Towards a model for community integrated residential aged care: Evidence from four case studies in New South Wales, Australia.

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Towards a model for community integrated residential aged care:

Evidence from four case studies in New South Wales, Australia.

PhD Thesis

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In doing so, it addresses three key research questions: 1. How have residential aged care delivery models in NSW incorporated the principles of community integration? 2. How do care receivers perceive the value of community integration? and 3. How well are the needs of high care residents accommodated in the practice of community integration principles? In the investigation of these three research questions, the views of stakeholders and residents are examined in four illustrative case studies of residential aged care in New South Wales via qualitative in-depth interviews. The findings of the research are used to better understand the nature and implementation of community integration by the development of a conceptual model of community integrated residential aged care (CI-RAC) model. This model is developed through a review of theory, research and international exemplars in the aged care sector. The CI-RAC model proposes three components of community integration focusing on a supportive operational environment, a supportive social environment and a supportive built environment of a care facility. The model demonstrates how these three components work together to deliver community integrated residential aged care settings. Secondly, the research proposes a four-tier conceptualisation of what constitutes 'community' for care receivers and providers, arrived at through the empirical findings of this study.

In the light of the findings, the model is extended with a refinement which presents an integrating schema of three cross-cutting dimensions - referred to as permeability, porosity, and propinquity - that seeks to integrate the components of care provision defined by the model.

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This thesis is dedicated to:

Dr. Baskaran Pillai. Ph.D.

CONTENTS

Glossary

Active ageing: Continued involvement of an ageing person in one's family, peer group and community.

Ageing in place: Ageing in place usually means an older person receiving care in their own home. (Aged Care Guide 2018b).

Aged care homes: A residential establishment that provides for a person no longer able to live independently at home. This type of accommodation may also be referred to as a nursing home, an aged care facility or a residential aged care facility.

Aged care assessment team (ACAT): The Aged Care Assessment Team (ACAT) helps the elderly and their carers determine what kind of support will best meet their needs when they are struggling in their current living situation. The team, often comprising a doctor, nurse, social worker and occupational therapist, will ask the client a series of questions to determine the best care options available, either at home or in a residential aged care home (Aged Care Guide 2018b).

Aged care funding instrument (ACFI): The Aged care funding instrument (ACFI) is used to measure the level of care for each residents' needs, based on activities of daily living, resident's behaviour and complex health care. Outcomes are then used to allocate Australian Government subsidy to residential aged care providers to care for the residents" (Aged Care Guide 2018b).

Approved aged care provider: A person or organisation who has been given approval by the Commonwealth Government (under Part 2.1 of the Aged Care Act 1997) to provide care that is eligible for funding by the Australian Government.

Accreditation: A process involving a self-assessment by the service provider, which is then validated by The Australian Aged Care Assessment Team (ACAT) by desk and site audits. Following this review an accreditation decision is made by the Australian Aged Care Quality Agency (Australian Government Department of Health 2018).

Accreditation standards: Services applying for accreditation will be assessed against the four Accreditation Standards:

- Management Systems, Staffing and Organisation Development
- Health and Personal Care
- Resident Lifestyle
- Physical Environment and Safe Systems

Each Standard is divided up into a number of expected outcomes. There is a total of 44 expected outcomes across the four accreditation standards (Australian Government Department of Health 2018).

Accommodation bond: An amount of money paid or payable to an approved provider by the person for entry to a service through which care is, or is to be, provided by an approved provider. A bond is repayable to the persons estate when the care recipient dies; the care recipient ceases to be provided with care by a service conducted by the approved provider; or the service ceases to be certified.

Age cohorts: The current classifications determined by the Australian Bureau of Statistics (ABS) with regards to the age cohorts of the general population are adopted as follows:

- Working Age population - aged 15-64 years

- Older people - aged 65 years and over
- Older people – aged 85 years and over (ABS 2019a)

Due to the nature of conditions such as dementia, it should be noted that residents of residential aged care can comprise of all three of the above age groups, although higher needs are generally associated within the 'older persons' categories, particularly 85 years and over.

Alzheimer disease: Alzheimer disease is the most common type of dementia, it is characterised by short-term memory loss, apathy and depression in the early stages. Onset is gradual and decline is progressive. Alzheimer disease is most common among older people with dementia, particularly among women.

Care plan: A care plan outlines a person's care needs, the types of services he or she will receive to meet those needs, who will provide the services and when. It will be developed by the service provider in consultation with the care receiver or their family.

Community: 'Community' is usually identified in terms of the internal interactions amongst residents, interactions with the external local neighbourhood, as well as the social connections an individual has beyond the local area. This thesis will show that two additional levels of community are important, shown in Figure 9.1.

Community integration: For the purposes of this thesis, community integration represents an approach to residential aged care that seeks to optimise social linkages both between residents and staff within the facility as well as with the external community through mutually initiated planned and unplanned social activities.

Communal facilities: A range of amenities and services for residents, which may include such elements as a community hall, bowling green, swimming pool, barbecue area or recreation centre.

Couples accommodation: Some aged care facilities have accommodation for couples who wish to remain living together, meaning they will not need to be separated in different facilities or rooms. The facility may have double or interconnected rooms, specifically designed or able to be converted for use by couples.

Consumer Directed Care (CDC): Consumer Directed Care (CDC) gives people control when making choices about the types of care and services they wish to receive at home. All Home Care Packages (HCP) are offered on a CDC basis (Aged Care Guide 2018b).

Connectivity: The state or quality of an aged care facility being linked to the local community with ease of access.

Cultural environment: In this thesis the cultural environment refers to the majority ethnic group of the facility. They may cater for particular dietary requirements to be met, and ethnic traditions observed.

Daily accommodation payment (DAP): This is a daily payment contributing to the cost of [A person's] accommodation and is paid periodically i.e. fortnightly or monthly. This is not a refundable payment. The DAP is calculated based on the refundable deposit multiplied by the maximum permissible interest rate and divided by 365 days (Aged Care Guide 2018c).

Dementia care: Specialised care for those suffering with a dementia related illness provided in a formal care setting (Aged Care Online 2016).

Dementia: Dementia is a term that describes a syndrome associated with over 100 different diseases; it is not a single specific disease. It is characterised primarily by impairment of brain function across several possible domains, including language, memory, perception, personality and cognitive skills. The type and pattern of its development, and the severity of symptoms, can differ from individual to individual and according to the specific type of dementia; however, it is typically marked by gradual onset, which progresses over time and is irreversible (AIHW 2017).

Diabetes: A chronic condition in which the body cannot properly use its main energy source, the sugar glucose. This is due to a relative or absolute deficiency in insulin, a hormone that is produced by the pancreas and helps glucose enter the body's cells from the bloodstream and then be processed by them. Diabetes is marked by an abnormal build-up of glucose in the blood, and it can have serious short- and long-term effects. Type 2 diabetes is the most common form and most serious form of diabetes, occurring mostly in people aged 40 or over, and marked by reduced or less effective insulin (AIHW 2017).

Diversity: There is no typical older person. Some 80-year-olds have levels of physical and mental capacity that compare favourably with 30-year-olds. Others of the same age may require extensive care and support for basic activities like dressing and eating. Policy should be framed to improve the functional ability of all older people, whether they are robust, care dependent or in between(WHO 2020).

Environmental design and planning: The internal layout of the facility including the inside living spaces and the outside garden and open space, as well as the interface of the facility with the public realm. Design quality includes the aesthetics of the building in relation to other surrounding buildings. The design of facilities includes variables such as permeability, accessibility and the nature of physical boundaries with the public domain and its form.

Environments: The surroundings, social and physical that include the home, community and broader society, and all the factors within them: the built environment, people and their relationships, attitudes and values, health and social policies, the systems that support them.

Environmental Gerontology: The study of the role of the environment as a significant contributor to the quality and nature of the individual human ageing process.

Ground Floor: The floor of a building closest to ground level; In the USA as First Floor.

Healthy ageing: The process of developing and maintaining the functional ability that enables wellbeing in older age. Functional ability is about having the capabilities that enable people to be and do what they value.

High-care: High care is provided for ACAT assessed people who require almost complete assistance with most daily living activities. It includes accommodation, meals, laundry, room cleaning and personal care. Nursing staff at the aged care home manage the medical needs (Aged Care Guide 2018a).

Inspired care model: Inspired care' is a person-centred approach that creates homes – not institutions – for residents (Uniting 2018).

Low-care nursing homes: Previously known as 'hostel care', this type of accommodation is provided for ACAT assessed people who require accommodation, meals, laundry, room cleaning as well as help with personal care and possibly nursing care (Aged Care Guide 2018b).

LGBTI: The acronym for 'lesbian, gay, bisexual, transgender and intersex' people.

Life expectancy: An indication of how long a person can expect to live, depending on the age they have already reached. Technically it is the average number of years of life remaining to a person at a particular age if age-specific death rates do not change (AIHW 2017).

Population ageing: The rise of the median age within the population of a country due to a combination of an increase in life expectancy and declining birth rates.

Palliative care: The care provided to patients living with a life limiting illness. It supports and improves patient's quality of life by providing medication and pain management. It can be provided at home, in a residential care setting or in a specialist palliative care service like a hospice.

Personal care: Assistance with personal hygiene, washing, showering, bathing, dressing, feeding and toileting.

Privately funded aged care: Non-government funded residential aged care facilities known as supported or assisted living complexes, independent living units and serviced apartments. These do not generally require approval by an ACAT/ACAS prior to a person entering the home (AIHW 2017).

Primary carers: A person who provides the most informal assistance, in terms of help or supervision, to a person with one or more disabilities, or aged 60 and over. The assistance has to be ongoing, or likely to be ongoing, for at least 6 months and be provided for one or more of the core activities (communication, mobility or self-care). Note, this definition applies to the ABS Survey of Disability, Ageing and Carers and may differ somewhat from other collections' definitions. (AIHW 2017)

Respite care: These services are designed to give carers a break from their caring role and can be arranged for planned breaks, regular weekly breaks, short holidays or emergencies. Services are available within the person's home, in a day care centre or in a residential care facility" (Aged Care Online 2016).

Residential aged care Residential aged care is for older people who can no longer live at home. Reasons can include illness, disability, bereavement, an emergency, the needs of their carer, family or friends, or because it is no longer possible to manage at home without help (Aged Care Online 2016).

Registered nurses: Senior nurses who care for the sick and injured in hospitals and other health care facilities, doctors' surgeries, and private homes (Aged Care Online 2016).

Secure dementia care: These facilities have a fully secure dementia care unit or wing exclusively and specifically for people with dementia or similar behavioural related conditions (Aged Care Online 2016).

The Aged Care Act: The Aged Care Act 1997 (Australian Government Department of Health 2018).

Volunteering: The provision of unpaid help, in the form of time, service or skills.

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Abstract

Gerontological theory and ageing policy have long emphasised the importance of older people's participation in the communities around them for active and healthy ageing. How this can be achieved for clientele with higher care needs in residential aged care facilities is a critical question. This thesis sets out to investigate the relevance of supporting higher care needs residents to remain socially engaged with the community, within emerging models of what is termed community integrated residential aged care. It does this through the lens of salutogenic theory and its application in Psychosocial Supportive Design.

In doing so, it addresses three key research questions: 1. How have residential aged care delivery models in NSW incorporated the principles of community integration? 2. How do care receivers perceive the value of community integration? and 3. How well are the needs of high care residents accommodated in the practice of community integration principles? In the investigation of these three research questions, the views of stakeholders and residents are examined in four illustrative case studies of residential aged care in New South Wales via qualitative in-depth interviews. The findings of the research are used to better understand the nature and implementation of community integration by the development of a conceptual model of community integrated residential aged care (CI-RAC) model. This model is developed through a review of theory, research and international exemplars in the aged care sector. The CI-RAC model proposes three components of community integration focusing on a supportive operational environment, a supportive social environment and a supportive built environment of a care facility. The model demonstrates how these three components work together to deliver community integrated residential aged care settings. Secondly, the research proposes a four-tier conceptualisation of what constitutes 'community' for care receivers and providers, arrived at through the empirical findings of this study.

In the light of the findings, the model is extended with a refinement which presents an integrating schema of three cross-cutting dimensions - referred to as *permeability*, *porosity*, and *propinquity* - that seeks to integrate the components of care provision defined by the model.

Chapter 1: Introduction

1.1 The growing need for aged care

i) Population aging

Population ageing is an international phenomenon. As in many other developed countries, "Australia's population is ageing as a result of sustained low fertility and increasing life expectancy…. Over the past two decades, the number of people aged 85 years and over increased by 117.1%, compared with a total population growth of 34.8% over the same period" (ABS 2019b). However, while many people are living longer in better health than previous generations, increasing longevity into old age is not necessarily accompanied by an extended period of good health (Beard et al. 2016). The implications are many, not least for the way older people are cared for later in life. This thesis focusses on an emerging approach in Australia for those requiring formal aged care (termed 'residential aged care' in the Australian aged care system) that aims to be more integrated within the community than traditional care models. As noted in the recent Royal Commission into Aged Care Quality and Safety, "We must work together as a nation to ensure that older people are a critical part of our present, a valued part of our community. Older people deserve our respect as valued members of society, with equal rights to a good quality of life and to services that support their needs." (Royal Commission into Aged Care Quality and Safety 2019a, p. 12).

While the proportion of the older population in permanent residential aged care has been steadily decreasing in recent decades together with the increase in home and community-based care (AIHW 2008, 2011) the numbers have been growing significantly due to population growth and the baby boomer cohort effect. According to the Australian Bureau of Statistics the number of residents in residential aged care has grown from 163,500 people in 2009 to 201,900 people in 2019, consistent with Australia's ageing population (ABS 2015, 2019b). This is an increase of 38,400 individuals requiring residential aged care. A somewhat different, and higher, figure for those in residential care can be deduced from data released by the Australian Institute of Health and Welfare which noted that more than 1.2million received aged care services during the 2017/18 financial year, with 77% receiving at home or in community-based care (AIHW 2019). This implies that the remaining 23% were receiving some form of residential aged care, denoting a figure of at least 276,000 residential aged care recipients. These figures confirm that the numbers of older people in residential care have grown and are significant. As a result, the sector is of major economic and political importance: as of 2018, the residential aged care sector comprised an expenditure of $12.4 billion (67.3%) out of the total government aged care budget of $18.4 billion (Australian Government Productivity Commission 2018).

The importance of this sector is only likely to grow. As noted by the Royal Commission into Aged Care Quality and Safety Report (2019), " … the share of the Australian population aged 85 or older will increase by 83% in the next 40 years ". This is due to simple population growth among the so-called 'Baby Boomer' generation (those born between 1946 and 1964), as well as the increase in the number of those people living beyond 80 years of age. Many of these will suffer from age-related degenerative and debilitating diseases with a concomitant need for higher levels of care (Productivity Commission 2011). Dementia, a strongly age related disease of cognitive decline, has also grown significantly as the aged population has increased (Goldman 2017; Kivipelto et al. 2018). Dementia is now the second leading cause of death of Australians, with an estimated 459,000 Australians living with dementia in 2020, including a daily addition of approximately 250 people (Dementia Australia 2020). These trends will increase the need for high care residential provision. As a recent Productivity Commission report notes: "As people age, their physical and mental functioning can deteriorate, and they may become susceptible to age-related conditions. Almost all (99.7%) people living in residential aged care in 2015 had at least one long-term health condition" (Australian Government Productivity Commission 2018).

ii) Older, but not always healthier

In Australia, as in other comparable advanced economies, the current policy emphasis on 'ageing in place' aims to maintain older people in their own homes where they are provided with the range of social and care programs to support them pursue an active and engaged lifestyle (Fernandez-Carro 2016; Foster & Walker 2014). This policy shift (explored in more detail in Chapters 3 and 4) has led to a major change in the provision of aged care with many more older people accommodated in their own homes while receiving the care they need to remain engaged and connected with their community. However, an increasing number of persons in the very old population lose the competence to remain at home and require alternative institutional care (Australian Bureau of Statistics 2019). This has meant that the cohort of older individuals entering into residential aged care do so at a far more advanced stage of care once they can no longer be cared for in their homes (Andrews-Hall, Howe & Robinson 2007; Jorgensen et al. 2018). While this may mean a shorter length of stay in residential aged care due to delayed entry at a more advanced age, the corollary is that they enter with a higher requirement for more specialised and intense care (Andrews-Hall, Howe & Robinson 2007; Joenperä 2017).

The recent Royal Commission into Aged Care Quality and Safety Interim report in 2019 notes the provision of residential aged care in Australia as "… specialised infrastructure—including

accommodation that is purpose-designed in terms of mobility and safety—and in the use of specialised resources, such as nursing staff, but at the cost of standardised accommodation arrangements and *loss of close contact with the external community*" (Royal Commission, 2019, author's emphasis). The fundamental premise of this thesis is that the increasing numbers of residents entering residential aged care at an advanced age with significant cognitive and physical decline does not necessarily need to result in a decline in close contact with their community supports or loose the personalised care that they would have been receiving while living in their own homes. Innovative models of residential aged care that foster stronger engagement and interaction with the community, however this is perceived by those being cared for, therefore need to be more widely adopted. This thesis aims to develop a conceptual model for how this might be achieved, drawing on examples in practice both in Australia and overseas.

iii) Integration, active ageing and person-centred care

To an extent, this is already happening. Within the broader international context of developed economies, there has been a gradual shift away from geographically isolated aged care homes, to those with a more socially integrated model of care (Bulmer 2015; Foster & Walker 2014). In Australia, however, even though geographically most aged care facilities may not be removed from communities, as evidenced in the first report of the Royal Commission into care facilities, they are not necessarily *socially* integrated into communities (The Royal Commission into Aged Care Quality and Safety 2019). Social integration means assimilation, both socially and in the physical living environment, with the established neighbourhoods and social structures in which the older aged residential population is located. Long standing gerontological research suggests that there is considerable value in the older aged population maintaining social engagement and physical activity within their surroundings as long as they are able to do (Gonzales, Matz-Costa & Morrow-Howell 2015; McPhee et al. 2016). This research shows that it is positive for older people, as well as society as a whole, to promote integration rather than the segregation of older people from both their spatial and social communities. Given the context of higher needs care in an institutionalised setting for growing numbers of the older population, the agencies that provide this care require organisational philosophies and operational delivery models that are supportive of social engagement and integration into the local community.

