives underway internationally (Alzheimer's Disease International, 2016).

A dementia-friendly community enables those people living in the community to remain engaged in usual daily life for as long as possible (Alzheimer's Disease International, 2016). Moreover, such communities enable people with dementia to continue to contribute as valued community members (Alzheimer's Society Cymru, 2017). While a community is usually defined by location, communities may also consist of groups of people who share the same characteristics such as religious affiliation, special interests and/or ethnicity (Alzheimer's Disease International, 2016). The concept of dementia-friendly communities focuses on the lived experience of people who have dementia (Lin & Lewis, 2015) and is most relevant to addressing their needs and the needs of those people who live with and provide support for them. Dementia-friendly communities are likely to be generally inclusive and facilitate engagement in community for all people, not just people with dementia (Mitchell, Burton, & Raman, 2004).

What does this paper contribute to the wider global clinical community?

- An understanding of the barriers and enablers to social inclusion for people with dementia is important for clinicians in low- to middle-income countries given the increasing prevalence of dementia in those countries.
- An awareness of the needs of the growing numbers of people with dementia worldwide will alert senior staff of the need to provide appropriate staff training to assist them to meet the needs of those people.

There are two key dementia-friendly community objectives. These are the reduction of the social stigma surrounding dementia, and empowerment of people who are living with dementia (Alzheimer's Disease International, 2016). These objectives support the human and disability rights of people who are living with dementia. The ultimate goal of communities becoming dementia-friendly is for dementia to be normalised and recognised as a disabling condition (World Health Organisation & Alzheimer's Disease International, 2012). With many international projects underway, it is timely to review the knowledge to date about dementia-friendly community initiatives.

1.1 | Aim

The aim of this integrative review was to synthesise international research conducted on dementia-friendly community initiatives, to provide a better understanding on the topic (Torraco, 2016). The review will add to the growing body of knowledge about dementia-friendly community initiatives and will be useful to scholars, policymakers, community organisations and practitioners across a wide range of health and social care disciplines.

2 | METHODS

An integrative review can be useful for conceptualising and providing new understandings about an emerging topic and can include reports of both qualitative and quantitative studies (Torraco, 2005; Whittemore & Knafl, 2005). Additionally, theoretical papers and research reports prepared for government and nongovernment organisations can be included in the review (Torraco, 2016). A rigorous process is then utilised comprising a defined search strategy, quality appraisal of identified articles, followed by analysis of the literature (data), and synthesis of the findings to develop a new understanding about the topic (Whittemore & Knafl, 2005). The review can be organised chronologically, methodologically or conceptually depending on the purpose of the review (Torraco, 2016). The methods described by Torraco (2016) and Whittemore and Knafl (2005) were followed while conducting this review.

2.1 | Search strategy

The electronic databases Scopus, MEDLINE, Web of Science and CINAHL Plus via Ebsco were searched in June 2016 and July 2017 and updated in April 2018, using the search terms:

- Dementia-friendly city,
- Dementia-friendly community,
- Dementia-capable community
- Dementia-friendliness
- Dementia AND social inclusion.

Boolean operators were used to include the widest range of results possible within the above search terms. Following the initial search and identification of relevant papers, the reference lists of those papers included in the review were searched to identify further relevant references. The search was conducted across all years in the database until April 2018. The table of contents of the peer-reviewed journals that were revealed to have published articles on this topic were searched, consistent with other review approaches (Neville, Napier, Adams, Wham, & Jackson, 2016). Those journals included the Australasian Journal on Ageing, Dementia, The Gerontologist, Health and Social Care in The Community, and Working with Older People. The published works of known authors in the field were located also. Articles were selected for inclusion in the review if they focused on dementia-friendly communities.

Selection was a two-stage process, with abstracts or executive summaries of retrieved articles and reports being read first to determine whether inclusion criteria were met, followed by full-text reading of identified articles and reports.

2.1.1 | Inclusion criteria

- Primary peer-reviewed research OR
- Research reports prepared for government and nongovernment organisations that described the data they collected
- Published in English
- Focused on dementia-friendly community initiatives.

2.1.2 | Exclusion criteria

- Theoretical or discussion articles
- Articles focused on aspects of dementia-friendliness rather than the concept as a whole, for example, articles focused on the built environment
- Not published in English
- Secondary analysis.

2.2 | Search outcome

The search for and screening of articles was guided by the PRISMA framework (Moher, Liberati, Tetzlaff, Altman, & Group, 2009) and

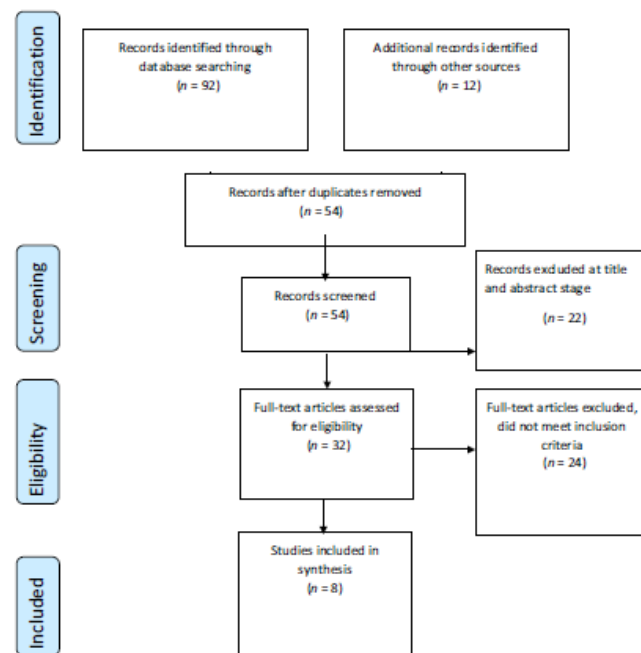


FIGURE 1 PRISMA flow diagram (Moher et al., 2009) [Colour figure can be viewed at wileyonlinelibrary.com]

is summarised in Figure 1. The study is reported in accordance with the PRISMA 2009 guideline (see Appendix S1; Moher et al., 2009).

2.3 | Quality appraisal

The selected articles were appraised for quality using methodologically appropriate checklists. Depending on the methods employed in each study, the appropriate criteria from the mixed method appraisal tool (MMAT; Hong et al., 2018) were used to assess study quality. Two researchers (Kay Shannon and Stephen Neville) independently assessed the quality of the included articles. The studies that did not report all of the information relevant to the MMAT checklist were all grey literature reports. In these cases, authors were contacted for clarification (Hong et al., 2018). Both researchers agreed that all of the included studies were of sufficient quality and met the inclusion criteria for the review.

2.4 | Data analysis

The matrix method described by Garrard (2017) was used to extract, abstract and analyse the data. Data from the studies were extracted and displayed in a review matrix under the following column topics, author, title, year and country; type of document; study aims in the form of a research question; design, data collection; participants and age range; and results. Two researchers (Kay Shannon and Kasia Bail) conducted this process independently, and then, the results were discussed and a consensus reached.

3 | RESULTS

This literature review has summarised the findings of eight papers which reported studies that were conducted evaluating and exploring dementia-friendly community initiatives. Of the studies reviewed, five were from the UK and one each from Australia, New Zealand and Canada. The information about the included studies related to type of document, study design, data collection methods, participant and settings is included in Table 1.

3.1 | Concepts identified in the literature

Four major concepts were identified in the literature, and these are described below.

3.1.1 | Characteristics of dementia-friendly communities

A number of attributes of dementia-friendly communities were identified in the literature. Dementia-friendly communities were described as places where people with dementia could participate in the usual life of the community, have continued access to

amenities such as services and businesses and feel valued and safe (Innovations in Dementia, 2011; Prior, 2012). In dementia-friendly communities, recognition of the need for community to remain accessible for people who have dementia is enshrined in policy and planning (Phillipson, Hall, & Cridland, 2016). Importantly, dementia-friendly communities include those people who are no longer able to live outside residential care facilities (Phillipson et al., 2016). Additionally, a rights-based approach recognises the human rights of people who are living with dementia as people with disabilities (Dean, Silversides, Crampton, & Wrigley, 2015b), entitled to disability support (World Health Organisation, 2016).

Social inclusion for people who have dementia is supported by knowledge and understanding of dementia among the wider community. This can be accompanied by a decreasing stigmatisation of dementia and people who are living with the condition (Innovations in Dementia, 2011; Phillipson et al., 2016; Prior, 2012), and an understanding that it is possible to live well with dementia (Prior, 2012). Dementia is normalised due to larger numbers of people with dementia interacting with other members of their communities (Innovations in Dementia, 2011).

Support to continue valued activities is important for people who are living with dementia. In communities that are dementia-friendly, people are enabled to remain independent or living in their own home with support for as long as possible (Prior, 2012; Wiersma & Denton, 2016). Support to participate in community life is sometimes required (Innovations in Dementia, 2011; Prior, 2012), and there are times when targeted or specific activities are preferred by people who have dementia and those who support or care for them (Innovations in Dementia, 2011).

In dementia-friendly communities, there are key characteristics that make a difference to the experience of people with dementia and their care partners. First, the people who work in customer-facing positions should receive training in how to interact with people who have dementia (Dean, Silversides, Crampton, & Wrigley, 2015a; Innovations in Dementia, 2011; Prior, 2012; Smith, Gee, Sharrock, & Croucher, 2016). Second, there should be access to and easy navigation around pleasant outdoor areas, which include quiet places within public spaces (Dean et al., 2015b; Smith et al., 2016).

The view that it is not helpful to use the term "dementia" when referring to people and resources for them highlights the human rights focus of the dementia-friendly communities concept (Dean et al., 2015a). Furthermore, people with communication and comprehension difficulties are a broader group than people with dementia. Continued accessibility to the physical and social aspects of community is important in supporting a good life for all people as they age (Turner & Cannon, 2018).