Residential aged care approaches that are considered to be successfully integrated into their surrounding and/or social communities are often considered to be promoting 'active ageing' through a 'person-centred' care approach (Australian Government Productivity Commission 2018). A person-centred care approach takes into account the unique ageing process of the

individual and their personal needs, preferences and aspirations, while the active ageing paradigm stresses the importance for older people to remain engaged and integrated with their wider community. While the nature of what is meant by integration is unique to each individual, some generalisations can be made. Both these concepts are utilised in the model developed in this thesis.

In particular, using salutogenic theory as its theoretical framework (see Chapter 2), this thesis sets out to investigate models of residential aged care in which the resident is supported to remain integrated and engaged with his or her community. Though the original premise of this thesis focussed on integration with the outside community, the research reveals a more nuanced conception of community that includes both the community within the facility as well as the external community. It is therefore the integration with both the life of the communities within the institution and outside it that is addressed in this thesis, informed through the views of the care receivers and care providers in four case studies in New South Wales, Australia.

The main contribution to knowledge through this research is a proposed conceptual model of community integrated residential aged care (CI-RAC) which is outlined in Chapter 4, Figure 4.1. The model identifies three aspects of the care model of an aged care facility that need to function well in order for community integration to occur. These are a supportive operational environment, a supportive social environment, and a supportive built environment.

This thesis explores the utility of the CI-RAC model in understanding the qualities of residential aged care and its theoretical and philosophical underpinnings, primarily through qualitative interviews with residents and staff in four care homes in NSW. The value of the CI-RAC model in understanding the nature of community integration in aged care facilities is further developed (in Chapter 10) with a cross-cutting multi-scalar three-dimension framework for understanding the quality and degree of community integration, referred to in the thesis as *porosity, permeability* and *propinquity*, which seek to describe different the qualities of the operational, social, and built environment of a facility work together to enhance community integration.

The CI-RAC model is therefore proposed as a tool to inform the implementation of successful community integrated residential aged care facilities and as a guide for examining and improving community integration in existing residential facilities and the care models they use.

iv) So, what is Community Integration?

Central to the research conducted in this thesis is understanding the nature of '*community*'. Four levels of community are identified through this research. At the centre of these is the individual, recognising the balance needed between their need for privacy as well as social connectivity.

The first layer of 'community' are the internal interactions amongst residents. The second layer of 'community' are residents' interactions between residents and staff, family and service providers. The third layer are interactions with the external local neighbourhood, and the fourth and final layer is connectivity with the wider society.

Thus, '*community integration'* means an approach to residential aged care that seeks to optimise social linkages both between residents and staff within the facility as well as with the external community through mutually initiated planned and unplanned social activities. Such connections imply a degree of *permeability* of the facility in enabling interactions to take place between the internal and external communities. They also imply a degree of *porosity* within the facility to support interactions between residents and others. And finally, the facility needs to create an environment which supports relationship building at the interpersonal scale, which for the purpose of this study is termed *propinquity*. Nevertheless, the relative importance and nature of interaction between the different layers of community is unique to each individual. These concepts are introduced in Chapter 10 as an enhancement of the initial CI-RAC model. First, however, it is important to identify the problem addressed in this study.

1.2 The nature of the problem: Ageing societies

Central to the questions about the future of residential aged care and the form and nature of the delivery of services, is the projected extent and profile of the demand for it. As noted above, significant factors influencing the profile of residents is the increasing number of frail people in the 85 years and above aged population brought about by increased longevity. This is a pervasive and structural trend on a global scale.

As defined in the glossary, population ageing in a society occurs when the median age rises due to a combination of an increase in life expectancy and declining birth rates. The result is an increased proportion of the older age groups relative to younger age groups (May 2012b; Kinsella and Phillips 2005; Haub et al. 2011; Van de Kaa, Dirk J 1987; Sanderson and Scherbov 2008; Birdsall et al. 2001). The population division of the United Nations General Assembly in its report *World Population Ageing 1950-2050*, discusses the growing problem as follows.

> "1. Population ageing is unprecedented, without parallel in the history of humanity;
> 2. Population ageing is pervasive, a global phenomenon affecting every man, woman and child;
> 3. Population ageing is profound, having major consequences and implications for all facets of human life;
> 4. Population ageing is enduring. During the twentieth century, the proportion of older persons continued to rise, and this trend is expected to continue into the twenty-first century" (United Nations 2002, xxviii).

As evidenced by this United Nations report, a global trend witnessed in all countries of the Organisation for Economic Cooperation and Development (OECD) as early as 1998 is an increase in persons over 65, accompanied by a decline in those 15 years and younger. This report further states that by 2050, at a world wide scale, the number of persons 60 years and older will exceed the population of persons below the age of 60 for the first time in history (United Nations 2002). This increase in the number of older people has a bearing on the economic and social structures of nations where the older population is increasingly supported by the younger working population (Bloom et al. 2010). Policy and governance in pension schemes and health care funded by taxation become highly affected (Bloom et al. 2003).

In many traditional societies around the world, the older population typically lived in an extended family structure dependent upon the younger generation. Alternatively, the older generations lived in their own home which would be later inherited by the next generation (Foner 1997). This arrangement was based on a mutual exchange of services, with the younger generation providing care for their parents in old age and the older generation providing child care for grandchildren, and passing down their knowledge, values, and life experience, to the growing young in the household (Wang 2011; Stuifbergen et al. 2008). In the majority of Western OECD countries, however, extended family structures are no longer the norm, and the expectation is increasingly for the state to support the care that is required for the older population (Franklin et al. 2009). As a result, with a disproportionately large increase in older populations around the globe, as compared to the working population, governments are becoming increasingly challenged to provide appropriate care levels and funding for the older population (Herrmann 2012; May 2012a). In advanced economies such as Australia, this has largely been framed in terms of a policy choice between maintaining older people in their own homes, which helps them retain the important active links to their wider community (see Chapter 3) through the provision of floating support services and care provided by relatives (often termed 'home support' or 'ageing in place' policies), or more formal residential care in specialist facilities (see Chapter 4). While in recent years the focus has shift to the former, the increased numbers of frail older people needing high care levels has not reduced the demand for the latter. The situation in Australia exemplifies this.

1.3 The Australian situation

According to the Australian Institute of Health and Welfare (AIHW 2015) within the Australian aged care system, residential aged care refers to formal institutionalised care, providing permanent accommodation and care to those of the older population who cannot meet their daily needs without assistance. The lower competence of this segment of the older population may be due to physical ill health or cognitive decline brought on by advancing years. Entry into

residential aged care therefore is often precipitated by a sudden health-related emergency such as a stroke or a fall requiring hospitalisation which leads to the incapability of an individual to return to his or her own home. Dementia is another reason people require residential care accommodation (Schmid and Rittman 2009). The increasing number of older persons requiring institutionalised formal care due to dementia has been a significant indicator of the need to re-think the care needs of those in residential aged care (Francesca et al. 2011).

The range of disabilities in the older population, demonstrates the need for a variety of services accompanying the nature of care needed (Howe 1999). As discussed by Mitchell and Kemp, unlike in younger age groups with impairments, older age group disabilities result from a wide variety of medical problems. These are often multiple in nature which lead on to many different functional limitations on the activities and thought processes of many in the older population (Mitchell and Kemp 2000). These disabilities often require long-term health care services to compensate for functional impairments and to help maintain an older person's psychosocial well-being. In such instances, it is evident that when in-home help is no longer sufficient, entry into formal care accommodation becomes a necessity.

As with diseases leading to physical decline, dementia is a strongly age-related syndrome, and a range of diseases associated with it significantly impair brain function, including language, memory, and perception that also affect personality and cognitive skills (Australian Institute of Health and Welfare 2002). As evidenced by data from the AIHW, these diseases will impact a significant proportion of the older population, with numbers expected to reach approximately 900,000 by 2050, with more than half being females over the age of 75 (AIHW 2017). Currently, forty-five percent of those suffering from a dementia related illness, most commonly Alzheimer's disease followed by vascular dementia, are those in the moderate to severe dementia category and therefore are likely to be in need of residential care accommodation (AIHW 2017). It should be noted though, that the higher number of female dementia sufferers could be attributed to the higher percentage of women in older age cohorts, in comparison to men. Although there has been an increase in life expectancy for both men and women over eighty-five, the number of females is over three times the number of males in this age group, with 2,900 females, for every 800 males (Australian Bureau of Statistics 2014).These changes in the basic demand for aged care support services have been associated with changes in the wider policy environment in which this demand is played out, especially as governments have responded to the increasing costs of such provision. These are in turn, impacting on the nature of the demand for such services, including residential aged care. For example, the policy changes resulting in an increased emphasis on self-funded retirement and self-funded care, accompanied by receding government funding to care homes, is having an impact on higher

costs incurred by consumers for care (Davidson 2016). As Kendig notes, this in turn leads to the increase of financial difficulties for many of the older population (Kendig 2017). But at the same time, the option of purchasing services in their own homes may well give older people the experience of better quality and choice in determining the services they need (Ottmann et al. 2013) , including their capacity to remain actively engaged with their wider community. The increased focus on choice and preference in the nature of aged care, in turn, will affect the design and delivery of residential aged care facilities for people as they become more frail that are likely to lead to consumer driven models of care that better support and enhance the ability of individual residents to retain a strong connection with their wider community to keep them engaged and active (Chapin and Dobbs-Kepper 2001; WHO 2007).

The problem underlying the motivation for this research is therefore twofold: first the perceived failure of the conventional aged care model as commonly employed in Australia care facilities to provide high quality care that aims to support the active engagement of residents with their wider communities of interest(Hicks 2000), as aptly demonstrated in the proceedings of the Royal Commission into Aged Care Quality and Safety (The Royal Commission into Aged Care Quality and Safety 2019) ; and second that alternative models of formalised residential care that include initiatives of community engagement and integration that might achieve this aim remain under-researched (Krajic et al. 2014) including emerging examples in Australia. This gap in knowledge requires investigation into the alternative approaches to providing community engaged care and support in residential aged care situations. This thesis sets out to do this drawing on a variety of cases in terms of scale, location, design and approaches to social integration of residential aged care.

1.4 Research objectives

Of primary importance to this study is the gerontological basis for the support of community integrated aged care. This is discussed in Chapter 2. With that established, the objective of this research is to understand the relevance and viability of different approaches to community integrated residential aged care. An immediate objective is to develop a model of integration in order to carry out this study. This is undertaken by an analysis of the research literature, and international exemplars, from which the CI-RAC model used in this thesis is developed. It is a creative step forward in studying the nature of community integration of residential aged care facilities. This CI-RAC model is then applied to the study of high-needs residential aged care in four selected case studies to examine its relevance for residents and their families, as well as providers and stakeholders of aged care. To the knowledge of the researcher, this approach has not previously been undertaken in either Australian or international research on the residential aged care sector, nor has a conceptual model demonstrating community integration of

residential aged care been previously developed. Importantly, the research is not concerned with making value judgements on the case study care facilities themselves. Rather, the CI-RAC model serves as a conceptual framework to understand the key elements of community integrated aged care based examined from the perspectives of stakeholders and residents.

Each case study demonstrates a particular care model and neighbourhood context. Through the case studies, the research demonstrates the utility of community integrated aged care. The overall objective is thus to answer three fundamental research questions based on an analysis of existing gerontological literature and in-depth interviews of stakeholders and residents of the selected case studies.

1.5 Research questions

This study sets out to answer three inter-related questions:

1. How have residential aged care delivery models in NSW incorporated the principles of community integration?
2. How do care receivers perceive the value of community integration?
3. How well are the needs of high-care residents accommodated in the practice of community integration principles?

1.6 The scope of the research

This research is based in New South Wales (NSW), Australia. It is focused on investigating residential aged care facilities that demonstrate community integrated care models. It is limited to four selected care studies. The basis of the selection of these case studies is discussed in Chapter 5 and the validity of generalising from these cases is discussed in the conclusion of this thesis in Chapter 11.

Importantly, this study *is not* concerned with comparing community integration of ageing in place in a person's own home versus that of institutional aged care. The author fully supports the notion that people should be supported to remain in their home environment for as long as they chose and are able to do so. Instead, the focus here is on reconciling the growing recognition of the importance of integrating older people with higher care needs requiring institutional care with notions of active ageing and engagement with their broader community.

1.7 The Theoretical Framework

This research is concerned primarily with social, behavioural and ecological theories of ageing. It draws in particular on gerontological theories of active ageing, and the internal and external community engagement of residents of residential Aged Care. It also draws on behavioural theories which are important in determining the nature of activities of an ageing individual in

relationship to his or her engagement in the community, while taking into account the unique ageing process of each individual.

These matters are discussed in Chapter 2. First the relevance of gerontological theory as applicable to the individual is examined. The theoretical framework then progresses to gerontological theory as applicable to group behaviour. The ecological theories of ageing are then discussed in understanding the connection of the ageing individual and their community with their physical surroundings. Finally, the development of the biological, social and ecological theories of ageing are discussed culminating in the selection of salutogenic theory as the primary theoretical framework, addressing a person's Sense of Coherence (SOC) based on the three constituent elements of *manageability, comprehensibility* and *meaningfulness* (Antonovsky 1979). The concept of *psychosocially supportive design* (PSD) articulated by Dilani (2001), is then considered as a practical application of salutogentic principles to the physical design of aged care facilities to support community integration. The resulting CI-RAC model extends these to encompass both the operational and social environments of a residential care facility, signifying a contribution to existing academic literature and knowledge through this research.

1.8 Research Methodology

This research was undertaken using a case study approach incorporating mixed qualitative and quantitative methods. The four case studies were scoped through preliminary exploratory discussions with key industry, academic and policy leaders in the field of aged care. The thesis then relies on in-depth interviewed questionnaires with both closed and open-ended questions administered to both stakeholders (comprising of aged care providers, architects, aged care providers and care workers) and residents and/or their families (see Chapter 5).

1.9 The outline of the thesis

Following this introduction, Chapter 2 examines the theoretical basis of community integration for residential aged care and outlines the approach adopted for this thesis drawing on salutogenic theory and the concept of psychosocially supportive design, the broad details of which were noted in Section 1.6 above.

Chapter 3 discusses a review of current government policy in the area of residential aged care and its development in Australia to set the context of the empirical case studies.

Chapter 4 discusses the nature of residential aged care to understand how gerontological theories have influenced practice. Innovative models of residential aged care both internationally and in Australia are then discussed within the common framework of the

challenges posed by population ageing. It culminates in the proposed conceptual model of community integration, referred to as the CI-RAC model, which is used as a basis for examining the community integration practices of the four selected case studies.

Chapter 5 describes the methodology adopted for this study including its qualitative approach, initial scoping interviews, selection and description of the four case studies (Dougherty Apartments, Chatswood; Sir Moses Montefiore Jewish Home, Randwick; Group Homes Australia, St. Ives; and Elanora, Shell Harbour), It then follows with the design of the interviewed questionnaire, its administration, and the ethical considerations of the research. Finally it outlines the methods used for analysis of data and its presentation. The detailed descriptions of the case studies are contained in Appendix 1.

The research findings are presented in four Chapters: 6, 7, 8 and 9. These chapters are divided into two parts. Part 1, Chapters 6, 7, and 8, deals with stakeholder interview findings. Chapter 6 is concerned with the forces that influence community integration of aged care. Chapter 7 reports on stakeholders' views concerning the practice of community integration in view of the increasingly higher care needs of the residents of the including those with dementia. Chapter 8 discusses stakeholders' views on the role of the built environment in community integration based on their experience.

Part 2, Chapter 9, discusses the findings based on resident and families' views including their understanding of what constitutes community and the nature of community integration. The resident sample included for this study is described in terms of their ability/competence level and age. A resident profile for each facility is included in Appendix 1.

Chapter 10 presents a discussion of the findings of this research in relationship to the literature reviewed in Chapters 1 to 4. Firstly, this chapter addresses the question of what the nature of 'community' is as it emerged through the findings of this research. The definition of community, which encompass a range of social and spatial scales, is presented as a four-tier phenomenon.

Building on this more nuanced understanding of what community means to both residents and staff, a multi-scalar three-dimensional schema is proposed in Section 10.6 as a refinement to the initial CI-RAC model to better explain how the community integration aspects of the operational, social and built environment of a facility actually work together *in practice* to create a community integrated environment. Three cross-cutting dimensions are identified as 'permeability', 'porosity' and 'propinquity', which attempt to express how the three structural components of the CI-RAC model work together in delivering a care model that supports

integration across the four levels of community to optimise resident's interaction and engagement both within the facility and with the outside community.

Finally, Chapter 11 draws conclusions based on recent Australian developments in community integration of residential aged care in the light of increasing higher care needs including dementia, by answering the research questions of the study. It discusses the originality of this study and the significance of its findings. The implications for policy and practice as well as planning and design are also outlined, concluding with the implications for future research.

Chapter 2: Theories of ageing and active ageing

It is important at the outset to establish the theoretical frameworks that underpin the importance of older individuals engaging in an active ageing lifestyle and maintaining social connections within their communities to ageing well. including those requiring higher needs care.

The first part of this chapter examines theories of ageing relevant to this study and precedes a discussion of population ageing informed by these theories. The latter discussion elaborates and defines with greater precision the growing challenges presented by an ageing population as an important background to understanding the need for the innovative care models that are detailed in Chapter 4. It focusses on the social, behavioural and ecological theories of ageing that emphasise the importance of active ageing and community engagement of residents of older people, including those in residential aged care.

Table 2.1 summarises the rationale of these theoretical fields which underpin this research. It outlines first the relevance of gerontological theory as applicable to the individual, in recognition of the unique and non-linear ageing process of each person. It then progresses to gerontological theory as applicable to group behaviour. The ecological theories of ageing are then discussed to provide the intellectual basis of this research. An understanding of the connection of the ageing individual and their community, including the behavioural, social and physical aspects, is essential to this study. Finally, these three theoretical fields are brought together into the realm of practice, through the concept of Psychosocially Supportive Design (PSD). The implications of these theories for this research are then discussed. This chapter concludes with identifying the foundational theoretical framework for this research as salutogenic theory applied in practice through Psychosocially Supportive Design as appropriate for understanding community integration of residential aged care.

Table 2.1 Summary of gerontological theories and their relevance to the research

Theoretical Field	Theory	Significance	Key references
Behavioural Theories	Disengagement / Activity Theory / Gero-transcendent Theory	As people age, the nature of engagement and activity will change according to changing needs in social ties and preferences Gero-transcendent Theory: An older person takes a more introspective view of the world, moving away from a materialistic view of a younger age group. This creates the need for time spent alone or positive solitude.	1961: Disengagement Theory of Cumming and Henry (Cumming and Henry 1961) 1961: Activity Theory of Robert J. Havinghurst (Havighurst 1961b). (Rawlins 2017) 1990: Gero-trascendent Theory of Tornstam (Tornstam 2005). (Jewell 2014)
Not specific to ageing, but an important consideration when an individual's autonomy is declining with age.	Privacy regulation Theory	Altman's theory explains why people sometimes prefer staying alone, but at other times desire social interaction. Denotes the importance of individual preferences and nature of interaction by the same person at different levels.	1975: Privacy Regulation theory of Irwin Altman (Altman 1975). (Stanley et al. 2016). (Thibaut 2017)
Also relevant in the environmental gerontology field discussed later.	Affordance Theory	Different people view and use the same space in different ways, according what the patterns of the built environment offers their individual needs and preferences.	1979: James Gibson (Gibson 1979; Gibson 2014)
Social Theories	Age Stratification Theory	Age Stratification explained satisfaction in old age as being dependent on active maintenance of personal relationships and endeavours	Bernice Neugarten 1968 (Hagestad and Neugarten 1985; Neugarten et al. 1965; Neugarten and Datan 1973). (O'rand 2018)
	Life Course and Social Structure /	Leonard Cain emphasised the components contributing to shaping a person's life (Marshall and Mueller 2003). Life	Leonard Cain 1964. (Cain 1964)

	Emerging Life Course Perspective	course is also related to social structures, where individual life experiences are organised by the social relationships and social structure in which individuals are located. Matilda Riley further developed life curse perspective into four structures.	Matilda White Riley 1979. (Riley 1979; Riley 1987) (Settersten 2018). (Hagestad 2018)
Ecological Theories	Environmental Gerontology	Focuses on the mutual relationship between older individuals and their physical and social environments	Kurt Lewin 1986 (Lewin and für Fernstudienentwicklung 2007; Lewin and Vandermeulen 2010; Lewin 1986) Blumer 1986 (Blumer 1986). (Wahl and Oswald 2016)
	Environmental Press -Stress Theoretical Perspective -Environmental Press Adaptation Model -Congruence Model	While the environment needs to evolve to offer the same level of ease in performing a task, there also needs to be a level of challenge in the performance of a task without causing undue stress to the individual. Under the intellectual leadership of Lawton, three ecological models of ageing were subsequently developed; the Stress Theoretical Perspective by Kermit Schooler, the Environmental Press Adaptation Model by Lawton, and The Congruence Model by Eva Kahana	Powell Lawton (Parmelee and Lawton 1990; Nahemow et al. 1973) (Settersten & Angel 2011). (Wahl and Oswald 2016)
Behavioural + Social + Ecological Theory	Salutogenic theory	The reasons people remain healthy, rather than how they get sick. The three principles of salutogenic theory, incorporating the concepts of Comprehensibility, Manageability, and Meaningfulness, form the foundational theoretical framework of this research.	Aaron Antonovsky 1987 (Antonovsky 1979, 1987a) (Apers et al. 2016). (Huss and Samson 2018)
Psychosocially Supportive Design (PSD)	Combination of Behavioural, Social and Ecological Theories in practice	PSD is a design concept derived from salutogenic theory, that is applied in hospital and high-needs care environments supporting the "wellness" model, as opposed to the "illness model". Central to this concept is the role of activity and community engagement.	Alan Dilani (2008) (Schofield and Chambers 2015) (Westrup 2015)

2.1 Behavioural theories: Ageing as a unique process.

In order to understand the theoretical basis for the community integration of residential age care facilities, first it is essential to understand the relevance and nature of social engagement of an ageing individual and how they participate in activities, taking into account the unique and non-linear ageing process of each individual.

2.1.1 Disengagement and Gero-transcendance Theory

Disengagement theory described and explained how an aged person retreats from social engagement. It was the first gerontological theory to be presented in a formal framework and described disengagement from society as a natural process of ageing. This theory was formulated by Cumming and Henry in 1961 in the book *Growing Old* (Cumming and Henry 1961). Fundamental to the consequent development of gerontological theory, Cummings and Henry (1961) however, neglected to factor in the vast diversity of the ageing population by assuming that every older person chooses to withdraw from society as a natural part of the ageing process. A much later development in gerontological theory, presented by Tornstam during the 1970s and formalised as a theory in the late 1990s, gero-transcendance theory, can be viewed as an extension of disengagement theory. It proposes that older people focus more on self-development than being involved in a rational view of the world. Therefore, although an aged person may withdraw from certain activities, a continued connection to society is achieved through activities as mundane as, perhaps, a regular walk or meeting up with others with similar interests which are seen to be more meaningful to their self-development (Tornstam 2005). This theory is relevant to this research in examining the nature of interaction and choice of activity of an older individual typically experiencing a re-definition of the self and of relationships to others. This may influence their social needs and subsequently inform the way in which the social and physical environment on residential aged care can affect an individual's choices about their engagement with other residents and the outside world. Therefore, Gero-transcendent theory is also relevant to this research since it does not focus on exclusion from society, but rather the degree and manner in which an older person chooses to engage or disengage from society according to their new-found aspirations and needs. It is then prudent to examine the relevance and nature of that engagement unique to an individual, particularly in the context of this research addressing the higher care needs residents of residential aged care. Is it still of benefit to a person's quality of life and is it relevant for an ageing individual in higher care needs residential aged care to be engaged and active within their capabilities? This question leads to the discussion of activity theory as an important theoretical development in gerontology which is relevant to this research.

2.1.2 Activity Theory

As a counterargument to disengagement theory, Havighurst formulated activity theory, also known as the implicit theory of ageing, normal theory of ageing, and lay theory of ageing. It suggested that successful ageing occurred when older adults remained active and connected by engaging in social interaction. This theory assumed a positive relationship between activity, quality of life and life satisfaction (Havighurst 1961a).

Activity theory is an important theoretical framework which has been influential in the development of policy and practice of aged care delivery and practice (Estes 2001; Hinterlong 2008). Life satisfaction is a key concept in activity theory. Life satisfaction depends on such variables as health, gender, culture, and socioeconomics, in addition to remaining active in older age. Facilitating opportunities for remaining active is also greatly assisted by the design of the physical environment (Dilani 2008; Frank et al. 2003; van Holle et al. 2012; Cunningham and Michael 2004). This observation suggests that the quality and nature of the physical environment is closely intertwined with the physical and mental wellbeing of the older population. The Australian Psychological Society (APS) further noted four themes as integral elements for building an inclusive society. These elements are the independence and self-provision of individuals, world class care, healthy ageing, and attitudes, lifestyle and community support for all people (Australian Psychological Society 2000). This statement is particularly relevant for older people, as it strongly suggests a focus on active participation of older individuals in society, supporting the concept of community integrated aged care. Central to social engagement, however, is the need for people to be able to also withdraw and have privacy. Activity theory has had an important influence on the development of active ageing policy as discussed further in Chapter 3.

2.1.3 Privacy Regulation Theory

Complimentary to the concept of individual preferences and needs informing the nature of activity and degree of community integration, is privacy regulation theory proposed by social psychologist Irwin Altman (Altman 1976). While not specifically gerontological, Altman's work complements gero-transcendance with its focus on the need for control over the extent of privacy desired by the individual at different points in time. It explains why people sometimes prefer staying alone, but at other times desire social interaction (Altman et al. 1981). It is relevant to this thesis since the traditional model of care catering to the high-needs sector in aged care has largely been based on a nursing home model of care, where individual autonomy and privacy have not been a priority given the frailty and dependence of an ageing person. With recently emerging models of community integration of residential aged care, control of

individual the nature, extent and context of social interaction is considered important, including the social, organisational and physical environments.

2.1.4 Affordance Theory

Also relevant from the field of psychology is Gibson's affordance theory suggesting that a person's behaviour cannot be examined in isolation from the larger context of their social and built environment (Gibson 2014). A critical aspect of the basis of this understanding is Gibson's observations that the world is experienced by the individual as opportunities for action. They pay attention to those aspects of their surroundings which are of importance to them. Therefore, the same environment may be viewed vastly differently by individuals according to the opportunities that are available to each depending on their motivation, needs and ability levels. Similarly, Sadler and Given note that "a reptile in a desert might perceive a large rock as a place to sunbathe or a place to hide; a human might perceive the same rock as a weapon or a building material" (Sadler and Given 2007, p. 117). According to Gibson, in this scenario "the affordances of the environment are what it offers the animal, what it provides or furnishes, either for good or ill. [An affordance] refers to both the environment and the animal [and] implies the complementarity of the animal and the environment" (Gibson 1979, p. 127). In the context of residential aged care, the ways in which an older individual with a declining ability level may use a setting or physical layout of a room could differ from the way in which a more able person is likely to use that same setting.

Therefore, activity theory, privacy regulation theory and affordance theory each provide theoretical perspectives that are useful to the examination of the influences and nature of unique behaviour patterns of older individuals in residential aged care. All theorise the nature of engagement of an older person with their community from and individual viewpoint, but also as embedded in the social and physical environment.

2.2 Social Theories

As this investigation considers institutional aged care, it is not only the behaviour of the individual, but also collective and group behaviours and relationships that need to be considered. A person does not exist in isolation, particularly given higher care needs which require community support and assistance to maintain social engagement. Understanding social theories of ageing, therefore, form an essential basis for this research. Three supportive theories are identified: *Age* stratification theory, which states that satisfaction in old-age is dependent on active maintenance of personal relationships and endeavours; Continuity theory, which stipulates that older individuals continue to maintain their habits, interactions and social connections throughout their life course; and finally, life course theory. Life course is also

related to social structures, where individual life experiences are organised by the social relationships and social structure in which individuals are located. Therefore, it powerfully shapes how people grow old and incorporates unique historical events and periods of social change reflecting the power of social ties and how an individual's life is affected by circumstances and the actions of others. These theories strongly support the idea of ageing within a person's familiar community or physical and social context, giving greater access and ease of maintaining existing social ties, which can be crucial to a positive ageing experience.

2.2.1 Age Stratification Theory

A development of activity theory, Neugarten's, age stratification theory, proposed that satisfaction in old age is dependent on active maintenance of personal relationships and endeavours (Bengtson et al. 2009). Age stratification is a sociological term referring to the hierarchical ranking of a population according to their age group (Anderson 2006; Andersen and Taylor 2012). By virtue of this stratification, certain age groups such as the ageing population could be generalised as less competent than younger age groups leading to social inequality associated with ageism (North and Fiske 2012). Ageism is a sociological concept that particularly addresses the marginalisation of the ageing population (Scott and Marshall 2009) Age stratification therefore, has many implications, affecting not only workforce trends, social norms, and family structures, but also government policies, which then impact on health outcomes (Dannefer and Settersten 2010).

Furthermore, House et al suggests that "psychosocial factors are both macrosocial and microsocial in nature. At the macrosocial level we focus on the system of social stratification in our society. We then try to show how position in the stratification system shapes exposure to microsocial risk factors that are the more proximate determinants of health over the life course" (House et al. 2013, p. 25). This theory becomes important for this research in examining the relevance of integrating aged care facilities into local communities, in order to maintain community connections and lifelong social ties for an older person moving into residential aged care. In Chapter 4, residential aged care and the nature and relevance of maintaining connections with local communities is discussed in detail.

2.2.2 Continuity Theory and Life Course Perspective

As presented by gerontologist and sociologist Robert Atchley in 1971, continuity theory stipulated that older adults try to maintain a continuity of lifestyle by adapting to strategies reminiscent of past experiences (Atchley 1989). Continuity theory is foundational to later theories of ageing because of its emphasis on the role of an ageing person's community to maintain continuity of lifestyle and community connections. In particular, continuity theory is

subsequently elaborated in the development of theories incorporating a life course model. The shortcomings of this theory include its neglect of chronic illnesses of older adults in distinguishing normal ageing from pathological ageing. The 'normal ageing' model taken in the formation of continuity theory was also limited by considering only a typical male population (Powell 2006) .

Life course perspective was initially presented by Cain as 'life course and social structure' (Cain 1964). Cain emphasised the components contributing to shaping a person's life (Marshall and Mueller 2003), noting that life course is also related to social structures, where individual life experiences are organised by the social relationships and social structure in which individuals are located. Therefore, individual life experiences powerfully shape how people grow old (Cain 2018). An individual's life course also incorporates unique historical events and periods of social change reflecting the power of social ties and how their life is affected by the circumstances and actions of others (Marshall and Mueller 2003). Fifteen years after Cains' foundational work on life course and social structures, Matilda White Riley defined the emerging life course perspective (Riley 1987; Henretta 2018) by articulating four central premises:

1. "Aging is a life-long process of growing up and growing old. It starts with birth (or with conception) and ends in death;
2. Aging consists of three sets of processors – biological, psychological, and social and these three processes are all systematically interactive with one another over the life course;
3. The life-course pattern of any particular person (or cohort of persons all born at the same time) is affected by social and environmental change (or history); and
4. New patterns of ageing can cause social change. That is, social change not only moulds the course of individual lives but, when many persons in the same cohort are affected in similar ways, the change in their collective lives can in turn also produce social change." (Riley 1979, p. 4).

For the investigation of this research, the third and fourth stipulation as set out by Riley are particularly significant in ascertaining the determinants of the social interaction of an older person in residential aged care. It is not only determined by an individual's activities and nature of engagement, but also as part of the activities and engagement of a group, or as a community and is central to the argument presented in this thesis that community integration leads to better health and wellbeing outcomes.

These social gerontological theories clearly support the idea that ageing can take place best within a person's familiar community or physical and social context, giving greater access and ease of maintaining existing social ties, which can be crucial to a positive ageing experience. Taking into account the higher degree of cognitive decline of residents requiring continuous care, it can be argued that the more familiar the surrounds, the more likely there will be opportunities to maintain social connections. Familiar surroundings of home or neighbourhood, therefore, should support ease of access and be more responsive to individual needs and preferences, and therefore underpin more successful integration of aged care with the wider communities.

2.3 Ecological theories of ageing

Having looked at behavioural and social theories that help to provide a theoretical framework for this thesis, it is important to look at those that are inclusive of the nature of the built environment in supporting or hindering active ageing. As described by Kendig, ecological theories provide a conceptual and empirical basis for advancing healthy ageing and age-friendly societies (Kendig 2003). The ecological theories are important for this research given its focus on healthy ageing in the residential care sector, where community integration can create better outcomes for older people. This is achieved by embracing the role of both the ecological and social domains which produces the opportunities and impediments to activity and engagement in society of older individuals. Ecological theories are therefore of central importance in understanding how both the social and built environment can assist in accommodating different needs, and behaviour patterns to promote active ageing and hence successful integration of residential aged care facilities into the community.

Environmental gerontology incorporates the role of the natural and built environment as a significant contributor to the quality and nature of the individual human ageing process uniquely to each person. For the purpose of this investigation, two such theories were investigated:

1. Environmental press theory: This theory is foundational for the recognition and development of environmental gerontology and its emphasis on an intricate and interwoven relationship between the physical, social, operational, and cultural environments (Lawton 1982).
2. Environmental gerontology: This theory focuses on the mutual relationship between older individuals and their physical and social environments (Wahl and Weisman 2003; Kendig 2003)

Environmental press theory is not, however, practically applied in the qualitative approach of this thesis but is discussed in relation to its foundational role in the development of Environmental gerontology and its implications for how features in the built environment can be adapted to the declining ability levels of each individual to enable activity and engagement for better ageing outcomes in aged care facilities.

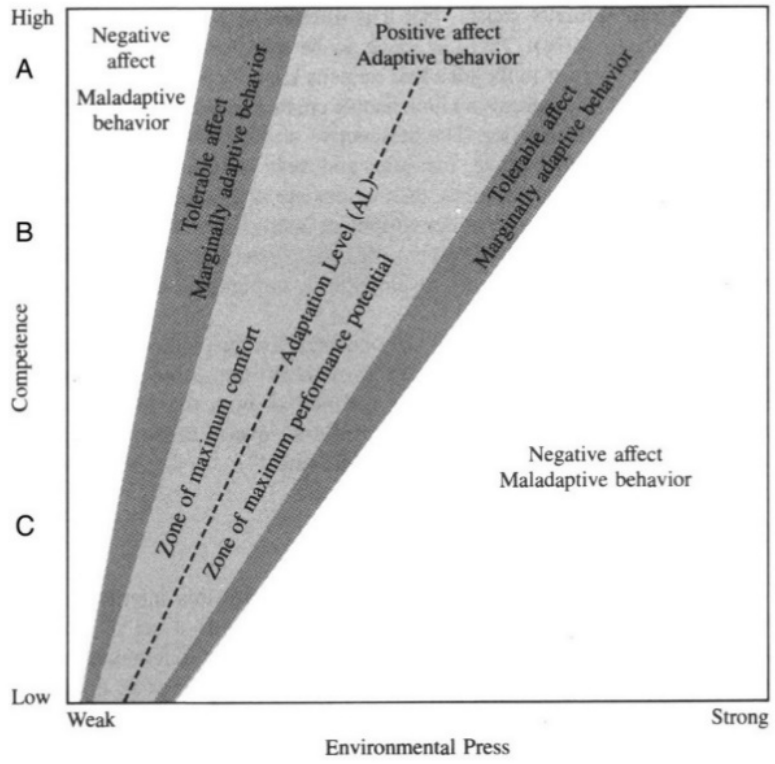
2.3.1 Environmental Press Theory

Environmental press theory developed by Lawton, marked a cornerstone in incorporating the role of the physical environment in facilitating the ease of performing tasks with the declining ability levels of ageing (Lawton 1982; Nahemow et al. 1973; Parmelee and Lawton 1990). Lawton and others stipulated that while the environment needs to evolve to afford the same level of ease in performing a task in relation to the competence of individuals, there also needs to be a level of challenge in the performance of a task without causing undue stress to the individual (Nahemow et al. 1973). Environmental press, therefore, is the degree of challenge of a person's environment that leads to a behaviour-activating response from the user.