3.1.2 | Facilitators and barriers to community engagement for people with dementia

Community characteristics can be supportive of community engagement for people who are living with dementia or, on the other hand, may act as barriers. Reasons given by people who have dementia

TABLE 1 Information about the included studies

| Author, title, year, country | Type of document | Aim(s) | Design, data collection | Participants and age range |
|---|--|--|--|--|
| Innovations in Dementia Dementia-capable communities: The views of people with dementia and their spouses 2011 UK | Grey literature-commissioned research report | What are the understandings about dementia-capable communities and facilitators to community engagement for people with dementia and their spouses? How can communities become more dementia-friendly? | Qualitative Group and individual interviews, observation, survey | People with dementia and care partners, professionals and volunteers who work with people with dementia ($n = 86$) No age range given |
| Prior Knowing the foundations of dementia-friendly communities for the North East 2012 UK | Grey literature-commissioned research report and literature review | What are the aims of dementia-friendly communities and how can they be achieved? What are the processes involved in creating dementia-friendly communities? | Qualitative Interviews and document analysis, literature review Literature review data not included in this review | People involved in or with knowledge about dementia-friendly community initiatives (number not specified) No age range given |
| Dean, Silversides, Crampton & Wrigley Evaluation of the York dementia-friendly communities programme 2015 UK | Grey literature-commissioned research report | How are dementia-friendly communities developed and supported? What were the outcomes of the York dementia-friendly communities programme? | Evaluation Individual and group interviews, online survey, observation, document analysis | People with dementia, care partners, family members, project staff, service providers ($n = 15$ stakeholder interviews, other participant numbers not specified) No age range given |
| Dean, Silversides, Crampton & Wrigley Evaluation of the Bradford dementia-friendly communities programme 2015 UK | Grey literature-commissioned research report | How are dementia-friendly communities developed and supported? What were the outcomes of the Bradford dementia-friendly communities programme? | Evaluation Individual and group interviews, online survey, observation, document analysis | People with dementia, care partners, family members, project staff, service providers ($n =$ approximately 100) No age range given |
| Phillipson, Hall & Cridland Dementia-friendly Kiama pilot project final evaluation report 2016 Australia | Grey literature-commissioned research report | How has the dementia-friendly Kiama project facilitated the physical and social environments in the Kiama area become more dementia-friendly? | Evaluation of a participatory action research design project (community-based) Tracking of project inputs and outputs Consultation with consumer and advisory groups Interviews, surveys, mapping, developing and testing an environmental audit tool | This information relates to the final survey in 2016 People with dementia and care partners ($n = 7$ dyads), care partners ($n = 3$) Community members ($n = 174$) Organisations providing services to people with dementia ($n = 27$) Age range = 17-71+ years |
| Smith, Gee, Sharrock & Croucher Developing a dementia-friendly Christchurch: Perspectives of people with dementia 2016 New Zealand | Peer-reviewed research article | What would make life better for people with dementia in post-earthquake Christchurch? | Qualitative Narrative and appreciative inquiry approach Interviews | People with dementia ($n = 26$) Age range = 60-95 years |

(Continued)

TABLE 1 (Continued)

| Author, title, year, country | Type of document | Aim(s) | Design, data collection | Participants and age range |
|--|--------------------------------|--|---|---|
| Howard, Innes, Cutler, & Hambridge Dementia-friendly communities: Challenges and strategies for achieving stakeholder involvement 2016 UK | Peer-reviewed research article | What are the difficulties around involving community members in dementia-friendly community initiatives and how might these be overcome? | Qualitative Individual and group interviews, document analysis | dementia-friendly community project workers (n = 4) No age range given |
| Wiersma & Denton From social network to safety net: Dementia-friendly communities in rural northern Ontario 2016 Canada | Peer-reviewed research article | How does social support for people with dementia and care partners contribute to the dementia-friendliness of 4 small rural communities in Northern Ontario, Canada? | Qualitative Interviews | People with dementia (n = 2), care partners (n = 15), health service providers (n = 37), other community members (n = 17), Total n = 71 No age range given |

for stopping doing the things they enjoy include worrying about getting lost or confused, difficulties communicating with staff in shops and lack of transport (Innovations in Dementia, 2011), feeling overwhelmed in crowded situations (Dean et al., 2015a; Smith et al., 2016) or embarrassment about symptoms of dementia (Smith et al., 2016).

Many people living with dementia have support from a care partner such as a spouse or significant other. Support for those who are care partners of people living with dementia is an important aspect of dementia-friendly communities (Innovations in Dementia, 2011; Prior, 2012). However, lack of support or respite for care partners has been noted by some (Dean et al., 2015a).

Being able to work in a paid or voluntary capacity is important to many people, including those who have dementia. Opportunities to participate in paid and voluntary work facilitate ongoing engagement in community life (Dean et al., 2015b). However, lack of understanding and lack of support from colleagues have been identified as contributing to the need to withdraw from the workforce for people who have dementia and are still working (Smith et al., 2016).

Rural communities have characteristics that may act as both barriers and facilitators to community participation for people who have dementia. In small communities where people know each other, informal support is provided when people notice there is a need (Wiersma & Denton, 2016). Examples of this type of informal support include helping with chores and noticing if a person is walking where they would not usually be and taking them home (Wiersma & Denton, 2016). However, rural communities are changing as younger people move elsewhere and new residents arrive who are not so engaged with the community (Innovations in Dementia, 2011). Demographic changes in rural communities threaten the fragile informal social support networks that exist there (Wiersma & Denton, 2016). Socially isolated individuals may experience less support from community members than those who have stronger social networks (Wiersma & Denton, 2016). In small communities where everybody knows each other, concerns about privacy may become a barrier to accessing services for some people (Wiersma & Denton, 2016).

People who have lived in their urban neighbourhoods for a long time report familiarity with neighbours as important, with members of local groups for people who have dementia providing support, friendship and community connections for each other (Innovations in Dementia, 2011). Communities where people know each other are seen as safe communities by people who live there (Smith et al., 2016). In larger communities where awareness-raising activities have occurred, people may be able to recognise whether a person with dementia requires help (Dean et al., 2015a).

Appropriate service provision has an impact on normal daily life for people with dementia. Access to a broad range of services enables people to retain their independence (Innovations in Dementia, 2011). Respite care services play an important role in keeping people who have dementia engaged in the community. Social media such as Facebook keep people with dementia

in touch with family, friends and other people who have dementia (Phillipson et al., 2016; Smith et al., 2016). Interest groups and clubs where people who have dementia can meet are seen as valuable sources of support (Smith et al., 2016). Technology can create unintentional barriers; for example, use of electronic payment methods in shops can cause confusion and anxiety, as can the need to use the Internet to access services such as local council and self-service checkouts in libraries (Innovations in Dementia, 2011).

The physical environment plays an important role in social connectivity for people who have dementia. Disrupted physical environments, such as what occurred after the earthquakes in Christchurch, New Zealand, make maintaining social relationships difficult (Smith et al., 2016). Confusing street layouts or unclear signs make navigating town centres difficult (Innovations in Dementia, 2011). Furthermore, for people who live in areas where there is no public transport, access to private transport is essential if they are to remain living in and connected to their community (Innovations in Dementia, 2011; Phillipson et al., 2016). Where public transport is available, timetables may be confusing to use (Dean et al., 2015a, 2015b), or staff may have unhelpful attitudes (Dean et al., 2015a, 2015b; Innovations in Dementia, 2011). For those who have no private transport and are unable to pay for transport services, access to community participation is restricted (Dean et al., 2015a). In general, people who have greater access to financial resources are more able to remain engaged in the community than those who have less financial resources (Dean et al., 2015a).

3.1.3 | Strategies for developing dementia-friendly communities

Participation of people with dementia is crucial in the development of dementia-friendly communities. Active participation of people who have dementia is a strategy for ensuring that dementia-friendly initiatives are aligned with the priorities of people with dementia (Phillipson et al., 2016). For example, in Kiama, Australia, a tool for assessing the environment, The Dementia-Friendly Communities Environmental Assessment Tool (Fleming, Bennett, Preece, & Phillipson, 2017), was developed with the participation of people who have dementia and their care partners (Phillipson et al., 2016). When people who have dementia are leaders of and spokespeople for dementia-friendly initiatives, greater acceptance of them as community partners occurs (Dean et al., 2015a; Phillipson et al., 2016). An additional benefit of involvement in dementia-friendly initiatives for people who have dementia is the peer-support and opportunity to develop social connections (Phillipson et al., 2016).

A range of facilitative administrative procedures were found to be supportive of dementia-friendly initiatives. For example, a steering group comprising community members and members of service organisations enables locally focussed dementia-friendly initiatives to keep progressing (Dean et al., 2015a; Heward, Innes, Cutler, & Hambidge, 2017). Networking and sharing ideas between local

steering groups facilitate learning between groups (Heward et al., 2017). Identification of action areas after determination of priorities has been an effective way of progressing dementia-friendly initiatives in some communities (Heward et al., 2017; Phillipson et al., 2016). Production of an action plan can identify the focus of efforts towards dementia-friendly community initiatives as well as promoting sustainability by identifying funding sources and promoting inclusion of members of the community (Phillipson et al., 2016). The use of action plans such as those published by Dementia Action Alliance can be useful in helping local steering groups guide their initiatives (Heward et al., 2017). Other strategies include listing all businesses and services likely to be used by people who are living with dementia and offering information to help them interact with their clients who have dementia (Prior, 2012). Employment of a coordinator at least at the start of dementia-friendly community initiatives can be helpful in bringing groups together and supporting the development of dementia-friendly businesses (Prior, 2012).

Partnerships between organisations contribute to the success of dementia-friendly initiatives. Multisectoral collaboration and resourcing are important in establishing initiatives (Dean et al., 2015a, 2015b; Innovations in Dementia, 2011; Phillipson et al., 2016; Prior, 2012). Connections with local government are important. In Kiama, Australia, the Dementia Alliance, a local interest group comprised of community members and representatives of service organisations, was represented on the local council's "disability and access committee" (Phillipson et al., 2016, p. 7). Partnerships with academia enabled research to be conducted simultaneously with dementia-friendly community initiatives (Phillipson et al., 2016). Partnerships with local Alzheimer's Associations are a feature of some dementia-friendly community initiatives (Phillipson et al., 2016). Funding is crucial for the success of dementia-friendly community initiatives (Dean et al., 2015a, 2015b; Innovations in Dementia, 2011; Phillipson et al., 2016; Prior, 2012), as is in-kind support from partner organisations (Innovations in Dementia, 2011; Phillipson et al., 2016). Local government should be an important source of funding and in-kind support (Phillipson et al., 2016).

Improving understanding about dementia has a role to play in destigmatising and normalising dementia. Strategies for increasing community awareness of dementia-friendly initiatives contribute to destigmatisation and normalisation. These include launching a website, engaging with local, state and national media, providing education to community members via information sessions and workshops, production of printed material and academic outputs such as journal articles and conference contributions (Phillipson et al., 2016). A community attitudinal survey identified more positive views towards continued community engagement for people who have dementia after attendance at a community awareness-raising event or information session (Phillipson et al., 2016, p. 57).

In some communities that are working towards becoming dementia-friendly, businesses and services where staff are trained to interact with people who have dementia are able to display a logo indicating that they are dementia-friendly. However, this practice is challenged by some who argue that attitudinal and behavioural

indicators are more important than working towards prescribed accreditation standards (Prior, 2012). Finally, dementia-friendly initiatives must coincide with the readiness of the community to accept them (Phillipson et al., 2016).

3.1.4 | Challenges encountered when developing dementia-friendly community initiatives

A number of challenges have been identified during the development of dementia-friendly community initiatives. These relate to collaboration, access to services, obtaining commitment from local businesses, ensuring steering groups are representative of their communities and funding. There is room for improvement in collaboration and information sharing between organisations and services to enable better service provision for people with dementia (Dean et al., 2015b). Buy-in from local businesses is necessary if they are to provide accessible and appropriate services; however, it can be difficult to get businesses to commit to dementia awareness training (Dean et al., 2015a) because of lack of time available to them and the inability to pay staff to attend training (Dean et al., 2015a; Heward et al., 2017).

Ensuring that steering groups enable all voices to be heard can be challenging. At the beginning of an initiative, it can be problematic to establish the networks that are needed for the project to be successful (Dean et al., 2015b). It can be difficult including community members, and ensuring the steering group is genuinely representative of the community (Heward et al., 2017). Accessing people who have dementia to be involved in consultation can be a difficult unless they have a care partner (Dean et al., 2015b; Heward et al., 2017). Furthermore, sometimes care partners talk for the person who has dementia (Heward et al., 2017). For those people who have dementia and are involved in dementia-friendly community initiatives as spokespeople, this role can become burdensome if there are only a few of them (Dean et al., 2015b).