Lawton presented a graphic model based on Lewin's Ecological equation, to illustrate the relationship between the person and their environment (Lewin 1986; Lawton 1982). An individual's personal competence could include their social, physical, psychological and intellectual abilities, while environmental press represents the level of stimulus and challenge provided by the environment. The ideal level of environmental press can be arrived at by plotting competence levels on the graph shown in Figure 2.1. In this diagram. Lawton rates a person's personal competence level as high or low, and the environmental press as weak or strong (or the affordances of a particular environment as many or few).

The strength of press can vary in positive, neutral or negative ways (Nahemow 2000; Nahemow et al. 1973; Lawton 1982; Golant 2003). Therefore, by addressing physical environmental solutions for declining ability levels in older people, it is relevant to this research, particularly given the increasingly higher needs of those in residential aged care.

Figure 2.1 Environmental press diagram



(Source: (Brush and Calkins 2008) after Lawton and Nahemow 1973)

Recognising the declining ability levels brought forth by increasing frailty, as well as diseases affecting cognition and memory, such as dementia related conditions, there is a need for appropriate interventions in the built environment which cater for these varied and complex ability levels. As indicated in Lawton's diagram, the ideal adaptation zone for the nature and design of the built environment to incorporate engagement and activity would be in the 'zone of maximum performance potential' supporting stimulation, or the 'zone of maximum comfort' providing maximum support.

Under the intellectual leadership of Lawton, three ecological gerontology models of ageing were subsequently developed: the 'stress theoretical perspective' by Kermit Schooler (1982), the 'environmental press adaptation model' by Lawton (1973), and the 'congruence model' by Eva Kahana (Settersten and Angel 2011; Schooler 1982; Kahana 1982). These models are particularly important to this research as they pertain to long term care environments, such as residential aged care, which is moving towards catering more to higher needs care.

Schooler's 'stress theoretical perspective' (1982) does not directly deal with the design aspects of the physical built environment but emphasises the effectiveness of social supports often provided by family. He also provides a framework for analysing detrimental factors on an

individual basis due to forced relocations, lack of privacy and crowding in many long term care facilities (Settersten and Angel 2011; Schooler 1982). Kahanas' 'congruence model' (1982) was aimed at theorising implications for person-environment interventions to enhance the well-being of the aged. It concluded that "personal and/or environmental characteristics rather than fit were found to be more important along the dimensions of affective expression and institutional control in explaining morale" (Kahana 1982, p. 584).These ideas are of relevance to this research because integration may be influenced by the location and size of a facility, as well as the ease of its access to/for family and friends. In doing so it may reduce the trauma of relocating an individual to formal care when the facility is located in a familiar or local area where the resident has lived.

2.3.2 Environmental Gerontology

The ecological theories of Lewin (Stivers and Wheelan 1986) and Blumer regarding environmental gerontology, focus on the mutual relationship between older individuals and their physical and social environments (Wahl and Weisman 2003). As Wahl and Weisman pointed out, over the previous few decades, gerontological theory has increasingly taken into account the role of the environment as a significant contributor to the quality and nature of the individual human ageing process (Wahl and Weisman 2003). This was given prominence with Parmalee and Lawton's 1990 study which identified a need to escalate research in the field of environmental gerontology (Parmelee and Lawton 1990). Lawton's environmental press theory laid the foundation for the recognition and development of environmental gerontology, and its emphasis on an intricate and interwoven relationship between the physical, social, organizational, and cultural environments (Wahl and Weisman 2003; Lawton 1982; Nahemow et al. 1973; Kendig 2003). Environmental psychologists, Canter and Craik coined the term 'socio-physical environment' in encapsulating the dynamic of this relationship (Canter and Craik 1981).

2.4 Salutogenic theory

The increasingly affluent society of the 1980s saw views of health move away from focusing on recovery from disease to one of supporting health and wellbeing through the prevention of disease. Salutogenic theory, devised by Aaron Antonovsky in 1987 (Sagy et al. 1990; Antonovsky 1979), explained the reasons people remained healthy, rather than how they became sick. Central to this concept was the principle of Sense of Coherence (SOC). SOC is strongly developed if a person sees the world as comprehensible, or believes that the world is comprehensible, consistent, predictable, and explicable. Antonovsky describes this theory as "a global health protective life orientation" (Kroninger-Jungaberle and Grevenstein 2013, p. 2; Antonovsky 1979). This theory, therefore, supports the role of both the social and physical

environment in obtaining positive outcomes for older people in residential aged care. For an increasingly older and frailer population, the nature of their social and physical environments not only can aid the prevention of further decline but, more importantly, can also positively promote health and well-being (Larson et al. 2006).

Antonovsky developed the concept of a sense of coherence (SOC), in order to measure a person's response to a salutogenic environment and its effectiveness in creating better health and wellbeing (Sagy et al. 1990). He noted that a person with a high sense of coherence predicts good health and a low sense of coherence predicts poor health. This concept is based on three central components;

(1) comprehensibility;
(2) manageability; and
(3) meaningfulness.

According to Antonovsky , *comprehensibility* denotes the perception of an individual to his or her surroundings as coherent. *Manageability* is that a person feels equipped with the resources needed to cope with a given challenge or demand. Important to this study with relevance to higher care needs of residents in residential aged care is "that the individual feels that she is influencing that which is happening around her and does not perceive herself as a victim of circumstance" (Dilani 2008, p. 55). *Meaningfulness* is connected to his or her perception that there are important and meaningful phenomena in life. The third component is described by Antonovsky as what motivates a person's Sense of Coherence. (Sagy et al. 1990).

Stokols later contributed to the development of salutogenic design of psychosocially supportive environments from a health perspective incorporating three further dimensions: physical, mental and social important to this study. The physical dimension incorporates ergonomic design and non-toxic environments. Mental health is a person's ability for personal control and predictability also incorporating aesthetic considerations, symbolic significance as well as spiritual elements. Of particular relevance to community integration in the context of this study, is the third element of social health which is a person's accessibility to social support networks. (Stokols 1996).

Considering that residential aged care is increasingly involved in providing higher needs care, incorporating clinical services, the opportunities of the environment must also be augmented by health and medical care support. Salutogenic theory (Antonovsky 1979) highlights the physical aspects of the environment and its role in fulfilling or proving for increased health and wellness of individuals.

As Scambler and Cockerham (2010) point out, viewing an older person's medical needs in isolation neglects the social needs of the resident, as it primarily emphasises the efficient physical care of the resident, not taking into account the psychological aspects of health (Scambler and Cockerham 2010) .

Antonovsky's salutogenic theory encourages a resident's health and wellbeing through a wellness approach rather than by responses to illness. In investigating the degree and nature of community interaction in residential aged care, it is clear that catering to a wellness model responds to recent trends in gerontological theory which promote positive and active ageing, even in cases of the increased frailty and more complex needs of the older population. Salutogenic theory therefore is adopted as the foundational theoretical framework for this research, as it proposes what makes a healthy environment, incorporating individual and group behaviours as determined by the suitability of the physical and social environment supporting a positive ageing environment. Salutogenic theory is also discussed in terms of its application through Psycho-socially Supportive Design, a notion which promotes the design of built environments particularly relating to health care through taking into consideration the social and psychological needs of a person alongside their clinical needs.

2.5 Psychosocially Supportive Design

Salutogenetic theory is also the basis for the concept of psycho-socially supportive design (PSD) formulated by Alan Dilani (Dilani 2008). An architect and founder of the International Academy for Design and Health in Stockholm, he formulated PSD to address the relationship between the design of the built environment and health (Dilani 2008). The concept of PSD was first presented by Dilani in response to the design of health care facilities such as hospitals, in promoting the therapeutic benefits of design (Dilani 2000; Dilani 2001a). In this context Dilani (2004) noted the promotion of health through environmental design (Dilani 2001b, 2004). Dilani (2001) argues that the "The modern disease concept is no longer narrowly pathogenic; rather, disease is seen as multifaceted and having a variety of causes or elements. The salutogenic perspective, which focuses on health promoting processes, has become much more central to the consideration of care philosophies and in the creation of new health care facilities" (Dilani 2001c, p. 20). PSD therefore is a theoretical model that "presents a possible paradigm for health promulgation by design within the physical environment, generally and in particular within healthcare facilities"(Dilani 2001c, p. 13).

Together with his Korean counterpart Lee et al, Dilani further demonstrates the application of PSD for health supportive design in their study of three aged care homes in Sweden, and its

consequent relevance in the Korean aged care context. Significantly for this research, they identify three valuable factors in supporting health and wellbeing for the older population;

> "1) Community integration: These elderly care homes are generally places close to a residential area center or a city center. Services are often shared between residents and community members at large, consequently there is a flow of "visitors" of all ages connecting with the facility on a daily basis. 2) Homelike environment: A noteworthy aspect of Swedish elderly care homes is keeping the facility appearance as homelike as possible. The associations with home may be explored through the appearance and configuration of both the exterior and interior of the building. These homes seemed to be designed with a conscious aim to create a homelike setting. 3) Small scale approach: Clustering of resident rooms is one method through which the small scale approach can be achieved in larger facilities. With unit clusters, the facility can foster opportunities for social interactions among resident. 4) Accessibility to garden and nature: The courtyard is a well developed concept in planning elderly care homes in Sweden. They are generally safe and easily accessible to the residents." (Lee et al. 2007, p. 9)

As demonstrated above by Dilani and Lee et al, the principles of PSD based on salutogenic theory can also be applied to residential aged care delivery and practice. As residential care moves more and more into dealing with higher care needs, health enabling environments can be seen as being of increasing relevance to the future of residential aged care. As Timonen and O'Dwyer point out (Timonen and O'Dwyer 2009, p. 597), "…there is limited research outlining what is important to older people who live in residential aged care settings". In creating health promoting environments, however, it is critical to understand the context of daily living in residential aged care, "…aimed at enhancing and creating conditions for health processes to evolve" (Dilani 2001c, p. 13).

As noted by Mitchell and Kemp (2000), typical models of higher needs institutional care, are based on a medical model serving residents in need of constant medical supervision provided by registered health care professionals. As Asadi-Lari et al (2004) argue, the importance of Quality of Life (QOL) in recent years has developed much traction and agreement among professionals. Within the assisted living environment, examining QOL is relevant for several reasons. Mitchell and Kemp note that one of the foremost reasons for QOL is that "…it is an experience of a component of the assisted living philosophy and needs to be taken into consideration when designing health care and social practice" (Mitchell and Kemp 2000, p. 117). Likewise, Dilani notes that in the design of care facilities, "along with their physical health needs the patient's psychological and social health needs are given major emphasis in the delivery of care activities and in the design of health care environments " (Dilani 2001c, p. 15). It is increasingly evident that the nature and form of residential aged care in the future will be one that increasingly incorporates a clinical health dimension (Dilani 2008; Lee et al. 2007; Schoenborn et al. 2016; Arbaje et al. 2014). Providing for long term care therefore, in this

context requires a multifaceted response that embraces the sociological, psychological and salutogenic needs of the older population.

Dilani describes the typical design and nature of older hospitals with endless corridors as spaces which lead to feelings of anxiety and disorientation, as spaces in which "if you weren't ill before, you certainly might be after waiting for hours in a crowded, stuffy, featureless waiting room" (Dilani 2008). In contrast, he describes the best of the new hospitals that provide psychosocially supportive environments that "challenge our mind in order to create emotion, pleasure, stimulation, creativity, satisfaction, enjoyment and admiration" (Dilani 2001c, p. 22). With the demography of an ageing population with increased frailty and higher needs residents entering into residential aged care, its delivery will need to reflect increasingly on the hospital design model. Unlike a hospital model though, the need for normalcy and salutogenesis in design may be seen as even more significant in residential aged care, as this setting comes closer to serving the functions of a person's residence, home, or place of living.

2.6 Research informed by theory

As noted in the introduction of this thesis, the population of Australia is ageing. The question is: in what way? This section discusses the literature drawn from gerontological theory relevant for community integration of residential aged care in an active ageing paradigm, incorporating the role of dementia.

2.6.1 The population of concern

The older adult population is an increasingly significant one, due to its increase in numbers, containing a wide variety of stages and ability levels, wielding increasing influence socially and politically. For the purpose of better differentiation, rather than grouping all older adults over the age of sixty-five as 'ageing', three broad groups are currently used within the Australian policy discourse, to understand the different needs with increasing age. These groups are defined as *older Persons* (aged sixty five years and over), *oldest-old persons* (aged eighty-five to 100) and *centenarians* (aged one hundred years and over) (Australian Bureau of Statistics 2019). With the ageing of the population, increased numbers in the oldest-old age group are likely to have physical and mental degeneration that has a significant bearing on the quality of life of many of them. In the case of Australia, the increased percentage of those suffering from dementia and related conditions as well as type two diabetes and obesity being projected to afflict many of the ageing population by 2050 (Dementia Australia 2019; Productivity Commission 2011), It could be surmised that older people will need to adapt to many challenges in response to their condition (Kalache et al. 2005). As Baltes (1987) states, learning to live with impairments, disease, and in many cases the absence of support from family, friends, or a

significant other, will require adaptation to contextual change (Baltes 1987; Wahl and Lang 2003). With a rise in single person households, higher divorce rates, and changing social structures, traditional support structures have become less defined and more complex in nature (Kautto 1999). Therefore, with declining ability levels amongst the oldest-old age group, the nature and importance of community engagement and its effects on the ageing process is a significant challenge.

2.6.2 Active ageing

In a social and political environment in which the nature of residential aged care in Australia is moving rapidly in the direction of higher needs care (Royal Commission into Aged Care Quality and Safety 2019c; Andrews-Hall et al. 2007; Borotkanics et al. 2018), it is evident that there should be a bridge between the traditional clinical model and the long-term care model, the latter being concerned with a much broader range of issues to support the wellbeing of the older population (Chenoweth et al. 2009; Schulz et al. 2004; Kemper and Murtaugh 1991; Koren 2010). Norton notes this division generates tensions among care professionals (Norton 2000). The World Health Organisation has noted: "often the long-term care professionals see themselves as protecting their clients from overly-aggressive medical activity, because the price of failure (an untoward event) is higher than the rewards of success, and an aura of therapeutic nihilism sets in" (World Health Organization 2003, p. 81). Older people have made decisions throughout their life factoring in the consequential risks which reflect on their interests and values according to their personalities, and continue to have strong views on how they wish to lead their lives (Nay and Garratt 2009). Therefore, the incorporation of an active ageing agenda which is sympathetic to the needs and wishes of the ageing cohort is an important factor in the development of residential aged care facilities moving towards increasingly higher needs care. To put it another way, it's not just up to the professionals to decide what is best for older people.

Recent studies have demonstrated that the relationship between physical and mental ability levels, and the psychosocial aspects of an individual of older age, can be shown to have effects on that person's level of cognitive wellbeing (Conroy et al. 2010). A study by Bennett *et al*, concluded that a larger social network size was suited to increased cognitive function in Alzheimer's disease, where the social network size modified the association between pathology and cognitive function (Bennett et al. 2006). Fratiglioni, further suggests that maintaining social bonds and remaining active in a person's community may also be a deterrent for the onset of such diseases (Fratiglioni et al. 2004). This conclusion was based on a longitudinal study exploring the effects of three lifestyle components: social network, physical leisure, and non-physical activity on cognition and dementia, with the suggestion that all three components had a beneficial effect on cognition and a protective effect against dementia (Fratiglioni et al. 2004).

As Fratiglioni argues, it is a common belief that an active lifestyle aids in mental and physical wellbeing particularly in older age groups. As Berkman pointed out in a study on the effects of social networks on cognitive ability, it is suggested that social isolation accelerates cognitive decline (Berkman et al. 2000). Fratiglioni's research demonstrated that while many studies have shown that social networks, leisure activities and physical exercise prolong life, they can also specifically diminish the development of dementia and Alzheimer's disease (Fratiglioni et al. 2004). Conversely, as Garfein and Herzog point out, inactivity can be linked to a deterioration of physical and cognitive ability in older people (Garfein and Herzog 1995).

In concurrence with the role of physical and mental activity levels, there have been recent studies to demonstrate that loneliness, lack of social support resulting in loss of companionship and emotional support leading to depression, are linked to deterioration in cognitive levels (Blazer and Hybels 2005; Cornwell and Waite 2009). As Carriere suggests, a socially integrated active lifestyle among the older population would guard against boredom. Carriere also believes that boredom is an inability to maintain attention on an object despite the freedom and ability to do so, and lapses in attention are related to attention-related cognitive errors (Carriere et al. 2008). As suggested by Seib and Vodonovic, the inability to maintain attention and focus, despite the ability to do so, correlates with cognitive functions (Seib and Vodanovich 1998). Therefore, boredom-prone individuals are less likely to have an active and healthy lifestyle (Watt and Blanchard 1994).

An older person's activity level and nature and degree of social engagement is influenced significantly by their cognitive status and physical capabilities (Kolanowski et al. 2006). As Kolanowski suggests, many residents in nursing homes are unoccupied and at risk of poor health outcomes because of inactivity (Kolanowski et al. 2006). Significant for this research is Kolanowski's suggestion that an indicator of the quality of a nursing home is the extent to which residents engage in meaningful activity (Kolanowski et al. 2006).

In the case of nursing home residents, interventions encouraging independence and enhanced quality of life brought on by increased social interaction and activity appear to assist in preventing further cognitive decline (Anderson 2006; Andersson and Abramsson 2012). In addition, dementia related illnesses as noted by the WHO (World Health Organization. Ageing and Life Course Unit 2008) are on the rise, requires a special level of attention (Schreiner et al. 2005; Williams and Tappen 2007; Ballard et al. 2001). The influence of the theories canvassed to the international (WHO) active ageing agenda, and the Age Friendly Communities movement, will be discussed further in Chapter 3.

2.6.3 Dementia and other higher-needs care

Seeman suggests that there is strong evidence of social integration having an impact on the incidence of disease, and that of physical as well as mental functioning and longevity (Seeman 1996; Seeman and Crimmins 2001). Seeman's study of the benefits of social integration, also indicates that both social isolation and non-supportive social interaction can result in lower immune function and higher neuroendocrine and cardiovascular activity, with the opposite taking place within those who have active meaningful social interactions (Seeman and Crimmins 2001; Seeman 1996). Therefore, while greater community integration and social networks of an individual have positive outcomes on health and ability levels, the quality and relevance of those interactions is considered important in maintaining and enhancing mental and physical ability levels.

Kolanowski suggests several factors affect interaction and activity among older persons in a nursing home environment. He believes that residents who are more agitated tend to be excluded from activity programs and that those who are new residents have lower social engagement. When combined with those who are suffering from depression, cognitive impairment, deficits in physical activity as well as those dependant on psychoactive drugs, residents could have withdrawal behaviour symptoms that have impact on activity levels, health and wellbeing, in terms of contributing to maintaining their physical and mental ability levels (Kolanowski et al. 2006). As found by Boyle, in the case of those suffering from Alzheimer's disease, there is a correlation between cognitive status and physical function (Boyle et al. 2003). Therefore, taking part in organised activity and social engagement is seen as relevant for both the cognitive and physical health of those suffering from Alzheimer's and dementia-related diseases. As Berkman states, it is now accepted, after more than twenty years of published research, that social relationships and networks have powerful consequences for physical and mental health (Berkman 1995).

2.7 Conclusion

As discussed in Chapter 1, population ageing, both in the global and Australian context, brings with it significant challenges. These challenges include the form and delivery of residential aged care that is projected to serve the older population requiring specialised higher care needs (Dementia Australia 2019; Vanden Heuvel et al. 2012; Productivity Commission 2011; Royal Commission into Aged Care Quality and Safety 2019c). Activity theory as discussed above in 2.1.2, promotes active ageing by remaining engaged in one's community and is a positive model for ageing. Whilst biological ageing is the key focus of disease prevention, encouraging healthy ageing with healthy cognitive functions is dependent on the role of the total environment of an

aged care facility in supporting a holistic approach to this process, and even helping to prevent negative ageing outcomes.

This chapter has traced the development of gerontological theory, looking at individual behaviour, the broader social context, and ecological theories incorporating the individual, social and physical environment in which older people live. It is clear that the evolution of gerontological theory, at its inception focussing solely on the biological aspects of ageing influencing psychology and behaviour, has increasingly embraced the role of the social and physical environments in which older people live and are cared for. Environmental gerontology, together with psychosocial gerontological theories are crucial in understanding how the characteristics of an aged care facility can be supportive and inclusive of an increasing older population.

For the purpose of this study, salutogenic theory is identified as the primary theory guiding the research, which incorporates the individual, group and ecological considerations of positive ageing environments for those in residential aged care. Salutogenic theory is then applied in practice using the concept of PSD which stresses the relevance and viability of active healthy ageing through a community integrated model of aged care. In the following Chapter, practical applications that demonstrate how elements of these theories have informed international precedents of innovative models of care are discussed, leading to the development of a theoretical model of community integrated residential aged care that is examined via the empirical findings.

Both salutogenic theory and its translation in practice through PSD, as demonstrated in this discussion is inherently based on keeping people active and socially engaged with the community by adopting a wellness rather than a sickness paradigm. This argument is central to the active ageing agenda that has strongly influenced the development of ageing and aged care policy, discussed in the next Chapter 3.

Chapter 3 Aged care policy development

As discussed in Chapter 2, gerontological theory has developed gradually. In its early development only the social and psychological aspects of the nature of community and community building were addressed. Gradually gerontological theory incorporated ecological aspects. Salutogenic theory, a general health and wellbeing theory, delivered in practice through Psychosocially Supportive Design (PSD), form the foundational theoretical framework for this study.

This Chapter details the development of policy demonstrating concepts of salutogenic theory, firstly through the global policy discourse mandated by the United Nations and the World Health Organisation in the form of an active ageing paradigm, and its subsequent filtration of the active ageing concept into the policy context in Australia. This discussion also demonstrates the significance of the selection of salutogenic theory and PSD as the theoretical framework for this research. The aim of this chapter therefore is to show how the development of theory applicable to health and wellbeing of the aging population has been translated into policy and practice in Australian aged care policy. This provides the policy context in which the conceptual and empirical focus of the thesis, the emergence of residential aged care facilities incorporating community integration characteristics, is developed in Chapter 4.

First the chapter discusses the developments in policy influenced by the active ageing agenda globally as set out by the United Nations (UN) and the World Health Organisation (WHO). It then discusses how these agendas provide the context for the development of residential aged care policy in Australia at both federal and state government levels. The discussion of the active ageing agenda and the policy response over the last several decades therefore links the theoretical discussion in Chapter 2 to the following discussion of the feasibility, nature and extent of community integration initiatives for higher needs care, as delivered through residential aged care in Australia.

3.1 Active ageing in the global policy context

The two main origins of current thinking globally on aged care over the last several decades stem from parallel policy reform initiatives, one promoted by the United Nations and a second closely related initiative developed by the World Health Organization. Both strands of policy provide somewhat different perspectives to the issue of active ageing in residential aged care that have influenced Australian policy and practice and are considered in turn.

i) United Nations policy initiatives

Perhaps the two most influential global policy initiatives incorporating the active ageing principle were the International Plans of Action on Ageing from Vienna (VIPAA) in 1982 (United Nations 1982) followed by the Madrid International Plan of Action on Ageing (MIPAA) in 2002 (United

Nations Madrid 2002). The VIPAA was the first international instrument guiding the thinking and the formulation of policies and programmes on ageing. The VIPAA aimed to "strengthen the capacities of Governments and civil society to deal effectively with the ageing of populations and to address the developmental potential and dependency needs of older persons" (United Nations 1982). Among its 62 recommendations that are applicable to this study and its theoretical framework was the inclusion of housing and environment, education, and health and nutrition as key policy directives to support active ageing (United Nations 1982).

Correlating to the development of salutogenic theory, these policy directives championed the contributions of older people to society and the implications of ageing for socioeconomic advancement (Kroninger-Jungaberle and Grevenstein 2013). As Kendig et al note, further developments of this global policy initiative were discussed in the 10-year review of the 1982 Vienna Plan (United Nations OHCHR, 1993), and current advocacy for inclusion of ageing in the influential and more recent UN Millennium Plan post-2015 has cemented the active ageing agenda as the standard for healthy ageing (Kendig et al. 2013; United Nations OHCHR 1993) . Developing on the 1982 VIPAA, the 2002 MIPAA mandated three priority directions at both national and international level: "older persons and development; advancing health and wellbeing into old age; and ensuring enabling and supportive environments" (United Nations Department of Economic and Social Affairs 2002, p. 7). Demonstrating the link to salutogenic theory and PSD, these developments in the global policy mandate have filtered into the policy context of many other countries (Sidorenko and Walker 2004). In this sense, active ageing is particularly important to this study in its practical application in residential aged care where a person's physical and mental ability may be at its highest levels of needing support in order to promote and maintain wellbeing. In this respect, the theoretical basis of this study as viewed through the salutogenic theory discussed in Chapter 2, states the importance in the focus of a person's *ability* level rather than *disability* level. For the purpose of this study, as Holstein and Minkler (2007) notes, active ageing was a 'new paradigm' of ageing which challenges the prevailing norm in perceiving the ageing process viewed through the 'decline and loss paradigm'. The principles set out by the MIPAA support the practical application of enabling environments by emphasising wellness rather than illness through the application of Psychosocially Supportive Design.

Over fifteen years has elapsed since the adoption of the MIPAA and thirty-five years since the adoption of its predecessor, the VIPAA, with numerous iterations to both the policy frameworks. They represent the two fundamental international policy frameworks on ageing and older persons that have attempted to influence policy development on active ageing during the last forty years across the globe. As Sidorenko and Zaidi note, "such international policy frameworks aim at offering universal solutions and proposing unified models for designing national policies in various areas of public concern" (Sidorenko Alexandre, & Zaidi Asghar 2018, p. 141).

ii) World Health Organization policy initiatives

Paralleling the policy initiatives of the UN, the WHO has also addressed the mounting global issue of aged care. According to the WHO, "measures to help older people remain healthy and active are a necessity, not a luxury" (World Health Organization 2002a). As a central theme in advocating the needs of the older population as a priority for development, the WHO's publication active ageing: A policy Framework in 2002, and subsequently updated and extended in 2007, highlighted the importance of social inclusion in the broader communities of the ageing population. It noted that the older population is an "often ignored resource that makes an important contribution to the fabric of our societies." (World Health Organization 2002a; Butler et al. 2007, p. 34; World Health Organization 2002b, p. 6). Active ageing is defined by the WHO as follows:

> "The term "active ageing" was adopted by the World Health Organization in the late 1990s. It is meant to convey a more inclusive message than "healthy ageing" and to recognize the factors in addition to health care that affect how individuals and populations age (Kalache and Kickbusch 1997)
>
> The active ageing approach is based on the recognition of the human rights of older people and the United Nations Principles of independence, participation, dignity, care and self-fulfillment. It shifts strategic planning away from a "needs-based" approach (which assumes that older people are passive targets) to a "rights- based" approach that recognizes the rights of people to equality of opportunity and treatment in all aspects of life as they grow older. It supports their responsibility to exercise their participation in the political process and other aspects of community life" (WHO 2000, p. 13).

Active ageing, as understood here, can be attributed to many determinants inclusive of individuals, their families and the wider society, and includes material conditions as well as socio-economic factors. A combination of all these factors and the interaction among them, as demonstrated in Figure 3.1, are noted as playing an important role in active ageing policy (WHO 2007, p. 5).

Figure 3.1 Determinants of Active Ageing *(WHO 2000, p. 19)*

The 2002 statement signalled a strong trend towards recognising participation and inclusion of the ageing population in community life as a positive move in maintaining health and wellbeing, and the functioning of healthy societies and communities. This was followed in 2007 with the WHO Age Friendly Cities initiative (later renamed as Age Friendly Communities). As stated in the 2007 *WHO Global Friendly Cities Guide*, "Older people are a resource for their families, communities and economies in supportive and enabling living environments" (WHO 2007, p. 1).

Within a context of increasing frailty and care needs of residents in residential aged care, the policy context pertaining to health care services and residential aged care have become increasingly intertwined. Reflecting this close relationship, the 2017 WHO Framework on Integrated People-centred Health Services (World Health Organization 2017) and mandated through the Tokyo Declaration on Universal Health Coverage (UHC), states the need to "provide all people with access to high-quality, integrated, 'people-centred' health services. This must include promotive, preventive, curative, rehabilitative and palliative health services… We acknowledge that health is a human right and that UHC is essential to health for all and to human security. We adhere to the principle of Leaving No One Behind, which requires special effort to design and deliver health services informed by the voices and needs of people. This prioritizes the most vulnerable members of the world's population " (World Health Organization 2017).

Indeed, the recent 2019 WHO handbook for Integrated Care for Older People (ICOPE) identifies intrinsic capacity and functional ability as keys to providing better health and wellbeing outcomes for older persons. Intrinsic capacity and functional ability are defined by the WHO as "the combination of the individuals physical and mental, including psychological capacities. Functional ability is the

combination and interaction of intrinsic capacity with the environment a person inhabits" (World Health Organization 2019a, p. 7).

The concept of active ageing as developed through iterations of global health policy discussed above therefore encompasses a range of possible solutions for delivering an integrated care model that meets the emerging psychosocial need of the increasing frailty of those in need of residential care in order to provide better health and wellbeing outcomes. These have been increasingly reflected in the development of aged care policy and practice in Australia and other countries. The UN and WHO global mandates have both influenced the National Strategy for an Ageing Australia (Bishop 2000), followed by the 'Living Longer, Living Better' Aged Care reforms (Australian Government 2015) leading on to the 2017 review of the aged care reform (Australian Government Department of Health 2017b). The development of these other Australian policy initiatives in residential aged care in Australia are reviewed next.

3.2 The Australian national Policy context

The origins of aged care provision in Australia has its roots in religious organisations such as churches providing assistance to its members in need (Kendig and Duckett 2001a). As Kendig and Duckett note, older people during earlier decades had low expectations, and care was provided primarily through family support and voluntary religious organisations, with little or no government involvement in regulation of service provision. The current highly regulated aged care policy environment in Australia has evolved through the past century from its origins of an entirely non-regulated environment with the expectation that "the delivery of aged care naturally rests in the religious, non-profit sectors; no government at the time would have the financial means nor make the political presumption of interfering with churches or their experts" (Kendig and Duckett 2001b, p. 6).

Government involvement in the provision of aged care in Australia really began with the Aged Persons Homes Act (1954). The initiative provided grants to the existing politically popular and vocal voluntary sector, during the post-war era in response to meet the needs of returning servicemen (Kendig and Duckett 2001b). Following on to the next decade of the 1960's, The National Health Act in 1963, attempted to address the increasing longer-term stay of older persons in hospitals, through pressure from private health insurance companies who were bearing the brunt of the costs of extended hospital stays. In order to address this, the National Health Act introduced substantial nursing home benefits almost on demand, to private as well as voluntary and government providers. Again with little or no regulation on service provision, the nursing home policy was divided between the Health department providing nursing home benefits and the Social Security Department providing "capital subsidies to voluntary organisations, increasingly for nursing homes rather than housing" (Kendig and Duckett 2001b, p. 7).

With the introduction of the Dwelling for Pensioners Act (1969), older people were recognised on the national public housing agenda (Bridge and Kendig 2005a). In the same year the Government also introduced modest personal care subsidies recognising that public housing was necessary for residents who were increasingly becoming frail. However, housing authorities generally did not permit entry or continued residence in public housing for the frail, with housing and hostel programs continuing under a welfare system with little relation to nursing homes or connection to a health care framework (Kendig and McCallum 1990).

The 1970's era under a Labour government saw an increase of equitable access for residential care with the introduction of capital funding and needs-based entry for residents in hostels. Capital funding for nursing home providers in the voluntary sector was also increased (Kendig and Duckett 2001b). It should be noted that an increased emphasis on national policy development also proposed challenges for the Commonwealth in negotiating funding with the State governments. However, as legislated through The Dwelling for Pensioners Act (1969) and the introduction of Medibank providing aged care support in public housing, there was an implicit expectation that good quality health could be available to all who needed it (Dargavel and Kendig 1986)

The lack of integrated care incorporating both health and community services for the older population began to be challenged in the 1980's, with the Combined Pensioners Association (CPA) and the Australian Council on the Ageing (COTA) championing the provision of aged care policy development (Kendig and Duckett 2001a). In aged care, a consolidated Department of Community Services brought together welfare and health aspects of aged care, which had formerly been divided between the Departments of Health and Social Security. However, as Kendig and Duckett (2001) note, although this consolidation considered community and residential care under the same bureaucracy, funding and policy structures were still separate for nursing homes, in the health portfolio, and hostels, in social security portfolio.

As Borowsky (2007) notes, remnants of this separation in culture is still evident in the provision of aged care. This separation of service provision to residential aged care on the one hand and community care on the other is further seen in the then Labour government's ten-year reform of aged care included the 1985 Home and Community Care (HACC) program. The HACC attempted to prevent premature entry into residential care as well while maintaining quality of life for both frail older people and their carers. Significant to this research is that care integrated in the community is seen as separate from care provided in residential aged care. As noted in the above discussion, the two decades of the 1970's and 80s however, saw developments in policy reflecting the increasing social justice and women's rights agenda, and incorporating an independent voice for the rights of the older population. This development has strong correlation with the theoretical review for this study in noting that gerontological theory began to acknowledge the autonomy of older people and their

changing needs, such as demonstrated by Life Course theory, Altman's privacy regulation theory highlighting individual preferences of older people, as well as the ecological theories addressing the suitability of physical environments in supporting evolving needs and ability levels of older people.

The next decade of aged care policy changes were significant with the new Howard-Costello Coalition government in 1996 implementing combined Commonwealth and State funding for aged care as well as devolving service delivery to the States within a broad framework of national guidelines (Duckett and Willcox 2015). At the same time, as Smith (2019) notes the 1997 policy changes introduced by the Howard-Costello government initiated an aged care system that unified the hostel and nursing home systems and allowed the frail older population needing care access to a full continuum of care. Accreditation against new care standards (see below) was also linked to funding and certification arrangements aimed at improving the building quality of aged care facilities.

It is worth noting here that the proportion of residential aged care users have decreased within the past 10 years. Within the Australian policy context, the proportion of older people using permanent residential aged care is referred to as the 'usage rate'. AIHW data note that at 30 June 2008, those aged 85 years and over had the highest rate of use, at 235.5 persons per 1,000, continuing the general decrease in usage rates by people in this age group since 1998. The usage data further demonstrates that usage rates for all five year age groups from 65-69 to 85+ had reduced over 1998 to2008 (AIHW 2008). The AIHW (2011) reports that by 2010–11 the usage rate (5.6%) was below that for 2002–03 (AIHW 2011). These figures indicate that the proportion of older people aged 65+ using permanent residential aged care has decreased over the time frames of 1998-2008 and 2002/3- 2010/11, allowing for the overlap, a total of 13 years. Therefore, while the proportion of older people in permanent RAC is decreasing, as discussed in Chapter 1.1, the numbers are increasing significantly due to population growth and baby boomer cohort effect.

3.3 Current Policy relevant to residential aged care

This section takes the narrative from the late 1990s up to the current time and describes the current policy framework within which residential aged care is located. It is this framework that sets the contemporary context for the conceptual model of community integration in residential aged care presented in the Chapter 4.

3.3.1 Federal Policy

Currently, the heavily regulated Australian Government policy system applicable to residential care is split between Federal and State Government responsibilities, with local government delivery services at a local community level (Australian Government Department of Health 2017a). Federal and State government policies are discussed here since they represent the primary factors impacting on residential aged care delivery.

The Australian Government has an overarching policy framework for funding, planning, and monitoring residential care. Service delivery though is legislated at the state government level. Federal tax revenues, with associated "federal benefits apply to all residents regardless of whether the provider is in the private-for-profit, not-for-profit, or state government sector" (Howe 2002, p. 104). An overarching regulatory framework applicable to all three provider types is now mandated nationally, discussed later in Section 3.3.2. At a Federal Government level, three main care streams are available within the current aged care system. These are: residential care services, community care services, and flexible care services (Productivity Commission 2008). Of these, the sector which is the focus of this research is the residential care sector, formerly known as 'nursing home care' within the Australian policy context. It serves the highest need groups in the older population requiring formalised care. As stated by the Social Policy Research Centre (SPRC), "it is of note that in both child care and aged care, government in Australia took some responsibility from the start, developing early a pattern of providing authority and financial support to voluntary non-government bodies to deal with many of the social needs that emerged" (Fine 1999, p. 18). Particularly during the decades of the 1980s and 1990s, government policy evolved to incorporate formalised residential aged care facilities "with government finance to provide compassionate support of a specialised, professional kind that family members were simply unable to provide" (Fine 1999, p. 18). This direction in policy can also be seen as aligned with the development of gerontological theory recognising the significance of ageing as a non-linear and vastly individualised process based on cross-disciplinary study and research (Bond et al. 1993). While dated, these statements form the basis for the current policy context, particularly as they incorporate developments in social science. The introduction of the *Aged Care Act* in 1997 abolished the separation of 'high-care' provided by nursing homes and 'low-care' provided by hostels. (Courtney et al. 1997).