Additionally, it is not easy to engage people with dementia who are also marginalised members of the community such as single people living alone who are socially isolated and those who have learning disabilities. Members of the LGBT community were noted to be absent from one steering group, indicating this group may also be hard to reach and engage with (Dean et al., 2015b). Involving other marginalised groups such as indigenous community members can also be challenging.

For any initiative to be successful, it must be adequately resourced. Scarcity of financial resources (Phillipson et al., 2016) and the competing commitments of steering group members is an ongoing challenge for dementia-friendly initiatives (Dean et al., 2015a; Heward et al., 2017; Phillipson et al., 2016). The uncertain nature of funding creates a further challenge to the sustainability of projects and services, as does instability in some sectors. In projects with funding for a fixed period of time, there is concern that the project will be unable to continue once funding has ceased (Dean et al., 2015a, 2015b). Additionally, funding cuts to services that are of value to people who are living with dementia are a threat to their ability to remain engaged in community (Dean et al., 2015a). Changes leading

to instability in service sectors and local government create some uncertainty for dementia-friendly initiatives (Phillipson et al., 2016).

4 | DISCUSSION

Based on the results of the studies in this review, dementia-friendly communities are places where people who have dementia can continue to participate in community life with support where necessary. They are places where these people whether they live in residential care or in their own homes remain connected to their community. Additionally, dementia is not stigmatised but is normalised. Finally, the role of care partners is respected and supported.

Barriers and enablers to community engagement for people living with dementia are both physical and social; this finding is also reflected in the research about age-friendly communities (Emlet & Mocer, 2012; Neville, Adams, Napier, Shannon, & Jackson, 2018; Plouffe & Kalache, 2010). Lack of access to transport is a key barrier to community connectedness, and inequality and marginalisation affect community connectedness for this group of people. Similarly, the intersection between transport availability and social connectedness is a common theme in the literature about age-friendly communities (Emlet & Mocer, 2012; Neville et al., 2018; Novek & Menec, 2014).

For people living in rural communities who have dementia, informal supports enable them to remain connected in their communities; however, these supports may be weakened when younger family members move away (Wiersma & Denton, 2016). Literature about age-friendliness in rural areas indicates that there is diversity between and within rural communities, and while some communities may be abandoned by younger residents, others experience an influx of comparatively wealthy retirees, marginalising poorer long-standing older residents (Keating, Eales, & Phillips, 2013). Access to transport can be a major barrier to community participation for older people in rural areas who are no longer able to drive due to limited public transport availability (Neville et al., 2018).

There are parallels between strategies used to develop dementia-friendly and age-friendly initiatives. Many of the communities developing dementia-friendly initiatives in the reviewed studies identified a multisectoral steering group comprising community members, local government, researchers and foregrounding people who were living with dementia. A similar multisectoral approach including researchers is a feature of age-friendly initiatives such as that described by Clark (2011). As described above, there are similarities between the age-friendly and dementia-friendly approaches. Phillipson et al. (2016) described the difficulty of developing a model that meets the needs of all people. It may be useful, as suggested by Turner and Cannon (2018) if initiatives were collaborative rather than parallel given their similarities and the likelihood that some organisations will have overlapping interests. Further information about the similarities and differences between age-friendly communities and dementia-friendly communities is contained in Table 2.

The studies included in this review were conducted in high-income countries as classified by the World Bank (Fantom & Serajuddin, 2016).

It is recognised that within high-income countries, there are disparities in income with some groups experiencing significant related disadvantage. For example, in countries with a history of colonisation indigenous people experience disparities in health, including a potentially increased risk of developing dementia (Dyall, 2014). In 2015, it was estimated that 58% of people with dementia lived in low- to middle-income countries, and those countries will experience the greatest increase in dementia prevalence between now and 2050 (Alzheimer's Disease International, 2015). However, social stigma associated with dementia is high in these countries, and the symptoms of dementia may be considered normal age-related changes (Ferri & Jacob, 2017).

Additionally, many people in developing countries are living in informal settlements, known as slums, as they age (Aboderin, Kano, & Owii, 2017). Those authors argue that an adaptation of the World Health Organization indicators for age-friendly cities (World Health Organisation, 2015) achieved via consultation with older residents could be a vehicle for improving social inclusion for older residents in those areas (Aboderin et al., 2017). Similarly, development of dementia-friendly initiatives has the potential to enhance social inclusion for people living in informal communities who have dementia. Complex factors such as cultural beliefs and the urgent health needs of younger community members mean that dementia-friendly initiatives may not be prioritised in areas such as Sub-Saharan Africa (Alzheimer's Disease International, 2017). However, for the dementia-friendly community concept to be international, it must be able to be applied to the needs of people in diverse settings worldwide.

Accessibility to healthcare services, enabling diagnosis and treatment of dementia is an important aspect of dementia-friendly communities (Alzheimer's Disease International, 2016). As the most numerous health professionals, nurses have an important role to play

in supporting and influencing dementia-friendly initiatives. Nurses may contribute to these initiatives by advocating for making their health services dementia-friendly and by promoting early diagnosis and treatment through their professional organisations (Alzheimer's Disease International, 2016). Further empirical research is needed to inform development of this important contributor to social inclusion for people with dementia.

4.1 | Limitations of the review

Despite a rigorous search strategy, we may not have identified all of the literature that is relevant to this topic. Restricting the inclusion criteria to papers published in English may have also excluded some relevant papers. Due to the relatively new and emerging nature of the topic, many of the papers included originated from the grey literature. As identified by Innovations in Dementia (2011), there may be a lack of rigour in the methodology underpinning such papers. Specifically, there is limited information provided regarding the methods of data analysis or the assumptions underpinning the research methods. Few studies to this date have actually evaluated Dementia-Friendly Community initiatives, possibly due to their complex nature. Moreover, besides persons with advanced dementia, the views of older adults living with dementia who lack social support or live in rural areas may not have been captured. These limitations have the potential to influence the emphases in the research reports.

The challenges of conducting research with participants who have dementia, including gaining access to such participants and obtaining ethical approval for their participation, may mean that the views of community members with more advanced dementia may not have been captured (McKeown, Clarke, Ingleton, & Repper,

TABLE 2 Similarities and differences between age-friendly communities and dementia-friendly communities

| Characteristics | Dementia-friendly communities | Age-friendly communities |
|------------------------|---|---|
| Origin of the concept | In 2012, the World Health Organization recognised dementia as a public health priority and noted the intersection of health and social inclusion in contributing to the well-being of people with dementia (World Health Organisation & Alzheimer's Disease International, 2012) | World Health Organization active ageing framework (World Health Organisation, 2007) |
| Focus | Increasing understanding and reducing the social stigma related to dementia by awareness raising. Empowerment of people with dementia by recognition of their human rights and their abilities. Supporting people with dementia to participate in living normal lives for as long as possible (Alzheimer's Disease International, 2016) | Supporting people to age actively through accessible "policies, services, settings and structures" (World Health Organisation, 2007, p. 5) |
| Principles and domains | There are four key principles of dementia-friendly communities, the inclusion of people with dementia and care partners during development, communities that facilitate accessible and appropriate activities that are not segregated and have physically accessible spaces and places, organisations and services that adopt a dementia-friendly approach including having appropriately trained staff who know how to interact with people with dementia and collaborative partnerships across organisations working to achieve dementia-friendly communities (Alzheimer's Disease International, 2016) | There are eight overlapping domains relevant to age-friendly communities, and these are outdoor spaces and buildings, transport, housing, social participation, respect and social inclusion, civic participation and employment, communication and information and community support and health services (World Health Organisation, 2007) |

2010). Researchers and formal research ethics committees have a responsibility to design and approve research that enables participation for a range of participants with varying levels of cognitive impairment (Gove et al., 2018). Doing so will help to ensure that research-informed change reflects what matters to those affected.

5 | CONCLUSION

This integrative review of five grey literature studies, two qualitative and one evaluation study available up until August 2018, has revealed that key characteristics of dementia-friendly communities focus on participation in usual life; continued access, feelings of being valued and safe, with people with dementia being the centre of dementia-friendly initiatives. Physical and social environment characteristics included contact between generations in the community, general knowledge and understanding of dementia in the community, decreasing stigma, increasing normalisation and positive attitudes with a recognition that it is possible to live well with dementia with an emphasis on remaining abilities. Support for carers, community customer service providers (such as taxi drivers, bank and counter staff) displaying patience and helpfulness were key.

Barriers revealed were lack of transport, embarrassment about symptoms and crowded situations, and these were escalated if there was no or minimal carer support. Enablers were financial resources, small communities, established communities including faith communities.

Strategies deemed to be successful for developing communities included steering groups with wide representation and particularly led by people with dementia, supportive action plans, partnerships with Alzheimer's groups, funding and in-kind support. Challenges encountered included ensuring representation of marginalised groups on steering committees, and scarcity of resources, both financial and time.

6 | RELEVANCE TO CLINICAL PRACTICE

- Practitioners need to develop an understanding of the impact of marginalisation and inequality on community participation for people with dementia
AND
- Offer additional support to enable community participation
- People in senior positions must commit to supporting the social inclusion of people with dementia
AND
- Commit to ensuring communities are appropriate places for people with dementia
- For those in senior positions in health services, an understanding of the need for training for all staff will inform the development of services positioned to meet the needs of the increasing numbers of people who are living with dementia.

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CONFLICT OF INTEREST

There is no conflict of interest to declare.

CONTRIBUTIONS

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of the article.

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Appendix B. List of conference contributions drawn from the study

- Shannon, K., Jeffs, T., Wright-St Clair, V., & Neville, S. (2019). Aged care resident participation in usual daily life: The Whare Aroha CARE transition study. In *International Association of Gerontology and Geriatrics Asia Oceania Regional Congress*. Taipei, Taiwan. Retrieved from <https://www.iagg2019.org/>
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Appendix C. Interview guide: Residents

- Can you tell me a bit about what it is like to live here?
- Can you tell me about your usual day here?
- What about special or unusual days?
- What gives you pleasure in life?
- Are you able to pursue that interest while living here?
- What do you enjoy about life here?
- Are there things that you don't enjoy about life here?
- What are they?
- Can you talk a bit about the other people who live and work here?
- Do you feel that you have similar interests or things in common with them?
- Can you talk a bit more about that?
- How does the place (or house after transition) compare with other houses you have lived in?
- Do you feel at home here?
- Do you feel able to live your own life here?
- Can you talk to me about your social life?
- Is this the sort of social life that you like to have?
- Can you talk about how your health is looked after here?
- Can you think of any examples?
- **New questions added after phase one of data collection**
- Can you talk about the way the people here care for you?
- Can you talk about the process of allocating residents to the different lifestyles?
- Some people told me they don't know what lifestyle they or their family members were allocated or they weren't clear on what the consultation process about the allocations was. Can you talk about that process?
- Does the house feel like a normal house to you?
- Do you have enough things to do here/
- What sort of things do you do?
- Do you feel that people are able to live a normal life here?

Appendix D. Interview guide: Family members

- Can you tell me a bit about what it is like to live here for (name of person)?
- Can you tell me about the person's usual day here?
- What about special or unusual days?
- What gives the person pleasure in life?
- Is the person able to pursue that interest while living here?
- What does the person enjoy about life here?
- Are there things that they don't enjoy about life here?
- What are they?
- Can you talk a bit about the other people who live and work here?
- Do you feel that the person has similar interests or things in common with them?
- Can you talk a bit more about that?
- How does the place (or house after transition) compare with other houses the person has lived in?
- Do you think that the person feels at home here?
- Do you think that the person feels able to live their own life here?
- Can you talk to me about the person's social life?
- Do you think that this the sort of social life that they like to have?
- Can you talk about how the person's health is looked after here?
- Can you think of any examples?
- Can you tell me about what it is like for you when you are here?
- How does it feel to come and spend time here?
- **New questions added after phase one of data collection**
- Can you talk about the way the people here care for your family member?
- Can you talk about the process of allocating residents to the different lifestyles?
- Some people told me they don't know what lifestyle they or their family members were allocated or they weren't clear on what the consultation process about the allocations was. Can you talk about that process?
- Can you talk about your role in the process of relocating your family member to The CARE Village?

Appendix E. Interview guide: Staff members

- Can you tell me a bit about what it is like to for people to live here?
- Can you tell me about a usual day here?
- What about special or unusual days?
- What do you think gives people pleasure in life here?
- Can you think of some examples?
- Are people able to pursue their interests while living here?
- Can you think of some examples?
- What do you think people enjoy about life here?
- Can you think of some examples?
- Do you think that there are things that people don't enjoy about life here?
- Can you think of some examples?
- Can you talk a bit about the other people who live and work here?
- Do you feel that you have similar interests or things in common with them?
- Can you talk a bit more about that?
- Do you think that residents feel at home here?
- Do you think that residents are able to live their own lives here?
- Can you think of some examples?
- Can you talk to me about the social life that residents have here?
- Can you think of some examples?
- Can you talk about how the health of the residents is looked after here?
- Can you think of any examples?

New questions added after phase one of data collection

- Can you talk about the relationships that are involved in making the transition happen/ Internal? External?
- Can you talk about the process of achieving regulatory compliance for The CARE Village?
- I have been told about the process of changing the culture within the organisation that started when the new management team took over.
- Can you talk to me about that process?
- Can you talk about the way care is delivered in the organisation?
- Can you talk about the process of allocating staff to the different lifestyles?
- Can you talk about the process of allocating residents to the different lifestyles?
- Some people told me they don't know what lifestyle they or their family members were allocated or they weren't clear on what the consultation process about the allocations was. Can you talk about that process?
- Can you talk about your role in the process of relocating residents and equipment/furniture/other essential items to The CARE Village?
- How have staff and management supported each other through the transition?
- How were residents handed over to staff who were not familiar with them?
- Can you talk about how you are adjusting to your new role?
- Does the house feel like a normal house to you?
- How are you managing disposal of body fluids?
- How are you managing the laundry?
- How are you managing the cooking?
- How are you managing food safety?
- How are you managing the cleaning?
- How is healthcare waste being disposed of?

Appendix F. Interview guide: Key informants

- I want you to tell me about your reasoning in planning and implementing the move to a new model of care for Whare Aroha residents. This is not easy to do. The best way to do it is to use concrete examples
- What has your role in the transition been?
- Can you tell me about how the decision to transition to a new model of care was made? (where appropriate)
- Can you describe the steps involved in bringing the idea to fruition? (where appropriate)
- What collaborations between the organisation and other organisations or government bodies have been needed in order to accomplish the transition?
- When did you first become involved with the project? (where appropriate)
- What have you had to accomplish in order to fulfill your role?
- Can you talk about what has gone smoothly?
- Can you talk about anything that has been difficult?
- Why do you think that has been?
- Can you talk a bit about your view of the purpose of the transition?
- How well do you think this has been achieved?
- Can you think of some examples?
- People have talked to me about the special atmosphere in Whare Aroha, can you talk about how that has come about?
- People have talked to me about the people at Whare Aroha being like a family. Can you talk about how that has come about?
- Is there anything else that you would like to talk about relating to the transition?
- Who are the key people I should talk to to help me understand the process of the transition?
- Would you be happy to have another interview at a later date?



Observation protocol

Number of residents to be observed at one time: 6-8

Observation periods: One hour at a time, mid-morning, lunchtime, mid-afternoon, during the evening meal, on two consecutive days, in public areas of the facility

Observation form: Researcher to complete one per resident per observation period

| | | |
|---|------------------|--------------------------------------|
| Name of resident: | Observer: | Date and time of observation: |
| Person's usual demeanour and ways of expressing themselves, ways of interacting with others, responsiveness to people and situations, usual body language and level of functioning as described by facility staff: | | |

| | Notes |
|--|-------|
| Does the environment resemble a normal household? | |
| Is the resident exercising autonomy with or without support? | |
| Is the resident interacting with others socially, with or without support? | |

| | |
|---|--|
| <p>Is the resident experiencing enjoyment of life's pleasures, with or without support?</p> | |
| <p>Is the resident being supported to maximise their remaining abilities and live a usual daily life?</p> | |
| <p>Is the household and routine of the day organised according to the ideas of residents?</p> | |

Appendix H. Participant demographic data

| 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 |
| 28 | 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 |
| 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 |

Appendix I. Letter of invitation



Invitation

My name is Kay Shannon, and I am a Lecturer in Nursing at Auckland University of Technology. The management of Whare Aroha Care has invited me to conduct this research to explain the transition of Whare Aroha Care residents to a new dementia-friendly village. This research is my Doctor of Philosophy project.



The aim of the research is to explain the transition of Whare Aroha Care residents to a new purpose-built dementia-friendly village. There will be two key outcomes from the research. The first will be an explanation of the transition from the existing Aged Residential Care facility to the new dementia-friendly village. The second key outcome will be an explanation of the effects of the transition to and resettlement in the new dementia-friendly village on the lives on the residents.

For staff members, volunteers and family members, data collection will involve an interview, which will take up to 1 hour. The interview questions will focus on the aims of the research. If you agree, I will talk to you before the move to the new facility and again after the move. The interviews will be recorded, and the recording will be transcribed by a professional transcriber, who has signed a confidentiality agreement.

Additionally, you may be present when I am observing daily life in the facility, either before or after the transition. Resident interviews will be a standard face-to-face interview or will involve me “going along” with the resident as they participate in their daily activities (excluding personal care and toileting) and you may be present at these times. If you are a family member of a resident and your family member is identified by facility staff as being suitable to participate in the study, I will ask you to support their decision to participate.

If you are interested in participating in the research, please leave your phone number with the receptionist, who will give you a Participant Information Sheet containing more information.

If you have any questions, please feel free to phone me on 02108358116.

Thank you,

Kay Shannon

Appendix J. Participant information sheet: Residents



| | | |
|--------------------|--|--------------------------------------|
| Study title: | Whare Aroha transition study | |
| Locality: | Rotorua | Ethics committee ref.: 16/NTA/133 |
| Lead investigator: | Associate Professor Stephen Neville | Contact phone number: 09 921 9379 |

You are invited to take part in a study on the transition of Whare Aroha Care residents to a new village.

The study is being organised by Auckland University of Technology. It is Kay Shannons Doctor of Philosophy project. Kay teaches nursing at Auckland University of Technology.

What the research is about

- The purpose of the study is to explain the transition of Whare Aroha Care residents to the new village at Ngongataha and the effects of the move on the lives of the residents.
- You can choose if you want to take part in the research. **It is your choice.**
- If you decide not to take part it will not affect your care at Whare Aroha Care.
- If you do take part, you can **change your mind** at any time, that is OK and you do not have to give a reason.
- You **do not have to decide now** about taking part in the study. **Please talk with your family or whānau** first if you wish.

What does it involve?

- We would like to talk with you about your daily life at Whare Aroha Care.
- We would like to do this before you move to the new village and after the move.
- We can do this in a face-to-face interview, or we can go with you as you go about your daily routine.
- You are free to talk about things that you are not happy with and nobody will be told what you said.
- Each of these options will take about half an hour.
- We would like to observe you going about your daily life at Whare Aroha Care.
- During the observation, the researcher will sit in the public area of the facility and observe up to 6-8 residents, for an hour at a time. This will happen up to four times a day, for two days in a row.
- We would like to do this before and after the move to the new village.
- You may be in a photograph that the researcher takes.
- The purpose of the photographs is to show people what Whare Aroha Care looks like.
- Your face will be blurred in any published versions of the photograph so that people cannot recognize you.

How does this research benefit me?

- You may feel that it is important to you to be able to express your views about living in Whare Aroha Care
- You will have the opportunity to talk about anything that concerns you about living in Whare Aroha Care. Your concerns will become part of the report for the organization and will help to make the village better.
- If you tell the researcher about abuse she will talk to the Health and Disability Advocate about what to do next. This might mean that she will have to tell the Health and Disability Advocate who you are.

Are there any risks?

- You may find talking with the researcher tiring.
- You can stop at any time if this happens and rest.



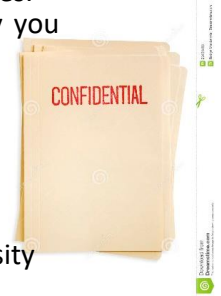
Who pays for the study?

- The study will not cost you any money.

How do the researchers keep information private?

We will keep your information private and confidential. This means:

- Your information will be stored in locked and password protected files.
- We will not use your name in any information that might identify you when presenting the findings.
- Only researchers will have access to your information.
- Information will be stored at Auckland University of Technology.

**What happens after the study?**

All information that you provided will be kept securely at Auckland University of Technology for 10 years. After 10 years this material will be destroyed.

Will I find out the results?**Yes**

- If you want to have a summary of the findings we can provide this to you or your family.

Who do I contact for more information?



If you want more information, please contact Stephen Neville.

Phone 9 921 9379

Email sneville@aut.ac.nz

If you want to talk to someone who isn't involved with the study, you can contact an independent health and disability advocate on:

Phone: 0800 555 050
Fax: 0800 2 SUPPORT (0800 2787 7678)
Email: advocacy@hdc.org.nz

You can also contact the Health and Disability Ethics Committee (HDEC) that approved this study on:

Phone: 0800 4 ETHICS
Email: hdec@moh.govt.nz

Appendix K. Participant information sheet: Family members



Study title: Whare Aroha transition study

Locality: Rotorua

Approved by Northern A
Health and Disability Ethics
Committee on 27/10/2016.

Reference number
16/NTA/133.

Approved by the Auckland
University of Technology
Ethics Committee on
28/11/2016 AUTEK Reference
number 16/424.

Lead investigator: Associate Professor Stephen Neville

Contact phone number: 09
921 9999 ext 9379

Information for family members

You are invited to take part in a study on the transition of Whare Aroha Care residents to a new village. Whether or not you take part is your choice. The study is Kay Shannon's Doctor of Philosophy study. Kay is a lecturer in nursing at Auckland University of Technology. If you don't want to take part, you don't have to give a reason. If you do want to take part now, but change your mind later, you can pull out of the study at any time.