The global mandate of the active ageing policy framework promoted by the WHO discussed above was echoed in the domestic policy framework in Australia with the *2002 Intergenerational Report* highlighting the impact of the baby boomer generation entering retirement. A *Productivity Commission Report* of 2005 followed by the *Intergenerational Report* of 2007 further highlighted the economic implications for Australia of an increasing percentage of the aged population in the eighty-four years and above age group, but also of increasing disability levels (Treasury 2007; Productivity Commission 2005). These concerns were again prominent in the *Intergenerational Report* of 2010 '*Australia to 2050: Future Challenges'* (Australian Government Treasury 2010). This report influenced the policy changes introduced in 2012, through the *Living Longer Living Better* aged care reforms which were effective from 2014 for all aged care providers who were required to align themselves with the policy changes by July 2015.

The introduction of a residential aged care sector designed to incorporate both high-care and low-care needs abolished under the 1997 Act was therefore embodied in the 2012 *Living Longer, Living Better*

aged care reforms. These reforms specified the provision of a continuum of care levels as a person's ageing needs progress, in the one facility, in order to provide 'ageing in place' (Australian Institute of Health 2012). With the introduction of this policy, the federal government also took responsibility for mandating a national policy framework for aged care services which included community- based services for the aged (over 65). This change in policy influencing aged care delivery models could be seen at the time as influenced by the development in gerontological theory which had extended to incorporate the psychosocial needs of the older population. Included in the *Living Longer Living Better* reforms was the introduction of the *Dementia and Severe Behaviours Supplement* (Federal Register of Legislation, 2013). This supplement was, however, short-lived and was discontinued from 31 July 2014 because the initiative was deemed financially unsustainable for the government to maintain given the increasing percentage of older adults suffering from dementia (Ageing and Aged Care, 2013). Nevertheless, a global drive for the inclusion of the growing ageing sector of the older population into communities for better health and wellbeing outcomes was still taking place. Describing the reforms as giving people greater choice and care based on their needs, the 2015 review identified four areas in which these reforms were implemented: sustainability, affordability, choice and flexibility (Australian Government Department of Health 2017a).

An important component of these policy changes is the formation of the *Aged Care Financing Authority* (ACFA), which has been given statutory recognition as an independent agency to assess the suitability and needs of an older person's entry into residential aged care (ACFA 2014). Other significant components of these reforms affecting residential aged care were the removal of the capping of daily payments in higher needs care and allowing lump sum payments for care for the remainder of residents' lives to be made to aged care providers (ACFA 2014). The choice of model is given to the resident or their family as to the mode of higher care payments being either periodic or in a lump sum, as well as removal from the regulatory restrictions on charging for higher care payments by aged care providers (Aged Care Financing Authority 2015). This has been seen as presenting challenges to aged care providers who depend on lump sum payments by residents to refinance capital for providing care and acquiring or building facilities. However, an incentive for the growth of new building work and refurbishment of existing aged care facilities was provided by an increased accommodation supplement for residents of such facilities (Aged Care Financing Authority 2015).

Legislated in 2015, and currently funded under the Commonwealth Department of Health, the Commonwealth Home Support Program (CHSP) as well as Home Care Packages, were required to incorporate a Consumer Directed Care (CDC) approach to service delivery. The CDC approach is designed to give the consumer greater flexibility and choice in their choice of care and delivery (My Aged Care 2016). With a focus on keeping older individuals independent in their own homes enabling an active ageing paradigm, the CHSP provides care through CDC packages to older individuals who require assistance with day-to-day activities but are able to exercise their own

independence or are under the care of a nominated formal carer. These packages are funded through tailored funding packages. (Ageing and Aged Care 2019b). Prospective care receivers are assessed and placed on a national queue, and once the appropriate level of package becomes available, the approved providers then liaise with care receivers or their carers to tailor services to their needs. Further, with the aim of increasing access to home care services as well as consumer choice, the Australian Government implemented the 'Increasing Choice in Home Care' measure, effective from 27 February 2017. This initiative awarded the home care packages directly to the consumer and provided for consumers to in turn choose their home care provider to direct the government subsidy to their chosen provider, as opposed to the previous legislation which awarded the home care packages to approved providers. These changes in legislation were implemented for greater consumer-driven, market-based responses to aged care services. (Ageing and Aged Care 2019b).

However, McCallum and Rees note in their 2017 report on *Consumer Directed Care in Australia: Early Stage Analysis* for National Seniors Australia that "there is some risk of market failure occurring in the delivery of CDC. Some consumers are experiencing lack of choice, insufficient or non-existent service provision, problems in accessing the My Aged Care gateway, and the need for advocacy and coaching". (McCallum, J. & Rees, K. 2017, p. 4). In other words, market-driven home-based care options are not always delivered is the way they were envisaged.

Nevertheless, with the predominant focus on maintaining older people their own homes and providing individualised care packages to support them living independently, it can be argued that options for residential aged care envisaged under these ongoing reforms could be viewed as a sub-optimal alternative to 'care in the community' options. The predominant policy thrust has been to stress that residential care should be obviated by home-based care and home support packages wherever possible so that people will have greater choice and flexibility to stay in their own homes (Australian Government Department of Health 2017b).

The dilemma between delivering aged care in an individual or group setting was identified by the recent Royal Commission on the future of residential aged care which noted " …residential care secures economies in specialised infrastructure—including accommodation that is purpose-designed in terms of mobility and safety—and in the use of specialised resources, such as nursing staff, but at the cost of standardised accommodation arrangements and loss of close contact with the external community aged" (Royal Commission, 2019). The premise of this thesis is that the application of active ageing principles in residential aged care should mean that close contact with the external community does not necessarily have to decrease if innovative models in residential aged care are introduced as the norm, rather than the exception. Those who *cannot* remain in their own homes and who require continuous and constant formal care, should benefit from the same kind of active support delivered in a residential aged care setting in order to maintain quality of life and have positive health

and wellbeing outcomes, including connectivity to the community. The principles of consumer directed care should therefore inform an active ageing model that supports a broader concept of well-being in residential aged care, even for those with high care needs.

To that end, a 2014 report on the '*Applicability of Consumer Directed Care principles in residential aged care homes*', for the Department of Social Services, the authors KPMG note three key findings:

- "CDC is both a philosophy and an orientation to service delivery where consumers can choose and control the services they get, to the extent that they are capable and wish to do so. Person-centred practice is a key component of CDC. It emphasises the wellbeing and quality of life of the individual person, as defined by the person. Consultations for this project indicated a high level of support for person-centred practice in residential aged care but suggested that the extent to which current practice is genuinely person-centred appears to vary considerably.
- International literature indicates some key features of consumer-direction in aged care homes including returning control and decision-making to residents; empowering direct care staff; transforming the facility into a more home-like environment; and inverting the formal decision-making chain. Consultations conducted for this project indicated broad, qualified support for these features, but did not identify many examples of their application in Australia.
- Australian literature suggests that current regulatory and funding environment is perceived as a barrier for aged care homes in providing more flexible care and support. The consultations confirmed that this is a widely held view. Overcoming this contention that regulations and funding are a barrier to CDC is a challenge that will need to be considered as the sector reorients to CDC." (KPMG 2014, p. 3).

It is clear from the above that within the Australian context, the development of policy has shifted from the separation of higher care needs to a more integrated form within this sector. It now encompasses an active ageing health and wellness care approach. As noted by the Prime Minister's Science, Engineering and Innovation Council in its report for promoting healthy ageing in Australia, notes healthy ageing as an "active, healthy, productive, positive or successful' ageing approach that sees ageing in terms of opportunity and capacity rather than decline and degeneration. This approach recognises that there are actions to be taken which can improve the outcomes for ageing individuals and Australian society" (PMSEIC 2003, p. 1). It is of note however, that higher-care needs individuals who require continuous formal care are a growing number of older individuals of the ageing cohort who may not be able to age in place in their own homes (Australian Bureau of Statistics 2019; The Royal Commission into Aged Care Quality and Safety 2019). To be truly effective, the person-centred policy language must flow through to higher-needs care in residential

home settings incorporating active ageing and community integration principles. It is of note that even though Australian policy may lag behind most European countries in creating an inclusive environment for ageing, Australian aged care practice has incorporated and developed good practice models of care based on the European models to answer a growing demand for services and support. Some 75% of aged care providers in Australia are within the not-for profit sector, whereby they are likely to be ethically bound to value care provision over profit (Kendig and Duckett 2001a; Kendig et al. 2014; Russell 2018).

3.3.2 Regulatory framework applicable to residential aged care

Given the importance of regulation and standards with which residential aged care facilities must comply, it is worth outlining the current regulatory environment for the sector that provides the structure within which the organisational functions of residential aged facilities have to operate. This has an important impact on how well such facilities are able to embrace innovative service delivery models to deliver consumer directed and community integrated care approaches.

The Aged Care Quality Standards, contained within the *Quality of Care Amendment (Single Quality Framework) Principles 2018*, is the overarching regulatory framework governing aged care provision within Australia (Australian Government, Federal Register of Legislation 2018). From July 2019, this single set of quality standards incorporating an end-to-end, market-based system developed with the aged care sector has been applied to all Australian Government funded aged care services including residential care. The intention of this single quality framework is that the consumer drives the quality of care and service provision. This includes;

- "a single set of quality standards for all aged care services called the Aged Care Quality Standards;
- improved quality assessment arrangements for assessing provider performance against quality standards;
- a single Charter of Aged Care Rights for all aged care recipients; and,
- publication of improved information about quality to help consumers choose aged care and services". (Ageing and Aged Care and Australia. Dept. of, Health 2019).

The Single Quality Framework aims to not only increase the quality of outcomes for aged care recipients, but also to recognise the diversity of providers and consumers, better target assessment activities incorporating best practice principles, and reflect best practice regulation. The introduction of the new *Aged Care Quality Standards*, replaced the previous regulatory framework which operated in the four different areas of;

- Accreditation Standards
- Home Care Standards

- National Aboriginal and Torres Strait Islander Flexible Aged Care Program Quality Framework Standards
- Transition Care Standards.

The Aged Care Quality Standards now apply to all aged care services including residential care, home care, flexible care and services under the Commonwealth Home Support Programme. However, there is a degree of flexibility in its application to the different service types, as outlined in the Application of Aged Care Quality Standards by Service Type (Ageing and Aged Care 2019a) , which provide for State and territory policy frameworks that may also be applicable.

The Aged Care Quality Standard (2019), consists of eight standards;

- Standard 1 Consumer dignity and choice
- Standard 2 Ongoing assessment and planning with consumers
- Standard 3 Personal care and clinical care
- Standard 4 Services and supports for daily living
- Standard 5 Organisation's service environment
- Standard 6 Feedback and complaints
- Standard 7 Human resources
- Standard 8 Organisational governance.

Each of the above eight standards include a statement outcome for the consumer, a statement outcome for the service provider organisation, as well as organisational requirements to demonstrate that the standards have been met.

With respect to this study in the delivery of aged care within a residential aged care environment with an increasingly complex and higher needs care user group, a multitude of service levels and delivery options may need to be incorporated. In this instance, the standard stipulates that "under cooperative recognition arrangements a Multi-Purpose Service's performance against a number of standards/accreditation requirements can be assessed through a single process. These arrangements are specified in the payment agreement between the Department of Health, the state/territory government and the service provider" (Ageing and Aged Care 2019a, p. 2).

3.4 New South Wales Policy

For the purpose of this research NSW State Government policy is discussed here, as the four case studies contained in this study are all located in NSW. Filtering down from the broader framework of policy at Federal Government level, the state governments in Australia are responsible for providing access to the older population to the services mandated by federal policy. These services include transport, health care, social housing and justice as well as access to public spaces, intended to enhance opportunities for older people to lead a better quality of life. At state government level, the

NSW Government is responsible for enhancing the quality of life of older people across the state. Partnerships are made between the state government, local councils, non-government, and not for profit organisations in the delivery of these services. However, it is in the area of planning policy that State governments take on a substantive role in the delivery of aged care facilities.

As the case studies chosen for this research are located in New South Wales, state planning legislation as applicable to aged care in NSW it is important to see this in its historic context and development. A significant item of state government legislation in this respect is State Environmental Planning Policy No 5 (NSW) (SEPP 5) Housing for Seniors and People with Disabilities, initiated in 1982 (NSW Government Planning & Environment 2018). This legislation, unique to NSW, mandated the provision of sufficient housing for seniors and people with a disability (Roseth 1987). The 2004 replacement of this original mandate incorporated the consideration of the character and feel of local neighbourhoods in provision of seniors' housing with the new State Environmental Planning Policy Seniors Living (NSW) (Knowles 2004). This legislation stipulates the location and access to aged care facilities being not more than 400m from essential services such as "(a) shops, banks and other retail and commercial services that residents may reasonably require, and (b) community services and recreation facilities, and (c) the practice of a general medical practitioner" (Knowles 2004, p. 17). This clearly addressed the need for seniors' housing and aged care facilities, seniors living developments and retirement villages to be developed within established neighbourhoods, with proximity to services that encourage ease of physical access and which facilitate an active ageing agenda focusing on health and wellbeing and community integration.

A significant outcome of the original SEPP5 and its successor SEPP (Seniors Living) has encouraged aged care development within established neighbourhoods which would otherwise have not been possible due to zoning restrictions and competition for good sites with the private development sector of regular commercial and residential properties. The entry of the private development sector combined with the availability of land for aged care development and other non-institutional seniors housing, is an important historical step in the physical integration of aged care facilities within established communities with proximity to commercial and transport infrastructure. This development in policy reflects the change in gerontological theory which had also developed from one that focused on the disabilities and social disengagement of the ageing individual to theories that encompass the individual, the interaction of older individuals in the broader community, the importance of incorporating the planning and design of the physical environment for positive ageing, and finally moving to a health and wellness focused approach.

Another step forward significant to this study, was the 2012 release of the first development of the NSW State Government's strategy on ageing (NSW Government Family & Community Services 2012). Its intention was to develop strategies to best answer evolving aged care needs going into the

future. These strategies, released in 2016 under the title *New Ageing Strategy 2016-2020* included strategies on "the priority areas of health and wellbeing, working and retiring, housing choices, getting around and inclusive communities" (NSW Government 2016, p. 32). Here, inclusive communities, as one of the five key policy areas, is particularly of relevance to this study, as it underpins the delivery of community integrated residential aged care. The objective of 'inclusive communities', as noted in this policy directive for "older people in NSW (is to) stay connected and contribute to their communities" (NSW Government 2016, p. 32). This concept is expanded in incorporating the key principles of living in communities that are inclusive, preventing isolation of older individuals, as well as providing opportunities for older individuals to make a positive contribution by staying connected to their communities, where they are included, respected and recognised. Significantly for this study, in examining the nature of Active Ageing in enabling community integration for residential aged care, the policy notes the importance of the integration of services and facilities which enable older individuals to stay active as well as protect them from abuse. The inclusion of those suffering with dementia in the policy's mandate of diversity and acceptance, is significant for this study in supporting the concept of greater community integration of residential aged care.

3.5 Conclusion

The discussion of policy both globally as mandated by the WHO and comparable policy initiatives by the UN, in the domestic context in Australia, and corresponding to the gerontological theory framework identified for this research, demonstrates the relevance and need for an integrated approach to residential aged care delivery. Incorporating principles of Active Ageing and consumer directed care, not only in the integration of service provision, but the integration of the frail older population within institutional care with their community and environments, provide possible solutions to such an integrated aged care paradigm. Whilst contemporary theory and practice demonstrate that the majority of the older population requiring a degree of care can be cared for in their homes, there will nevertheless be some who are likely to require residential aged care. In this context. Therefore, integration with their broader community should be a part of the continuum of care. As Chenworth notes, aged care recipients now have considerable influence in the direction of policy development in the current policy context (Chenoweth et al. 2009). This concurred with the concepts of salutogenic theory and its application in practice through PSD, in the consideration of aged care recipients as active agents of their own life choices supporting an active ageing agenda.

The current policy context therefore reflects clearly the theoretical framework identified for this study culminating in salutogenic theory and the applied concept of psychosocially supportive design extended to the delivery of residential aged care. Antonovsky's salutogenic

theory states the importance of a wellness focus rather than a sickness focus. Dilani in turn has extended the wellness focus to include consideration of the built environment as proposed in the concept of PSD to higher care needs environments such as hospitals and aged care facilities (as discussed in Chapter 2). Subsequently, the argument of this study in demonstrating the importance of not only the integration of services in aged care delivery but integration of the frail older population themselves irrespective of physical or mental ability levels into the community in influencing future directions in policy development is demonstrated by Dilani's Psychosocially Supportive Design.

In reality, the boundary between home care and residential aged care is now blurring, with the introduction of innovative aged care models that are integrated into the community. A variety of these models as relevant to this study is discussed the next chapter, leading on to the development of a model for community integrated residential aged care that provides an analytical framework for the empirical component the thesis.

Chapter 4 Towards a Model of Community Integrated Aged Care

This chapter provides a definition and explanation of the concept and terminology of community integrated aged care used in this research, its relationship to the concept of active ageing and the age-friendly communities movement, generational attitudinal change and the implications of an increasingly higher needs cohort in residential aged care. It then introduces five innovative international precedents that demonstrate aspects of a community integrated approach in practice. Drawing also on the progressive development of gerontological theory and its influence on policy development in Chapters 2 and 3, it then presents a conceptual model of community integrated aged care which provides a conceptual framework to present and assess the empirical findings in Chapters 6, 7, 8 and 9 from a salutogenic theoretical perspective which was identified as the most appropriate theoretical framework for this study.