This Participant Information Sheet will help you decide if you'd like to take part. It sets out why we are doing the study, what your participation would involve, what the benefits and risks to you might be, and what would happen after the study ends. We will go through this information with you and answer any questions you may have. You do not have to decide today whether or not you will participate in this study. Before you decide you may want to talk about the study with other people, such as family, whānau, friends, or healthcare providers. Feel free to do this.

If you agree to take part in this study, you will be asked to sign the Consent Form on the last page of this document. You will be given a copy of both the Participant Information Sheet and the Consent Form to keep.

This document is 7 pages long, including the Consent Form. Please make sure you have read and understood all the pages.

What is the purpose of the study?

- The purpose of the study is to explain the transition of Whare Aroha Care residents to the new village at Ngongataha and the effects of the transition on the lives of the residents. Because the new Whare Aroha Care village is the first village of its type to be completed outside The Netherlands, the results of the study will be useful to other aged residential care providers who want to develop similar villages. The results of the study will also be useful to policy-makers.
- The study is being funded in part by a small doctoral allowance provided by the Auckland University of Technology and by scholarships applied for by Kay Shannon from Auckland University of Technology.
- The project supervisors are Associate Professor Stephen Neville and Associate Professor Valerie Wright-St Clair from Auckland University of Technology. If you have any questions about the project please phone Stephen Neville on 09 921 9999 extension 9379 or Kay Shannon on 09 921 9999 extension 7765.
- The study has been granted ethical approval by the Northern A Health and Disability Ethics Committee.

What will my participation involve?

- You have been chosen to participate in the study because you have a relative or friend who is a resident of Whare Aroha Care aged residential care facility.
- Your participation in the study will involve being interviewed by the researcher about the effect of the transition to the new village at Ngongataha on the life of your relative or friend. With your permission we may interview you before and after the transition. It is estimated that the interview will take up to one hour each time. The interviews will be electronically recorded with your permission. The interview may be conducted at the Whare Aroha Care facility and the new Whare Aroha Care village, or at another place that you choose.
- Interviews will be conducted in English. We are unable to provide an interpreter.
- A photograph containing your image may be taken by the researcher during the study.
- If your image is included in any photograph taken by the researcher it will not be included in any published results of the study unless you specifically consent to this.
- The purpose of including photographs in the study data is to help people reading reports or attending presentations about the study to understand what the environment at Whare Aroha Care looks like. This is important because the purpose of changing the environment is to improve the lives of Whare Aroha Care residents.
- If your image is included in any published results of the study, it will be blurred so that you are not able to be recognised.

- Information contained in any reports or presentations about the study will be de-identified.
- The study will be completed in late 2019.

What are the possible risks and benefits of this study?

- There is a slight possibility that you may become distressed during your participation in the study. If this occurs we will stop the interview if that is what you would prefer.
- You may benefit from the study by being given the opportunity to express your views about the impact of the transition on the life of your relative or friend.
- You are free to express any negative views that you may have and your confidentiality will be maintained.
- If you disclose abuse the researcher will consult with the Health and Disability Advocate about the appropriate steps to take. In some circumstances this may mean that confidentiality about the disclosure may not be able to be maintained.

Who pays for the study?

- It is not expected that you will incur any costs other than transport costs by participating in the study.
- You will be offered a \$20 fuel voucher in as reimbursement for fuel costs.

What if something goes wrong?

- If you were injured in this study, which is unlikely, you would be eligible for compensation from ACC just as you would be if you were injured in an accident at work or at home. You will have to lodge a claim with ACC, which may take some time to assess. If your claim is accepted, you will receive funding to assist in your recovery.
- If you have private health or life insurance, you may wish to check with your insurer that taking part in this study won't affect your cover.

What are my rights?

- Participation in the study is voluntary, you are free to decline to participate or to withdraw from the research at any time without disadvantage.
- You have a right to access information about you collected as part of the study.
- The recording of your interview will be transcribed by the researcher or a professional transcriber, who has signed a confidentiality agreement. You will not be able to be identified in any published documents related to the research.

What happens after the study or if I change my mind?

- Electronic and hard copies of your interview transcript will be securely stored at Auckland University of Technology for ten years and will be securely destroyed after the end of that time.
- The study findings will be communicated to participants in the form of a study summary that will be posted or emailed to you. The study findings will be published in the researcher's Doctor of Philosophy thesis, in peer-reviewed journal articles and as presentations at gerontology conferences. The study summary will be available at the end of 2019.

Who do I contact for more information or if I have concerns?

If you have any questions, concerns or complaints about the study at any stage, you can contact:

Associate Professor Stephen Neville
 Head of Department, Nursing
 Auckland University of Technology
 Phone 09 921 9379 Email sneville@aut.ac.nz

If you want to talk to someone who isn't involved with the study, you can contact an independent health and disability advocate on:

Phone: 0800 555 050
 Fax: 0800 2 SUPPORT (0800 2787 7678)
 Email: advocacy@hdc.org.nz

For Maori health support please contact :

Name: Jean Batt
 Position: Associate Director of Nursing Maori, Lakes District Health Board
 Telephone number: 027 6832701
 Email Jean.Batt@lakesdhb.govt.nz

You can also contact the health and disability ethics committee (HDEC) that approved this study on:

Phone: 0800 4 ETHICS
 Email: hdecs@moh.govt.nz



**AUT CENTRE FOR
ACTIVE AGEING**

Consent Form For family members

Please tick to indicate you consent to the following (Add or delete as appropriate)

I have read, or have had read to me in my first language, and I understand the Participant Information Sheet.

I have been given sufficient time to consider whether or not to participate in this study.

I have had the opportunity to use a legal representative, whanau/ family support or a friend to help me ask questions and understand the study.

I am satisfied with the answers I have been given regarding the study and I have a copy of this consent form and information sheet.

I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without this affecting the care of my relative/significant other.

I consent to the research staff collecting and processing my information

If I decide to withdraw from the study, I agree that the information collected about me up to the point when I withdraw may continue to be processed.

You can choose one or both of the options below.

I understand that I will be interviewed as part of this study.

Yes ☐

No ☐

I understand that I may be photographed as part of this study. If my image is included in any photograph taken by the researcher I consent to it being included in published results of the study. My image will be blurred so that I am not able to be recognised.

Yes ☐No ☐

I understand that my participation in this study is confidential and that no material, which could identify me personally, will be used in any reports on this study.

I understand the compensation provisions in case of injury during the study.

I know who to contact if I have any questions about the study in general.

I understand my responsibilities as a study participant.

I wish to receive a summary of the results from the study.

My address is

My email address is

Declaration by participant:

I hereby consent to take part in this study.

Participant's name:

Signature:

Date:

Declaration by member of research team:

I have given a verbal explanation of the research project to the participant, and have answered the participant's questions about it.

I believe that the participant understands the study and has given informed consent to participate.

Researcher's name:

Signature:

Date:

Appendix L. Participant information sheet: Staff and volunteers



Study title: Whare Aroha transition study

Locality: Rotorua

Approved by Northern A
Health and Disability Ethics
Committee on 27/10/2016.
Reference number
16/NTA/133.
Approved by the Auckland
University of Technology
Ethics Committee on
28/11/2016 AUTEK Reference
number 16/424.

Lead investigator: Associate Professor Stephen Neville

Contact phone number: 09
921 9999 ext. 9379

Information for staff and volunteers

You are invited to take part in a study on the transition of Whare Aroha Care residents to a new village. The study is Kay Shannon's Doctor of Philosophy study. Kay is a lecturer in nursing at Auckland University of Technology. Whether or not you take part is your choice. If you don't want to take part, you don't have to give a reason. If you do want to take part now, but change your mind later, you can pull out of the study at any time.

This Participant Information Sheet will help you decide if you'd like to take part. It sets out why we are doing the study, what your participation would involve, what the benefits and risks to you might be, and what would happen after the study ends. We will go through this information with you and answer any questions you may have. You do not have to decide today whether or not you will participate in this study. Before you decide you may want to talk about the study with other people, such as family, whānau, friends, or healthcare providers. Feel free to do this.

If you agree to take part in this study, you will be asked to sign the Consent Form on the last page of this document. You will be given a copy of both the Participant Information Sheet and the Consent Form to keep.

This document is 6 pages long, including the Consent Form. Please make sure you have read and understood all the pages.

What is the purpose of the study?

- The purpose of the study is to explain the transition of Whare Aroha Care residents to the new village at Ngongataha and the effects of the transition on the lives of the residents. Because the new Whare Aroha Care village is the first village of its type to be completed outside The Netherlands, the results of the study will be useful to other aged residential care providers who want to develop similar villages. The results of the study will also be useful to policy-makers.
- The study is being funded in part by a small doctoral student allowance provided by the Auckland University of Technology and by scholarships applied for by Kay Shannon from Auckland University of Technology.
- The project supervisors are Associate Professor Stephen Neville and Associate Professor Valerie Wright-St Clair from Auckland University of Technology. If you have any questions about the project please phone Stephen Neville on 09 921 9999 extension 9379 or Kay Shannon on 09 921 9999 extension 7765.
- The study has been granted ethical approval by the Northern A Health and Disability Ethics Committee.

What will my participation in the study involve?

- You have been chosen to participate in the study because you are a staff member of Whare Aroha Care aged residential care facility or a volunteer at the facility.
- Your participation in the study will involve being interviewed by the researcher about the transition to the new village at Ngongataha and the effects of the transition on the lives of the residents of Whare Aroha Care. With your permission we may interview you before and after the transition. It is estimated that the interviews will take up to one hour each. The interviews will be electronically recorded with your permission.
- Interviews will be conducted in English. We are unable to provide an interpreter.
- The interview will take place at the Whare Aroha Care facility or the new Whare Aroha Care village, or if you prefer, at a place of your choosing.
- A photograph containing your image may be taken by the researcher during the study.
- If your image is included in any photograph taken by the researcher it will not be included in any published results of the study unless you specifically consent to this.
- The purpose of including photographs in the study data is to help people reading reports or attending presentations about the study to understand what the environment at Whare Aroha Care looks like. This is important because the purpose of changing the environment is to improve the lives of Whare Aroha Care residents.

- Information contained in any reports or presentations about the study will be de-identified.
- If your image is included in any published results of the study, it will be blurred so that you are not able to be recognised.
- The study will be completed in late 2019.
-

What are the possible benefits and risks of the study?

- It is not foreseen that participation in the study will expose you to any risks.
- You may benefit from the study by being given the opportunity to express your views about the transition to the new village and its effects of the lives of the residents of Whare Aroha Care.
- You are free to express any negative views that you may have and your confidentiality will be maintained.
- If you disclose abuse the researcher will consult with the Health and Disability Advocate about the appropriate steps to take. In some circumstances this may mean that confidentiality about the disclosure may not be able to be maintained.

Who pays for the study?

- It is not expected that you will incur any costs other than transport costs by participating in the study.
- You will be offered a \$20 fuel voucher in as reimbursement for fuel costs.

What if something goes wrong?

- If you were injured in this study, which is unlikely, you would be eligible for compensation from ACC just as you would be if you were injured in an accident at work or at home. You will have to lodge a claim with ACC, which may take some time to assess. If your claim is accepted, you will receive funding to assist in your recovery.
- If you have private health or life insurance, you may wish to check with your insurer that taking part in this study won't affect your cover.

What are my rights?

- Participation in the study is voluntary, you are free to decline to participate or to withdraw from the research at any time without disadvantage.
- You have a right to access information about you collected as part of the study.
- The recording of your interview will be transcribed by the researcher or a professional transcriber, who has signed a confidentiality agreement. You will not be able to be identified in any published documents related to the research.

What happens after the study or if I change my mind?

- Electronic and hard copies of your interview transcript will be securely stored at Auckland University of Technology for ten years and will be securely destroyed after the end of that time.

- The study findings will be communicated to participants in the form of a study summary that will be posted or emailed to you. The study findings will be published in the researcher's Doctor of Philosophy thesis, in peer-reviewed journal articles and as presentations at gerontology conferences. The study summary will be available at the end of 2019.

Who do I contact for more information or if I have concerns?

If you have any questions, concerns or complaints about the study at any stage, you can contact:

Associate Professor Stephen Neville

Head of Department, Nursing

Auckland University of Technology

Phone 09 921 9379

Email sneville@aut.ac.nz

If you want to talk to someone who isn't involved with the study, you can contact an independent health and disability advocate on:

Phone: 0800 555 050

Fax: 0800 2 SUPPORT (0800 2787 7678)

Email: advocacy@hdc.org.nz

For Maori health support please contact :

Name: Jean Batt

Position: Associate Director of Nursing Maori, Lakes District Health Board

Telephone number: 027 6832701

Email Jean.Batt@lakesdhb.govt.nz

You can also contact the health and disability ethics committee (HDEC) that approved this study on:

Phone: 0800 4 ETHICS

Email: hdec@moh.govt.nz



Consent Form For staff and volunteers

Please tick to indicate you consent to the following (Add or delete as appropriate)

I have read, or have had read to me in my first language, and I understand the Participant Information Sheet.

I have been given sufficient time to consider whether or not to participate in this study.

I have had the opportunity to use a legal representative, whanau/ family support or a friend to help me ask questions and understand the study.

I am satisfied with the answers I have been given regarding the study and I have a copy of this consent form and information sheet.

I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time.

You may choose one or both of the options below

| | | |
|--|------------------------------|-----------------------------|
| I understand that I will be interviewed as part of this study. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|--|------------------------------|-----------------------------|

| | | |
|--|------------------------------|-----------------------------|
| I understand that I may be photographed as part of this study. If my image is included in any photograph taken by the researcher. I consent to it being included in published results of the study. My image will be blurred so that I am not able to be recognised. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|--|------------------------------|-----------------------------|

I understand that my participation in this study is confidential and that no material, which could identify me personally, will be used in any reports on this study.

I understand the compensation provisions in case of injury during the study.

I know who to contact if I have any questions about the study in general.

I understand my responsibilities as a study participant.

I wish to receive a summary of the results from the study.

My address is

My email address is

Declaration by participant:

I hereby consent to take part in this study.

Participant's name:

Signature:

Date:

Declaration by member of research team:

I have given a verbal explanation of the research project to the participant, and have answered the participant's questions about it.

I believe that the participant understands the study and has given informed consent to participate.

Researcher's name:

Signature:

Date:

Appendix M. Participant information sheet: Key informants



Study title: Whare Aroha transition study

Locality: Rotorua

Approved by Northern A
Health and Disability Ethics
Committee on 27/10/2016.
Reference number
16/NTA/133.
Approved by the Auckland
University of Technology
Ethics Committee on
28/11/2016 AUTEK Reference
number 16/424.

Lead investigator: Associate Professor Stephen Neville

Contact phone number: 09
921 9999 ext 9379

Information for key informants

You are invited to take part in a study on the transition of Whare Aroha Care residents to a new village. The study is Kay Shannon's Doctor of Philosophy study. Kay is a lecturer in nursing at Auckland University of Technology. Whether or not you take part is your choice. If you don't want to take part, you don't have to give a reason. If you do want to take part now, but change your mind later, you can pull out of the study at any time.

This Participant Information Sheet will help you decide if you'd like to take part. It sets out why we are doing the study, what your participation would involve, what the benefits and risks to you might be, and what would happen after the study ends. We will go through this information with you and answer any questions you may have. You do not have to decide today whether or not you will participate in this study. Before you decide you may want to talk about the study with other people, such as family, whānau, friends, or healthcare providers. Feel free to do this.

If you agree to take part in this study, you will be asked to sign the Consent Form on the last page of this document. You will be given a copy of both the Participant Information Sheet and the Consent Form to keep.

This document is 7 pages long, including the Consent Form. Please make sure you have read and understood all the pages.

What is the purpose of the study?

- The purpose of the study is to explain the transition of Whare Aroha Care residents to the new village at Ngongataha and the effects of the transition on the lives of the residents. Because the new Whare Aroha Care village is the first village of its type to be completed outside The Netherlands, the results of the study will be useful to other aged residential care providers who want to develop similar villages. The results of the study will also be useful to policy-makers.
- The study is being funded in part by a small doctoral allowance provided by the Auckland University of Technology and by scholarships applied for by Kay Shannon from Auckland University of Technology.
- The project supervisors are Associate Professor Stephen Neville and Associate Professor Valerie Wright-St Clair from Auckland University of Technology. If you have any questions about the project, please phone Stephen Neville on 09 921 9999 extension 9379 or Kay Shannon on 09 921 9999 extension 7765.
- The study has been granted ethical approval by the Northern A Health and Disability Ethics Committee.

What will my participation in the study involve?

- You have been chosen to participate in the study because you have key information to offer about the transition of Whare Aroha Care residents to a new dementia-friendly village.
- Your participation in the study will involve being interviewed by the researcher about the transition to the new village at Ngongataha and the effects of the transition on the lives of the residents of Whare Aroha Care. It is estimated that the interviews will take up to 90 minutes. The interviews will be electronically recorded with your permission.
- Interviews will be conducted in English. We are unable to provide an interpreter.
- Information contained in any reports or presentations about the study will be de-identified.
- A photograph containing your image may be taken by the researcher during the study.
- If your image is included in any photograph taken by the researcher it will not be included in any published results of the study unless you specifically consent to this.
- The purpose of including photographs in the study data is to help people reading reports or attending presentations about the study to understand what the environment at Whare Aroha Care looks like. This is important because the purpose of changing the environment is to improve the lives of Whare Aroha Care residents.
- Information contained in any reports or presentations about the study will be de-identified.

- If your image is included in any published results of the study, it will be blurred so that you are not able to be recognised.
- The study will be completed in late 2019.

What are the possible benefits and risks of the study?

- It is not foreseen that participation in the study will expose you to any risks.
- You may benefit from the study by being given the opportunity to express your views about the transition to the new village and its effects of the lives of the residents of Whare Aroha Care.
- You are free to express any negative views that you may have and your confidentiality will be maintained.
- If you disclose abuse to the researcher the researcher will consult with the health and Disability Advocate about the appropriate steps to take. In some circumstances this may mean that confidentiality about the disclosure may not be able to be maintained.

Who pays for the study?

- It is not expected that you will incur any costs other than transport costs by participating in the study because the interview will take place at the Whare Aroha Care facility or via Skype.

What if something goes wrong?

- If you were injured in this study, which is unlikely, you would be eligible for compensation from ACC just as you would be if you were injured in an accident at work or at home. You will have to lodge a claim with ACC, which may take some time to assess. If your claim is accepted, you will receive funding to assist in your recovery.
- If you have private health or life insurance, you may wish to check with your insurer that taking part in this study won't affect your cover.

What are my rights?

- Participation in the study is voluntary, you are free to decline to participate or to withdraw from the research at any time without disadvantage.
- You have a right to access information about you collected as part of the study.
- The recording of your interview will be transcribed by the researcher or a professional transcriber, who has signed a confidentiality agreement. You will not be able to be identified in any published documents related to the research.

What happens after the study or if I change my mind?

- Electronic and hard copies of your interview transcript will be securely stored at Auckland University of Technology for ten years and will be securely destroyed after the end of that time.

The study findings will be communicated to participants in the form of a study summary that will be posted or emailed to you. The study findings will be published in the researcher's Doctor of Philosophy thesis, in peer-reviewed journal articles and as

- presentations at gerontology conferences. The study summary will be available at the end of 2019.

Who do I contact for more information or if I have concerns?

If you have any questions, concerns or complaints about the study at any stage, you can contact:

Associate Professor Stephen Neville
Head of Department, Nursing
Auckland University of Technology
Phone 09 921 9379
Email sneville@aut.ac.nz

If you want to talk to someone who isn't involved with the study, you can contact an independent health and disability advocate on:

Phone: 0800 555 050
Fax: 0800 2 SUPPORT (0800 2787 7678)
Email: advocacy@hdc.org.nz

For Maori health support please contact :

Name: Jean Batt
Position: Associate Director of Nursing Maori, Lakes District Health Board
Telephone number: 027 6832701
Email Jean.Batt@lakesdhb.govt.nz

You can also contact the health and disability ethics committee (HDEC) that approved this study on:

Phone: 0800 4 ETHICS
Email: hdecs@moh.govt.nz



Consent Form For key informants

Please tick to indicate you consent to the following (Add or delete as appropriate)

I have read, or have had read to me in my first language, and I understand the Participant Information Sheet.

I have been given sufficient time to consider whether or not to participate in this study.

I have had the opportunity to use a legal representative, whanau/ family support or a friend to help me ask questions and understand the study.

I am satisfied with the answers I have been given regarding the study and I have a copy of this consent form and information sheet.

I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time.

I can choose one or both of the options below

| | | |
|---|------------------------------|-----------------------------|
| I understand that I will be interviewed as part of this study | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|---|------------------------------|-----------------------------|

| | | |
|--|------------------------------|-----------------------------|
| I understand that I may be photographed as part of this study. If my image is included in any photograph taken by the researcher. I consent to it being included in published results of the study. My image will be blurred so that I am not able to be recognised. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|--|------------------------------|-----------------------------|

I consent to the research staff collecting and processing my information

If I decide to withdraw from the study, I agree that the information collected about me up to the point when I withdraw may continue to be processed.

I understand that my participation in this study is confidential and that no material, which could identify me personally, will be used in any reports on this study.

I understand the compensation provisions in case of injury during the study.

I know who to contact if I have any questions about the study in general.

I understand my responsibilities as a study participant.

I wish to receive a summary of the results from the study.

My address is

My email address is

Declaration by participant:

I hereby consent to take part in this study.

Participant's name:

Signature:

Date:

Declaration by member of research team:

I have given a verbal explanation of the research project to the participant, and have answered the participant's questions about it.

I believe that the participant understands the study and has given informed consent to participate.

Researcher's name:

Signature:

Date:

Appendix N. Ethical approval letter: Health and disability ethics committee



Health and Disability Ethics Committees

Ministry of Health
Freyberg Building
20 Aitken Street
PO Box 5013
Wellington
6011

0800 4 ETHICS
hdec@moh.govt.nz

27 October 2016

Associate Professor Stephen Neville
Private Bag 92006
Auckland 1142

Dear Associate Professor Neville

| | | |
|-----|--------------------|---|
| Re: | Ethics ref: | 16/NTA/133 |
| | Study title: | The transition of Whare Aroha Care residents to a new dementia-friendly village |

I am pleased to advise that this application has been approved by the Northern A Health and Disability Ethics Committee. This decision was made through the HDEC-Full Review pathway.