4.1 The nature of 'community'

What is meant by 'community' is a complex, allusive and contested, but is critical in understanding what is meant by community integrated aged care in this research. Historically, the definition of community dealt purely with the social bonds among people, but gradually incorporated physical settings within which these bonds develop. Raymond Williams in his Keywords, *A Vocabulary of Culture and Society*, refers to the origin of the term community as stemming from the Latin *communis*, meaning "common, public, and shared by all or many" (Williams 2014, p. 42). George Herbert Mead (1863-1931), the seminal philosopher and sociologist in the nineteenth century, discussed how the mind and the self of a person were developed as a result of social processes (Mead 1934). He argued that an individual's personality and behaviour is largely influenced and dependent on interactions with others or their community. Mead termed significant relationships who influenced a person's life significant others, and further conceptualised the term "generalized others" to demonstrate attitudes of a social group (Blumer 1986). Max Webber (1864-1920), theorised the concept of 'verstehen' which denoted that in order to accurately predict and understand social or group behaviours, one must immerse themselves in that particular cultural context, while also making allowance for the cultural bias of even the researcher (Weber 1978, 2009). This approach allows for a deep understanding in examining the meaning of social relationships and group behaviours to the effects it produces (Weber 2009). These historical understandings of theorising social behaviour and communities are centred on the psychological bonds within a group.

By the 1990's however, the physical environment also became incorporated as an important factor in the creation of community. Patrick and Wickizer provide an integrated definition of three elements that form community:

> "1. A place denoted by a geographically bounded location;
> 2. Social interaction, in which social networks and social supports are crucial; and
> 3. Political and social responsibility, involving political and social motives in the formation of communal groups" (Patrick and Wickizer 1995, p. 46).

This is a key definition in relation to the subsequent development of the community integrated residential aged care (CI-RAC) model below as it opens up a wider conceptualisation of what community means to include social as well as spatial notions which transcend strictly locational or group-defined attributes.

An expansion of the social and locational determinants of community by MacQueen et al (2001) further captures the dynamic of diversity in the formation of community in their definition:

1. "A locus, a sense of place, referring to a geographic entity ranging from neighbourhood to city size, or a particular milieu around which people gathered (such as a church or recreation centre);
2. Sharing common interests, perspectives, and values that could cross geographic boundaries;
3. A joint action, a sense of coherence and identity, including informal common activities such as sharing tasks and helping neighbours, but these were not necessarily intentionally designed to create community cohesion.
4. Social ties involving relationships that created the ongoing sense of cohesion; and
5. Diversity referred not primarily to ethnic groupings, but to the social complexity within communities in which a multiplicity of communities co-existed" (MacQueen et al. 2001, p. 1929).

MacQueen et al. (2001) also found that interviewees in their study comprising of 118 respondents of diverse communities in the United States, varied in how they viewed the importance of each element according to their personal needs and preferences. They further highlighted the need for health providers to tailor interventions to various levels of community according to the varied definitions of community unique to each group. This is an important finding for this study in recognising the vast diversity, and non-linear process of ageing for each individual and their experience of community.

Building on the definition of community set out by MacQueen et al, Brown summarises the definition of community into four elements:

1. "Communities include a variety of geographic and trans-geographic groupings, and sometimes involve a mixture of both types;
2. Whether bounded or un-bounded, communities only function effectively when they provide social support through social networks;
3. Communities generate collective social action, but are also formed as a result of such action; and
4. Community definitions change, even over a short time period" (Brown P 2004, p. 2).

The incorporation of the element of social activity in building community is of note for this research in the context of the healthy ageing agenda as set out by the World Health Organisation (WHO 2007).

In sum, it is evident from the above literature that the term community is used in many different ways. It can refer to the interactions among members of territorially based groups to small groups, incorporating the dynamics of interaction within and between the micro and macro levels of a society. Therefore, considering the broader definition of community to capture social, geographical, built environment, and gerontological determinants, five principle elements are assumed for this study:

1. A community consists of multiples levels of social interactions;
2. Each individual is a member of a set of communities;
3. A community is diverse in their needs and function;
4. One meaning of community is a geographic area; but
5. A community is also formed of social networks and responsibilities.

The concept of community for the purpose of this study is therefore used in its broader sense with all of its dimensions of social interactions, networks and support structures, social responsibilities and physical geography. This definition of community as it applies to residents of aged care facilities in this study underpins the definition of the CI-RAC model proposed later in this chapter and will be further examined and refined in the discussion of the empirical evidence from the research in Chapter 10.

4.2 Age-Friendly Communities

It is important here to consider here the relevance of the Age-friendly Communities construct discussed earlier in Chapter 3 to residential aged care. Lui et al (2009) provide a summary of key features of what constitutes an age friendly community drawn from international models identified in their study including consideration of policy trends and types of aged care provision (see Table 4.1) drawing on ecological, sociological, and gerontological evidence. Noting that health and wellbeing in older age is dependent on both social needs and day to day comforts being provided for, the attributes are presented in both the categories of social environment and physical infrastructure (Lui et al. 2009). These models capture an

international response, comparing the seminal WHO Age-Friendly Cities Guide with models adopted in Canada, USA and the UK, as below:

1. Age-Friendly City (WHO);
2. Lifetime Neighbourhood (Department for Communities and Local Government, UK);
3. Liveable Community (American Association of Retired Persons, USA);
4. Liveable Community (National Association of Area Agencies on Aging, USA);
5. Elder-friendly Community (Universities Canada);
6. Elder-friendly Community (The AdvantAge Initiative, USA).

These six examples also demonstrate the diversity of terms used internationally in the adoption of Age-friendly Cities (later renamed Age-Friendly Cities and Communities) guidelines in different social and policy contexts. The six examples are presented in a table of comparative characteristics demonstrating what is meant by an age-friendly community under the two categories: the social environment (11 elements), and the physical environment (15 elements). A limitation of this categorisation is that it does not address the internal environments of aged care facilities, which according to the above broad definition of community may also be an enabler of community integration.

Table 4.1: Key features of an age-friendly community identified by selected models

Source: Lui et al (2009)

	Age-friendly city (World Health Organization)	Lifetime neighbourhood (Department for Communities & Local Government, UK)	Livable community (American Association of Retired Persons)	Livable community (National Association of Area Agencies on Aging, USA)	Elder-friendly community (University of Calgary, Canada)	Elder-friendly community (The AdvantAge Initiative, USA)
Physical Infrastructure	Outdoor spaces and buildings	Built environment	Land use	Planning and zoning	–	–
	Transportation	–	Transport and mobility	Transportation	Being mobile	Maximising independence
	Housing	Housing	Housing	Housing	–	–
	Communication and information		Cooperation and communication	–	Ready access to information and services	–
Social Environment	Social participation	Social cohesion and sense of place	–	–	Maintaining independence and involvement in activities	Promotes social and civic engagement
	Respect and social inclusion	Social inclusion	–	Public safety	The importance of being valued and respected/Financial security and personal safety	Addresses basic needs
	Civic participation and employment	–	Public education and involvement in community planning	Culture and lifelong learning	–	Promotes social and civic engagement
	–	Innovation and cross-sectoral planning	Leadership	–	Community development work	–

Lui et al note that this table recognises the role of social relations affecting quality of life concerns, such as respect for and inclusion of the older population, rather than an emphasis solely on architecture or design specifications to suit the needs of an ageing person(s). The climate of inclusiveness is also noted as an important aspect of age-friendly communities, as

well as how society accepts and views the older population as a part of their community and in which they can contribute to society (Lui et al. 2009).

In order to create supportive physical and social environments, it is clear from this global discussion that creating age friendly communities needs the participation both government and the private sector (Lui et al. 2009). The table, comparing three different countries with WHO elements draws out aspects of both the social and physical environment. Thus, it represents an important basis from which to view the age-friendliness of the case studies included in this research. In relation to the ecological factors aiding community integration, this schema only considers social and physical issues as applicable to aspects such as outdoor spaces and buildings, land use, geography, and transportation, and not factors that are internal to a facility. The present thesis will address this lacuna by incorporating the internal elements of the facility's design in the model proposed later in this chapter.

4.3 Community Integration

Having discussed the meaning of 'community' it is now important to address the word 'integration' as used in this research. In terms of its etymology, integration is an early 17th Century word, originating from the Latin *integratio* from *integer*, meaning 'whole' and defined as "the act or process of mixing people who have previously been separated, usually because of colour, race, religion etc" (Oxford Advanced Learner's Dictionary 2019). The use of this term in this thesis with reference to residential age care refers to an approach that enables the mixing of older people in residential aged care with the 'community' as defined earlier (i.e. however they may conceive it) to the benefit of their health and wellbeing.

The use of the term 'community integration' is also used by McColl et al (2009, p. 17) in relation to individuals with brain injury, albeit stating that "the definition of community integration continues to elude researchers and service providers". Never-the-less, they identified three concepts common to discussions on the topic, that "integration involves relationships with others, independence in one's living situation and activities to fill one's time." (McColl et al. 2009, p. 17). This term can also be usefully applied to older persons in residential aged care due to reduced physical and/or cognitive function. Given the diversity of older people in care, it follows that the nature of community integration is likely be a vastly individual process depending on the varying importance of different community groups to each individual.

Lee et al (2007), discuss community integration as one that enhances health supportive design, underpinned by salutogenic theory. In this study of three aged care homes in Sweden, they note that a facility which is sited within a community system foster resident independence for social interaction with other residents, visitors, and local community. For those with more limited

mobility or cognitive impairment, Lee et al note that community integration in such an environment takes place via people watching or with aid from care workers. In either case, it is noted that through the shared services between the community at large and the residents of a facility, there is "consequently a flow of visitors of all ages connecting with the facility on a daily basis" (Lee et al. 2007, p. 9). It is also significant for this study that they use the term community integration to describe this approach, though again the emphasis is primarily on integration with the external community rather than within the facility.

Building on the dictionary definitions and the principles observed by McColl et al's (2009) and Lee et al (2007), community integration represents an approach to institutional care that encourages relationships with others (both within and external), independence in living, and activities that fosters greater social mixing with the communities within and outside the institution For the purposes of this thesis, therefore, community integrated residential aged care refers to aged care facilities that aim to encourage and foster relationships of residents with the communities in which they are located, both within and outside the facility, through their philosophy, operational policy, delivery of car, location and physical design. This is in contrast to conventional aged care models and facility location and design which have typically been based on segregation of residents from the community (Franck et al. 2016; Grenade and Boldy 2008; Harris et al. 2005; Brownie and Horstmanshof 2011a)

As discussed in Chapter 2, the integration of older people into the community outside the residential environment, as opposed to segregation, has been identified as a contributor to healthy ageing (Kochera and Bright 2006; Stenner et al. 2011; WHO 2000; Fratiglioni et al. 2000; Lui et al. 2009; Hillcoat-Nalletamby et al. 2010). As discussed in Chapter 3, ageing in place has also been promoted by policy makers, in relation to an older person's satisfaction, better health and wellbeing but a sector of the older community desire to move on from their own homes (Hillcoat-Nalletamby 2014). Scourfield et al note that much of the current literature, on institutional aged care for those with higher needs, report it as a marginalising environment, contributing "to the sense of loss of identity, lowering of self-esteem and a reduced sense of personhood" (Scourfield 2007, p. 1136).

He further notes that:

> "Residential care represents the 'end of life's road'—a place that people go to await death; it is often assumed that when someone enters residential care, their disability or illness is so all-consuming that they have no interest in anything other than their personal care and their day-to-day comfort. This is not only reductionist and unfounded, but also self-perpetuating". (Scourfield 2007, p. 1136)

It is now recognised that "initiatives have been narrowly focused on care home residents as service users and not as citizens in a more holistic sense" (Abbott et al. 2000, p. 327). This concept is supported in principle in the Australian policy context. As stated in the National Strategy for an Ageing Australia, the inclusion and participation of older individuals in community life is a key consideration in building age-friendly communities in Australia (Bishop 2000). The academic research also links built environment measures and older persons' health and wellbeing (Burton et al. 2011). However, the literature review suggests that Federal and local government policy in Australia, in relation to age friendly communities tends to concentrate on architectural and town planning issues of community integration rather than the social aspects of life (Australian Local Government Association 2006; Australian Government 2011; Judd 2014; Shiels 2016; Australian Government 2011; Kendig et al. 2014). Although social gerontology has traditionally concentrated on the study of the social, economic and demographic characteristics of older people, in recent years its scope has expanded to include health, technology and overall lifestyle concerns (Phillips et al. 2010). The meaning of the varying degrees and nature of independence in different residential settings, irrespective of care needs level is described by Hillcote-Nallatamby as:

> "Independence has multiple meanings for older people, but certain meanings are common to all settings: Accepting help at hand; doing things alone; having family, friends, and money as resources; and preserving physical and mental capacities. Concepts of delegated, executional, authentic, decisional, and consumer autonomy, as well as social interdependencies and spatial and social independence, do provide appropriate higher order interpretive constructs of these meanings across settings" (Hillcote-Nalletambi 2014, p. 419).

However, as Vernon and Quereshi note, there is a need to combine independence with the need for privacy or solitude, within the cohort of older and often frail individuals. This duality is relevant to this research, given the increasing higher care needs of residents. They further note that this desire for independence and maintaining personal autonomy are kept as independent variables in this study (Vernon and Qureshi 2000).

The prevalence of loneliness as a common feeling among residents in institutional settings is associated with poor self-rated health and psychological well-being that can even impact on mortality (Jansson et al. 2017). Loneliness in nursing homes should therefore receive more attention and be taken into consideration in the care and support of residents. Jansson et al conclude that staff in nursing homes should receive training on identifying lonely older residents and supporting them, with new interventions aiming to help them to develop

meaningful relationships and communication within the resident community, their families and visitors, as well as with staff.

A paradigm shift has been signalled in the public discourse on ageing over the past decade (Lui et al. 2009). As Powell and Edwards note, the traditional viewpoint of older individuals disengaging from society has been replaced with one that recognises their participation and valuable contribution to society (Powell and Edwards 2002). Stenner et al notes that this notion of older individuals as active participants in society engaging in their communities has influenced the policy discourse (Stenner et al. 2011).

Not only do older individuals seek independence but also the ability to function and remain active in a location of their choice and to continue to enjoy their desired level of support and interaction with other people (Bruhn 2011). The nature of interaction of older people within their location of choice could also have reciprocal consequences for positive ageing. Kochera and Bright note that an environment which offers a liveable community for older people provides services and features that do more than simply facilitate physical independence (Kochera and Bright 2006).

The increasingly higher care needs of older people in residential aged care does not therefore negate the need for greater community integration, but rather highlights its importance as a means of optimising health and wellbeing by remaining part of a community and engaging in activities, within their capabilities, in a supportive environment.

A similar concept to community integration in academic literature is that of group cohesiveness, presented by McMillan and Chavis as *sense of community* (McMillan and Chavis 1986). However, Nowell and Boyd point out that this is a needs-based theory, as opposed to a responsibility-based theory. They argue that McMillan saw sense of community only as a resource for people in order to meet their "physiological and psychological needs such as the need for affiliation, power and affection" (Nowell and Boyd 2010, p. 833). They identify sense of responsibility as an aspect important to building a sense of community, where people feel responsible for engaging with and supporting one another (Nowell and Boyd 2010).

Both these concepts are relevant to community integration. Social networks represent "the web of social relationships that we each maintain, including both intimate relationships with family and close friends and more formal relationships with other individuals and groups. It is through this web of social ties that individuals can be said to be socially integrated into the larger society in which they live" (Seeman, 1996a, p. 442). In the context of residential aged care, maintaining social ties with family, while at the same time having opportunities to build new social ties

within the residential community in which they now live and beyond, is central to the concept of community integration adopted in this thesis. It also suggests that what might constitute community integration for an individual can be highly personal, depending on their personal needs, capabilities, circumstances and aspirations.

Integration as opposed to segregating older individuals of increasing frailty is shown to be just as relevant to the ageing population as well as being an essential part of the social fabric of the broader community. A more holistic concept of community integration that is not narrowly based on ageing in place with care delivery to an individual's own home, but also includes residential aged care provision is an important matter for policy makers to consider. This is particularly so in the context of the increasing frailty of residents which can lead to isolation, inability to engage with others as well as the unsuitability of homes and environments to provide for safety and security, both physically and psychologically. Those suffering from dementia and other diseases of cognitive decline, which impact directly on health and wellbeing are particularly vulnerable.

4.4 Generational change and residential aged care

Changing accommodation preferences of older people currently entering into retirement characterised by the baby boomers, are informed by more independent lifestyle preferences (Bridge and Kendig 2005a). Spurred on by this increasing demand, a wide variety of retirement living lifestyle communities are available for the over 55s, including exclusive lifestyle resorts (Hu et al. 2017). This generation is also marked by the increase in the prevalence of diseases such as diabetes and dementia requiring higher care needs (AIHW 2016; Buckley et al. 2013). This increase is in part a function of them living longer than previous generations (Holland et al. 2010; AIHW 2015; Knickman and Snell 2002). However, as the baby boomer generation are perceived to exercise more independence than their predecessors with greater control and influence over their choice of lifestyle, innovative models of care incorporating high-needs care will need to be taken into consideration (Quine and Carter 2006). As discussed by Pinnegar et al. "..the choices, constraints, behaviours and expectations of the baby boom generation influence their decisions and outcomes regarding housing and location" (Pinnegar et al 2012, p. 4). Therefore, the collective financial power, independent outlook of the Baby Boomers and their desire to stay socially engaged is already bringing about policy changes (Quine and Carter 2006). These changes have far reaching consequences for aged care delivery models, and it is worthwhile looking specifically at this emerging group and the implications of how models of aged care will need to evolve to meet this cohort's needs and aspirations.

For the purposes of this investigation, these distinctive characteristics of the baby boomer cohort are important in the discussion of community integration. Quine and Carter (2006) note that "…baby boomers assumed that they would be a different kind of older person than previous generations, and it was frequently noted that boomers have lived through enormous social change and had more diversity of experience than earlier generations, are better educated and travelled, more often divorced, have had higher exposure to marketing and media, and instituted greater gender equality" (Quine and Carter 2006, p. 4). However, they are also at proportionately increasingly higher risk of dependence on formal care in older age (Redfoot et al. 2013; Martin et al. 2009; Lynn and Adamson 2003; Knickman and Snell 2002). Therefore, community integration of aged care is also driven by the demands and expectations of the vast numbers of the baby boomer generation who desire to stay connected to society, but may be unable to age in their own homes due the high cost of personal nursing care (Buckley et al. 2013).