Conditions of HDEC approval

HDEC approval for this study is subject to the following conditions being met prior to the commencement of the study in New Zealand. It is your responsibility, and that of the study's sponsor, to ensure that these conditions are met. No further review by the Northern A Health and Disability Ethics Committee is required.

Standard conditions:

1. Before the study commences at *any* locality in New Zealand, all relevant regulatory approvals must be obtained.
2. Before the study commences at a *given* locality in New Zealand, it must be authorised by that locality in Online Forms. Locality authorisation confirms that the locality is suitable for the safe and effective conduct of the study, and that local research governance issues have been addressed.

Non-standard conditions:

- For the consent forms please ensure only the truly optional statements have the yes/no options next to them so if a participant were to select no, they could still take part in the study.

Non-standard conditions must be completed before commencing your study. Non-standard conditions do not need to be submitted to or reviewed by HDEC before commencing your study.

If you would like an acknowledgement of completion of your non-standard conditions letter you may submit a post approval form amendment. Please clearly identify in the amendment that the changes relate to non-standard conditions and ensure that supporting documents (if requested) are tracked/highlighted with changes.

For information on non-standard conditions please see section 128 and 129 of the Standard Operating Procedures at <http://ethics.health.govt.nz/home>.

After HDEC review

Please refer to the *Standard Operating Procedures for Health and Disability Ethics Committees* (available on www.ethics.health.govt.nz) for HDEC requirements relating to amendments and other post-approval processes.

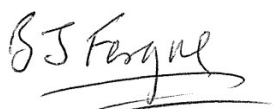
Your **next progress report** is due by **26 October 2017**.

Participant access to ACC

The Northern A Health and Disability Ethics Committee is satisfied that your study is not a clinical trial that is to be conducted principally for the benefit of the manufacturer or distributor of the medicine or item being trialled. Participants injured as a result of treatment received as part of your study may therefore be eligible for publicly-funded compensation through the Accident Compensation Corporation (ACC).

Please don't hesitate to contact the HDEC secretariat for further information. We wish you all the best for your study.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'B J Fergus', with a horizontal line underneath.

Dr Brian Fergus
Chairperson
Northern A Health and Disability Ethics Committee

Appendix O. Ethical approval letter: Auckland University of Technology Ethics Committee

28 November 2016

Stephen Neville
Faculty of Health and Environmental Sciences

Dear Stephen

Re Ethics Application: **16/424 The transition of Whare Aroha Care residents to a new dementia-friendly village**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 28 November 2019.

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/researchethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 28 November 2019;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/researchethics>. This report is to be submitted either when the approval expires on 28 November 2019 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,



Appendix P. Locality agreement



Locality Agreement

Full Project Title: **The transition of Whare Aroha Care residents to a new dementia-friendly village**

Short Project Title: **Whare Aroha transition study**

Brief outline of study:

The research will explain the resettlement of Whare Aroha Care residents into the new village, based on the Hogeweyk model, and the effects of the resettlement on the lives of the residents. Study participants will be facility management, staff, residents and family members as well as other key informants from organisations such as the Ministry of Health. Study data will be collected using interviews, focused observation and key relevant documents, guided by the theoretical propositions for the study. Iterative data analysis will occur parallel to data collection, guided by the theories identified at the beginning of the study and refined during the course of the study. Beginning with coding and progressing to abstraction, analysis will build explanations of the transition to the new village and the effects of the transition on resident lifestyle. The village will be the first based on the Hogeweyk model completed outside The Netherlands, with the setting adapted to the New Zealand lifestyle, including a cultural house for people accustomed to living a Māori cultural way. The study is unique because it seeks to provide robust qualitative evidence about the transition to a dementia-friendly village and its' effects on the lives of residents. The results of the study will be useful to policy makers and to other organisations seeking to develop villages based on the Hogeweyk model and adapted to their local contexts.

Co-ordinating Investigator:

Associate Professor Stephen Neville
 Head of Department, Nursing
 Auckland University of Technology

Contact details:

Department of Nursing
 School of Clinical Sciences
 Faculty of Health and Environmental Sciences

AUT University, Private Bag 92006,
Auckland 1142, New Zealand
Telephone: 09 921 9379
Email: sneville@aut.ac.nz

Local investigator:

Kay Shannon
Lecturer in Nursing
Auckland University of Technology

Contact details:

Postal address as above
Telephone: 09 921 7765, 02102298461
Email: sshannon@aut.ac.nz

Locality Organisation signoff

Ethics committees review whether investigators have ensured their studies would meet established ethical standards, if conducted at appropriate localities; each locality organisation is asked to use the locality assessment form to check that the investigator has also made the appropriate local study arrangements.

Ethics approval for study conduct at each site is conditional on favourable locality assessment at that locality.

Locality issues:

1. Suitability of local researcher

Are all roles for the investigator(s) at the local site appropriate (eg has any conflict the investigator might have between her or his local roles in research and in patient care been adequately resolved)?

The researcher is independent to Rotorua Continuing Care Trust and Whare Aroha Care and has no involvement in the services provided by the service. As such no conflict is identified.

2. Suitability of the local research environment

Have the resources (other than funding which is conditional on ethical approval) and/or facilities that the study requires locally been identified? Are they appropriate and available?

Whare Aroha Care has had input to developing the research methods and made recommendations for making the study appropriate for key informants, staff and volunteers, family members and residents to participate.

The researcher can liaise with Whare Aroha Care for assistance with the interview, or for use of a room at the request of any participant. No charge will be made for room utilization. If approved by the ethics committee, the facility receptionist can give potential participants a copy of the letter of the invitation letter and answer routine questions about the study. Advice will be given on interpretation of research findings where relevant.

1. What are the specific issues relating to the local community?

Are there any cultural or other issues *specific* to this locality, or to participants for whom study recruitment or participation is primarily at this locality? If so, how have they been addressed?

A significant proportion of the clients and staff of Whare Aroha Care are Māori and the researcher is pakeha. Jean Batt, Associate Director of Nursing - Maori at Rotorua Hospital is prepared to act as an advisor on cultural matters to ensure procedures are conducted sensitively and participants have access to independent support regarding cultural matters.

Information sheet/consent form contact details:

If you want to talk to someone who isn't involved with the study, you can contact an independent health and disability advocate on:

Phone: 0800 555 050
 Fax: 0800 2 SUPPORT (0800 2787 7678)
 Email: advocacy@hdc.org.nz

I understand that I may withdraw locality approval if any significant local concerns arise. I agree to advise the Co-ordinating Investigator and then the relevant ethics committee should this occur.

Signature:**Date:****Name:** Thérèse Jeffs**Position:** Chief Executive Officer, Whare Aroha Care**Contact details:** 1092 Hinemaru Street, Rotorua, phone: 07 347 9612

Appendix Q. Case study protocol



Whare Aroha Care Study Protocol

The transition of Whare Aroha Care residents to a new dementia-friendly village.

Abstract

This project aims to explain the transition of Whare Aroha Care residents from a traditional aged residential care facility to a new bespoke dementia-friendly village.

Objectives: To explain the resettlement of Whare Aroha Care residents into the village and the effects of the resettlement on the lives of the residents.

Design: The study will utilise a critical realist methodology and a single case study research design with embedded units of analysis. Data collection methods are interviews with key informants, examination of relevant documents, interviews with facility staff and volunteers, residents and family members, and focused observation of resident life before and after the transition.

Settings: Whare Aroha Care aged residential care facility prior to the transition and after the transition. Key informants will be interviewed in their offices or via Skype.

Participants: Key informants for the study are the senior staff at Whare Aroha Care, current and past board members of the Rotorua Continuing Care Trust, the operators of the Whare Aroha Care facility and the two HealthCert staff who will be involved in the certification process for the new facility. Other participants will be staff and volunteers of the facility as well as residents and family members of residents.

Design and methods

Commencement –October 2016 (pending ethical approval)

Completion – December 2019

Recruitment

Participants who are key informants will be recruited via the following process:

Key informants that the researcher has not already met will be introduced to the researcher via email by either organisation management or the project supervisors. Key informants will be invited to participate by being emailed a letter explaining the research, inviting them to participate and providing them with a participant information sheet (PIS).

Participants who are facility staff or volunteers, or family members of residents will be given a letter explaining the research, inviting them to participate and providing them with a PIS. Initial contact with this group of participants will be made by the facility receptionist, rather than a more senior person in the organisation which could be perceived as pressuring people to participate in the study.

Participants who are residents will be identified by the nurse manager of the facility. The nurse manager will then approach the resident and ask if they would like to volunteer and provide them with a participant information sheet (PIS). Their next of kin will also be given an information sheet. The clinical nurse manager will follow up with the resident and their next of kin within a week to answer any questions. If the resident volunteers to take part in the research, their name and next of kin's contact details will be given to the researcher.

Eligibility criteria

A person is eligible to be included in the study if they are:

1. A key informant for the study as identified above OR
2. A staff member or volunteer of Whare Aroha Care OR
3. A resident of Whare Aroha Care who is able to have a "meaningful" conversation (for residents participating in interviews. AND/OR
4. A resident of Whare Aroha Care who has dementia, as identified by the nurse manager OR
5. A family member or other person who is significant in the life of a resident of Whare Aroha Care

A person is excluded from the study if they:

1. Are deemed by the nurse manager as not being able to have a "meaningful" conversation
2. Are deemed by the nurse manager as likely to be distressed by their participation

Consent

For participants who are facility residents and have cognitive impairment, the researcher will obtain consent from the participant, where possible, and support from their next of kin for their participation in the study.

This is the same process that was followed for recruitment into a study with participants who have dementia that was granted ethical approval (reference number 16/NTB/121). The participant can withdraw from the research at any stage and their on-going care will not be affected.

For other participants informed consent will be obtained for their participation in the study. Participants can withdraw from the study at any time, and in the case of family members of facility residents, the care of their family member will not be affected.

Method

Observation

Resident life, both in the existing facility prior to the transition and in the new facility, will be observed in a focused and replicable way using a protocol that has been developed using the Hogeweyk care. The same residents will be observed prior to and after the transition to the new village, enabling a picture of the lives of resident participants to be built up over time. Observations will be conducted for one hour blocks of time, up to four times a day for two days.

Interviews

In-depth interviews will be conducted with key informants (Yin, 2014) such as facility management, board members, and members of other relevant organisations. Additionally, focused interviews (Yin, 2014) will be conducted with facility staff and volunteers, family members of residents and other significant people in the lives of residents, in order to gather multiple perspectives on the case (Stake, 1995). Interviews will be conducted before and after the transition.

It is important to capture the views of residents because the aim of the transition is to improve their lives and well-being. Challenges in capturing the views of people with dementia and concerns about their ability to meaningfully contribute to research have meant that there is limited research that directly involves participants who have dementia, however this situation is changing and researchers are exploring ways of including the voices of people with dementia in their data (van Baalen, Vingerhoets, Sixma, & de Lange, 2011). Participants who are residents will be offered the option of standard face to face interviews or go-along interviews, a way of conducting interviews where the researcher accompanies the participant on their normal activities, and the interview questions are woven into the routine conversation about what is happening (Carpiano, 2009; Evans & Jones, 2011). Go-along interviews are a useful way of exploring the ways that participants interpret their environments and interact with them, while simultaneously exploring those environments (Carpiano, 2009). This method of interviewing has been used successfully with people with learning disabilities (McClimens, Partridge, & Sexton, 2014), indicating that it can be used with participants who have cognitive difficulties. Because people with dementia can interpret an interview situation as threatening (Murphy, 2007) the go-along interview has been chosen as a way of gathering interview data in a non-threatening way. Interviews will be recorded and the recordings transcribed by the researcher or a professional transcriber.

If facility staff identify that a participant has lost capacity to consent to participate in the study during the course of the study, advice will be sought from their Next of Kin about whether they would be agreeable to continue participating, as per the procedure for participants who are unable to give informed consent. If a participant who has previously consented to participate displays dissent, either verbally or otherwise, during data collection, data collection will be discontinued at that time.

Examination of documents

Organisational documents such as minutes of meetings, email and other correspondence, documents and policies related to auditing, administrative documents and also media reports will be examined in order to supplement and corroborate the data gathered in interviews. Because the physical environment is an important part of the case, photographs will be included as part of the documentation. Photographs of people will only be included as data with the informed consent of the person who has been photographed, or for people who are cognitively impaired the researcher will obtain assent from the participant, and written informed consent from their next of kin for the inclusion of photographs of them in the data for the study.

Procedure for reporting abuse if disclosed by participants

In the event that a participant discloses abuse to the researcher, the researcher will seek advice from the Health and Disability Advocate (Office of the Health and Disability Commissioner) by phoning (09) 373 1060. The researcher will verbally inform the participant of the result of the consultation and take the action recommended by the Health and Disability Advocate. This is explicit in the Participant Information Sheets.

Researcher safety

If a participant wishes to have their interview conducted at a place other than the current Whare Aroha Care facility or the new village, the researcher will ensure that she informs one of the other members of the research team of the address that she will be attending, as well as the time she will be starting the interview. She will phone the other team member to notify

them that the interview has finished. If this does not occur within 90 minutes of the time the interview commences, the other researcher will phone her, and if the call is not answered the Police will be notified.

Data analysis

Miles, Huberman and Saldana (2014) apply a realist approach to data analysis, the procedures they describe, along with those described by Yin (2014), will be used to analyse the project data. Data analysis, will occur parallel to data collection (Costello, 2000), include all of the data collected for the study and be guided by the programme theories identified at the beginning of the study and refined during the course of the study (Yin, 2014). Explanation building is an iterative process involving comparing the data to the theory, revising the theory, comparing the data to the revised theory and repeating the process, considering rival explanations and keeping in mind the purpose of the study (Yin, 2014). Analysis will build explanations of the transition to the new village and the effects of the transition on resident lifestyle, including alternative, or rival explanations.

Analysis and data display processes described by Miles et al. (2014) will be used in the study beginning with coding, a process of grouping similar sections of data together under a descriptive title, prompting the researcher to think about the data. Because, in the proposed study it is important to hear the voices of participants, including facility residents, in vivo coding, using the participant's words as code names, will be used where appropriate, as will process coding, the naming of codes with gerunds to indicate action. Operational definitions for the codes will be developed to ensure consistency of coding. Following initial coding, the coded data will be re-analysed and higher level codes will be developed using abstraction. Abstraction involves thinking about the interactions and combinations of the components of the data to inform understanding of events and subsequent theory building (Pawson, 2013). Analytic memos, providing details of the researcher's thinking and decision-making will be kept. Data will be displayed in a matrix to facilitate analysis and the drawing of conclusions (Miles et al., 2014).

References

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Appendix R. Interim report to the facility management



The Whare Aroha CARE transition study: Report after phase one data collection

Kay Shannon (PhD candidate), Auckland University of Technology

Project supervisors: Associate Professor Stephen Neville and Associate Professor Valerie Wright-St Clair

**The support of the HOPE and Selwyn Foundations is gratefully acknowledged
September 2017**

Background

The end of its lease in Whakaue Street Rotorua presented Whare Aroha CARE age-related residential care facility management with the opportunity to transition to a new model of care for their residents. At the request of Whare Aroha CARE management research is being conducted to explain the transition of Whare Aroha CARE residents to a new village based on the Hogeweyk model (van Amerongen- Heijer, 2015). The chosen model of care enables residents to maximize remaining abilities and live normal lives in a domestic environment.

The qualitative study is utilizing a critical realist methodology (Bhaskar, 1978; Pawson, 2013) and a case study research design (Yin, 2014) to answer two research questions. The research questions are: 1. Why and how has the decision for Whare Aroha Care to transition to a new facility been made and implemented by Whare Aroha CARE management, and: 2. How has the transition affected the way residents live their lives?

Work to date

Before Whare Aroha CARE residents moved to The CARE Village data were collected by interviewing facility staff, residents and family members. Additionally resident daily life was observed and photographs of the physical environment and some residents were taken. Relevant documents were also examined. Informed consent for participation in the study was obtained from participants, including those who were living with dementia, who were supported in their decision-making by their family members. Thirty participants have been interviewed in this first phase of data collection. The daily life of 11 residents has been observed for a total of 82 hours.

Information about the numbers and roles of participants who were observed and interviewed appears in the table below.

| Participant role | Resident | Family member | Staff member |
|----------------------------|-----------------|----------------------|---------------------|
| Participant numbers | 11 | 6 | 13 |

Data collection commenced in January 2017 and concluded in July 2017. Data from phase one of data collection are currently being analyzed and preliminary findings are described below.

Preliminary findings

The first phase of data collection had two purposes. The first purpose was to begin to understand the process of the transition to The CARE Village. The second purpose was to gain an understanding of how residents were able to live their lives in the original facility. This understanding is essential to explaining the effect of the transition on resident daily life, the outcome of the transition.

Preliminary findings indicate that the management of Whare Aroha CARE has facilitated the transition to The CARE Village in a number of ways. Strong themes at this stage of analysis include communicating the vision of how resident life will be in The CARE Village, changing the organizational culture to support the new model of care and fostering relationships to enable the transition to take place. The inclusive culture of the organization, valuing all people including residents, staff and family members was evident at the farewell for a staff member when impromptu speeches were made and gifts were given by residents and family members as well as staff members. Supporting this observation was the response of a resident participant when asked at interview what she liked about living at Whare Aroha CARE, she answered

"Just being with the family." (Participant 18).

Further work to be done

Phase two of data collection will commence in January 2018. Interviews will be conducted with village staff, residents, family members and key informants. Resident daily life will be observed and photographs and documents examined. Study data will be analyzed and explanations of the process and outcome of the transition of Whare Aroha CARE residents to The CARE Village will be developed. The research project will be completed by March 2020.

References

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Appendix S. Report to the facility management after the completion of data collection



The Whare Aroha CARE transition study Progress report 2018

Kay Shannon (PhD candidate), Auckland University of Technology

Project supervisors: Professor Stephen Neville and Professor Valerie Wright-St Clair

The support of the HOPE and Selwyn Foundations is gratefully acknowledged

October 2018

Background

The residents of Whare Aroha CARE Age-Related Residential Care home in Rotorua have moved to The CARE Village, where they live in six or seven bedroom homes with like-minded others. People are accommodated according to previous lifestyle rather than care levels. The chosen model of care enables residents to maximize remaining abilities and live normal lives in a domestic-scale environment.

The qualitative study is utilizing a critical realist methodology (Bhaskar, 1978) and a case study research design (Yin, 2014) to answer two research questions. The research questions are: 1. Why and how has the decision for Whare Aroha Care to transition to a new facility been made and implemented by Whare Aroha CARE management, and: 2. How has the transition affected the way residents live their lives?

Work completed in 2018

Data collection is complete, with a total of 42 people participating in the study. Analysis of the study data is in progress. Preliminary findings indicate a number of generative mechanisms intersected to produce the outcome. A high-level collaboration between the Ministry of Health, Lakes District Health Board and The CARE Village management ensured the contractual and regulatory compliance of The CARE Village. Changing the organizational culture paved the way for delivery of a changed model of care in a new setting. Finally, the change in the physical environment has facilitated greater participation in usual daily activities for residents. I have 45,000 words in draft, with some work completed on each thesis chapter.

Study outputs

I attended the New Zealand Association of Gerontology conference in September 2018, where I presented a paper about the preliminary results of the study (Shannon, Jeffs, Wright-St Clair, & Neville, 2018). Additionally, a journal article based on the literature review has been accepted for publication in Journal of Clinical Nursing.

Further work to be done

I have sabbatical in 2019, when I will complete and submit the thesis and work on further articles for publication. I have submitted an abstract for the International Association of Gerontology and Geriatrics Europe conference in May 2019, and will also submit an abstract for the International Association of Gerontology and Geriatrics Asia/Pacific conference in September 2019.

References

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Appendix T. Report to participants

The creation of a dementia-friendly village in aged care: Report for research participants

Kay Shannon

Thank you for participating in the Whare Aroha CARE transition study. Forty-two people participated in the study. Without your participation the results of the study would not have been complete.

In 2017, the residents of Whare Aroha CARE moved into The CARE Village, a purpose-built village at Ngongataha inspired by de Hogeweyk in the Netherlands. In The CARE Village residents live in small houses with others who have previously lived in similar ways. The village model of care is new to New Zealand.

The study has explained the process and outcomes of the move from Whare Aroha CARE to The CARE Village. This brief report summarises the main findings of the study. The report begins with a summary of the main parts of the process of the transition.

- Management at Whare Aroha CARE worked with staff to help them to care for residents in ways that gave residents greater choice about day to day things
- Management worked with architects and builders to create a village where residents are able to do more of the everyday things that are important to them and give them pleasure
- Management worked with government officials to manage any risks associated with moving to The CARE Village and to change the contract to enable residents with different care needs to live together in the same houses

Moving in-to The CARE Village has resulted in changes for staff, residents and their families. These changes are briefly listed below, beginning with changes for staff.

- The role of the home lead is complex, combining the care, cooking, cleaning and activities needed to run each house. Home leads are responsible for the daily running of the homes, helped by support staff and Registered Nurses.

Residents live in small houses that provide a peaceful atmosphere and reminders of daily activities. They are supported to do things they enjoy, such as cooking, by the staff. The home leads work with the Registered Nurses to care for resident health.

- Residents seem calmer and happier than they were in Whare Aroha CARE. Residents with different care needs are living together and can walk around the whole village if they want to. People who need a secure environment are supported by technology and people who don't need a secure environment can come and go as they please.
- Family members enjoy visiting in an environment that is more like visiting someone at home than visiting them in a hospital. Family members are more confident that help from staff is available when their relative needs it.

The research has shown that in this particular situation the combination of supporting staff to care for residents in ways that respect choice, creating a supportive physical environment and working with government officials has resulted in the creation of a dementia-friendly village in residential care. If any of those elements were missing the outcome is likely to have been different. Thank you again for your participation in the study.

Kay Shannon

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