4.5 Higher needs care and Community Integration

This literature review highlights the increase in the number of people requiring more intensive care in residential aged accommodation, due to cognitive decline (Kalache et al. 2005; Productivity Commission 2011; Wahl and Lang 2003). As detailed in the WHO report on *Ageing and Life Course* (WHO 2007), in 2011 25-30% of the global population aged 85 years or older had some degree of cognitive decline, with an increase in Type 2 diabetes and Alzheimer's disease (McKinney 2011). In Australia, three in 10 people over the age of 85 and almost one in 10 people over 65 have dementia (Dementia Australia 2019). Chapter 1 further expands on the increasing numbers with higher care needs as applicable to the Australian aged care context. Gerontological theory as discussed in Chapter 2, stresses the positive correlation of health and wellbeing and activity even among older individuals with high levels of cognitive decline (Stowe and Cooney 2014; Holstein and Minkler 2003; Shanas et al. 2017). Therefore, aged care models will need to cater to this demographic of older individuals who are less mobile, yet still retain the ability to be engaged with society. For individuals with higher care needs, an environment that provides formal specialised care greatly enhances their ability to live a meaningful life with dignity (Stowe and Cooney 2014). Independent studies have confirmed that such an environment contributes to the extension of life by protecting against age related diseases through a healthier, active and engaged lifestyle (Partridge et al. 2011; Dilani 2008). These findings clearly point to powerful social forces driving the demand for more community integrated facilities and the need for research on the health and wellbeing outcomes of their residents.

Learning to live with impairments, or disease, and in many cases with the absence of support from family, friends, or a significant other, will require adaptation (Wahl and Lang 2003). As Macrae et al (Macrae et al. 1996) pointed out, nursing home residents were clearly frailer than independently dwelling older-adults. It is unclear whether the increased frailty of nursing home residents leads to lower physical activity levels or if lower physical activity levels cause conditions that lead to physical decline. In any case, it is argued that physical inactivity may exaggerate the rate of physical and cognitive decline in older institutionalised residents (Cavanagh et al. 1998; Cho et al. 2017).

The quality of the nursing home seems to influence the extent to which residents engage in meaningful activity (Kolanowski et al. 2006). A study by Duncan-Myers and Huebner note that "occupational therapy strategies to empower residents through increasing choice and control, include increasing a sense of community in the facility emphasizing personal responsibility, and enabling choices in everyday tasks"(Duncan-Myers and Huebner 2000, p. 504).

These views are consistent with the findings of Kane who points out that the conventional models of nursing home care tends to deliver a poor quality of life for consumers by isolating them (Kane 2001). Eliopoulos further proposes that the answers to a better quality of life for older people needing long term care are "security, comfort, meaningful activity, relationships, enjoyment, dignity, autonomy, privacy, individuality, spiritual well-being, and functional competence" (Eliopoulos 2013, p. 150).

These observations are in keeping with recent studies demonstrating that loneliness and the lack of social support resulting in loss of companionship, emotional support and dissatisfaction leading to depression, are linked to a deterioration in cognitive levels (Blazer and Hybels, 2005; Cornwell and Waite, 2009). Carriere et al further suggest that a socially integrated lifestyle guards against proneness to boredom among the older population (Carriere et al. 2008).

Studies that link physical decline with mental ability levels by Middleton et al, (2011) note the importance of education programs for residents as an enabler to staying active in the community. In addition, education of the public on the inclusion of increasing numbers of the older population into society and them staying engaged in society despite suffering from cognitive decline is necessary (Sumic et al. 2007). The longitudinal study of Fratiglioni (2004), which explored the effects of three lifestyle components: social network, physical leisure, and non-physical activity on cognition and dementia suggests that an active and socially integrated lifestyle in late life might help protect against dementia. However, privacy, the control by an individual over what they participate in, as an essential component of an older and less able age group's life, is essential to the effectiveness of individual functioning (Altman 1976). It is clear

therefore that despite higher care needs and increasing frailty of those in residential aged care, the integration of such older individuals into communities (both within and outside the institution) delivers better health and wellbeing outcomes to older individuals as well as society at large. Such an approach has been demonstrated in a number of international precedents of community integrated residential aged care as presented in the following section.

4.6 Precedents for community integrated aged care

Having defined and justified the relevance of community integration to residential aged care, it is important now to briefly review a series of policy and practice exemplars drawn from a range of jurisdictions and a variety of settings and contexts that incorporate aspects of community integration in aged care. These exemplars are useful in demonstrating the application of the concept of community integration and help to inform the development of the conceptual model that follows in the succeeding section and also provides the framework for the analysis of the case studies in Chapters 6, 7, 8 and 9 .

4.6.1 Extra Care Housing (UK)

Central to an Active Ageing concept in the higher needs care sector of the older population is the aim to promote maximum autonomy within ”a normal, safe and familiar environment, that include provision for dementing residents”(Tinker et al. 2013, i). Similar to the Consumer Directed Care approach discussed in Chapter 3, Section 3.3.1, within the Australian policy discourse, Extra Care Housing UK, is based on a person-centred approach in residential aged care. The Health Innovation Network in the United Kingdom, defines Person Centred Care as “a way of thinking and doing things that sees the people using health and social services as equal partners in planning, developing and monitoring care to make sure it meets their needs. This means putting people and their families at the centre of decisions and seeing them as experts, working alongside professionals to get the best outcome” (Health and Innovation Network, South London 2019). Person Centred Care therefore emphasises a “voice and choice to disabled people while preventing deterioration of health. In this context, social relationships, allowing for frequent face to face interaction, are recognised as vital to older people’s health and well-being” (Tinker et al. 2013, i). Incorporating these concepts in the realm of dementia suffers presents formidable challenge since the aim of maximising an older person’s choice and control, and subsequently assessing the efficiency of a person centred approach becomes difficult (Argyle 2012). However, in the United Kingdom significant strides have been made in addressing these challenges in the development of aged care incorporating the principles of active ageing and person-centred care through community participation and integration, such as through Extra Care Housing(Aldridge et al. 2012).

Extra Care Housing is a UK Government policy initiative intended to provide a form of housing which serves as an alternative to residential aged care or delaying entry into residential aged care. This is achieved by creating a supportive physical and social environment for ageing individuals to enable them to lead an independent life while continuing to be a part of their own communities by co-sharing housing. In the UK, there are, social, private and public subsidised models of Extra Care housing. At its heart is the concept of housing which provides for enhanced sense of quality of life through a person-centred care approach. Four elements support the Extra Care housing model: customer base, lifestyle, environment, and services (CSIP 2008). These elements are intended to augment the person centred care approach as previously discussed in section 4.6.1. The building types can vary from large scale developments containing up to 300 properties, in the form of apartments, bungalows, houses or a mix of types, in a variety of modern or traditional styles. Other apartments and bungalows may be built around the Extra Care housing for older people who do not require continuous care but have the opportunities for access to care when required. Larger developments include more facilities and services with 'continuing care and retirement communities. The Extra Care Housing model also includes very small developments of 6 apartments or bungalows, incorporated in the grounds of a care home or in rural areas (Aldridge et al. 2012). However, the Housing Learning and Improvement Network (HLIN) notes that "the nature of Extra Care Housing creates challenges for commissioning and funding structures not necessarily designed for the flexibility it entails" (Housing LIN Report 2010, p. 4).

According to the Care Services Improvement Partnership (CSIP), the Extra Care housing model includes medical care and community nursing similar to that provided for older people in ordinary housing, although some Extra Care developments include a wing, or a part of the development, for those with dementia (CSIP 2008). Residents who later develop dementia, having previously entered into regular Extra Care Housing usually continue to be supported by their neighbours. However, the CSIP cautions that moving people with dementia to live alongside people who don't have dementia requires careful management. This form of housing can also be seen as beneficial for a couple where one partner is caring for the other who has dementia.

4.6.2 Dementia Care Partnership (UK): Independent living houses for people with dementia.

Also originating in the United Kingdom is the Dementia Care Partnership (DCP), a voluntary organisation formed by a group of family carers who were unable to find appropriate care solutions for their own family and loved ones. Having first commenced by providing individualised services and care to dementia care suffers in their own homes, they very soon

encountered the need for continuous formal care which could not be addressed that way. Combining the reluctance of most family members to send their loved ones to a large institutional facility, and the philosophy of the organisation to provide individualised care, DCP initiated a care model which was based on small independent living houses. They used ordinary residential dwellings in existing neighbourhoods adapted for specialised use, to enable those with dementia to live together in groups of between 3 and 5 people. Services were provided using local teams of carers based around the expressed needs and wishes of the guardian and person with dementia. The specialised dwelling adaptation includes features such as a walk-in shower in the bathroom, or a stair lift for ease of mobility. The care philosophy of DCP is thus embedded in the 'normalisation' of life, living in ordinary dwellings, with residents engaged in ordinary activities, such as going out to the shops, cinema, and taking part in housework or cooking, within their capabilities. As noted by the Care Services Improvement Partnership, "DCP believes that this is easier to achieve in a domestic rather than larger group living setting. DCP has developed the PEACH philosophy which is at the heart of its approach:

P = Person and Partnership;
E = Empowerment and Employment;
A = Attachment, Attitude, and Approach;
C = Control, Choice, and Continuity;
H = Home for life" (CSIP 2008, p. 3).

The popularity of this model is noted by the CSIP, as resulting from its care model providing:

- A regular domestic dwelling which offers friendship and companionship, private space and communal facilities;
- Ageing in place [once the move has taken place to the aged care facility]: Security of tenure and a commitment, for a person to be cared for with advancing needs, unless there is challenging behaviour which affects the group;
- Involvement in decision making about day to day living and maintaining links with the local community; and
- Person centred care, support and supervision by staff on a 24 hour basis. (CSIP 2008).

The CSIP notes that this model incorporates a staff ratio of 1:2 or 1:3 carers per resident, within a domestic scale environment and that it results in improved mental and physical wellbeing and a higher quality of life with family relationships intact. In addition to its popularity with residents, it is also favoured amongst staff reflected in staff turnover being very low. This model is also now replicated also for the younger-old suffering from dementia. The DCP has further developed a model of integrating the different age groups and care needs, in the grouping of

bungalows on the same site, similar to the models in the Netherlands and Denmark, thus achieving economies of scale without losing the independent living philosophy (CSIP 2008).

4.6.3 Humanitas Apartments for Life (Netherlands)

Apartments for Life is a care model developed by the community-driven Humanitas organisation in The Netherlands emphasising a sense of community, and active ageing in an integrated community environment. The model incorporates a "governance and institutional structure aligned with a value system based on community-related values" (van Marrewijk and Becker 2004, p. 205). Spearheaded by its founder and CEO, Dr. Hans Becker, Humanitas is an organisation based in Rotterdam that employ 2100 persons and 900 volunteers and provides care and housing services to 6000 people seeking aged care accommodation. The concepts that govern Humanitas are based on four broad principles:

- "Age proofing residential complexes;
- Allowing the resident to age in place with advancing physiological, psychological and other care needs;
- The extended family concept; supporting self-determination and self-reliance among clients and employees; and
- Supporting fun through positive attitude, surroundings and atmosphere" (van Marrewijk and Becker 2004, p. 210).

These principles directly address the negative characteristics traditionally associated with residential aged care, namely the loss of autonomy and privacy, the increase in isolation and a clinical institutionalised environment. (Bužgová and Ivanová 2011; Barber et al. 2009; Wenger et al. 1996; Grenade and Boldy 2008; Cattan et al. 2005; Brownie and Horstmanshof 2011a)

There are currently fifteen Apartments for Life complexes in the Netherlands. Following the first ones in 1995, and its global recognition, there are a reported 10,000 to 12,000 older individuals on waiting lists. According to, available anecdotal evidence suggest the costs of these non-institutional settings providing care are 10 to 25 percent lower than comparable institutional care (Glass 2014b). Possible reasons for these cost savings are the high level of volunteering that builds interdependence, and a strong focus on the realisation of fulfilment of individual talents and potentials, in these communities.

The housing is specifically designed to allow the resident to remain in the same apartment until death, while providing support for their increasing frailty and specialised care needs. The required care is brought to the resident, rather than the resident moving to access that care.

Becker calls this concept "levesloopbestendige" or "age-proof dwellings" (Regnier 2013, p. 4). The major design characteristics are the incorporation of universal design principles in all living units, the ability to accommodate patient lift equipment and oxygen, and wheelchairs and corridors wide enough to provide for stretcher use (Ijeh 2013). The mid-rise apartment buildings have elevator access and individual apartments include adjustable kitchen sinks units that can be raised or lowered (Regnier and Denton 2009) and lockable doors, so that no one, including care staff, can enter without permission (Glass 2014a).

A later development of the Humanitas model has integrated student accommodation with aged care housing to encourage intergenerational interaction (Yates 2017). Living in the village is a transactional arrangement whereby the older population value the presence of the youth and the students benefit in their own growth and development from the interaction with the older community.

4.6.4 De Hogeweyk (The Netherlands)

The De Hogeweyk dementia care village is a socially oriented model of care in a high-needs aged care environment. The physical environment of this model is designed to resemble a traditional suburban village setting. This concept is applied in dementia care models in several projects in Europe. De Hogeweyk, in Amsterdam, is one such large scale residential care environment for higher needs older individuals with dementia that incorporates the Dementia Village model (Mens and Wagenaar 2014). Since its commencement of operations in 2008, this De Hogeweyk Village is now home to 152 residents suffering from severe dementia. They live in twenty-three small houses of no more than two storeys. Each has six to seven bedrooms, two bathrooms, and a kitchen. The bedrooms were intentionally made smaller, as people felt safer in close proximity (Glass 2014b).

Designed by Dementia Village Architects, the concept is described as follows: "Around the common and familiar building blocks lifestyles are built from a social approach… the nursing home groups residents with shared interests and backgrounds, who live together in a *lifestyle-group*. The design and decoration of the homes and surroundings is tailored to the lifestyles" (DVA Architects 2014). This is achieved through the grouping of its 152 residents into *lifestyle-groups* of seven residents, who share similar interests and backgrounds. Active engagement is provided through the many recognisable stimuli which challenge the resident to actively engage and participate in activities designed for that lifestyle.

A fundamental philosophy of the De Hogeweyk village is the grouping of like-minded residents in these small houses. Using a Dutch database reflecting the social and cultural makeup of the national population, seven 'lifestyle groups' were identified for the grouping of residents. This

approach goes beyond demographics and differentiates between choices translated in English as:

- Homey: simple life, focus on housekeeping and family;
- Christian: religion is an important part of life, may affect lifestyle choices;
- Craftsman: traditional, hardworking, early to rise/early to bed;
- Arts and culture: international travellers, colourful interior design, more adventurous in food choices;
- Aristocracy: formal, classic design, accustomed to having servants;
- Indonesian/colonial: interested in nature, spirituality, Indonesian food;
- Urban: outgoing, informal. This design is intended to make life as normal as possible. (Glass 2014a, p. 74)

Archer notes that the ability to live among those with whom residents have something in common, is important in building a sense of community (Archer 2012). He also notes the importance of familiar surroundings, including design elements, and interior design influenced by the personal tastes of the seven different lifestyle groups. The inclusion of restaurants, gardens, a grocery store, pub, theatre, and hair salon encourage the tight knit community atmosphere of the village. All the essentials found in a village create a familiar environment that aids in reducing anxiety. The residents can also walk freely throughout the community without danger of leaving the premises. The landscaping and design were created to offer variety and interest, stemming from the belief of the creators of De Hogeweyk, that social interaction, fresh air, sunlight, and exercise are all beneficial for those with dementia. Familiarity and normalcy are further noted by the 120 volunteers and 240 employees (170 are full-time) who dress in street clothes and are specifically trained to work with individuals with dementia. Specialised training and skills are noted to be important to assist residents who are mostly bedridden to live their lives as normally as possible and in safety (Hurley 2012). According to one of the founders of De Hogeweyk, Van Amerongen-Heijer, the cost of care provision is the same government reimbursement level as other Dutch facilities serving those with dementia, but the quality and cost-effectiveness have not been formally studied (Tinker et al. 2013). Even though the monthly cost of residency can be comparable to other nursing homes at US $6,555 per month, the high quality of lifestyle at De Hogeweyk is incomparable (Sampson, 2014).

Glass et al note that both De Hodgewick and Apartments for Life have specific physical design elements and philosophies that support the model and use ‘small houses’ for severe dementia care (Glass 2014b). They further note that the general approach of community integration

incorporates offering services, such as home care, to the wider community as well as having businesses in the facility that make neighbours feel welcome. The success of these models is being emulated in other European countries such as Germany and Switzerland who are starting to build similar villages (Archer 2012).

4.6.5 Continuing Care Retirement Communities (CCRC) (USA)

A Continuing Care Retirement Community (CCRC), is a concept developed in the United States. which offers a continuum of aged care ranging from independent living, to assisted living and skilled nursing for high-care clients within the same place (Ziegler 2010; American Seniors Housing Association 2017). Also known as Life-care Communities, "these various levels of shelter and care may be housed on different floors or wings of a single high-rise building or in physically adjacent buildings. These buildings may be garden apartments, cottages, duplexes, mid- and low-rise buildings, or spread out in a campus setting" (American Seniors Housing Association 2017). This model again aims to provide for residents to remain in the same community or their accommodation throughout their life even with higher care advancing needs (CCRC Task Force 2010). Residents move into CCRC housing at the point of retirement, and remain in their housing throughout their life (Help Guide 2018). If specialised medical care is required at a hospital, the resident is able to return to their CCRC housing having accessed the medical services needed (PTAC 2018).

CCRC's are targeted for seniors who want to live in a community environment until the end of their lives with others of similar age, particularly to combat loneliness and isolation in older age, and at the same time planning for their long-term health care needs to be met (CCRC Task Force 2010). The community environment is enhanced through the incorporation of recreational services conducive to providing opportunities for creating community bonding and social connections (AARP 2018).

"In most CCRCs there are three levels of care:

- *Independent living*, in which residents care for themselves and enjoy housekeeping services and a wide array of other services and amenities in the community. Some CCRCs have special programs, e.g. in partnership with Masterpiece Living, to help residents age successfully;
- *Assisted living*, in which residents are given help as needed with daily tasks such as bathing and dressing in the residential unit or in a dedicated facility in the community;
- 24-hour *nursing home* care, usually in a dedicated skilled nursing facility". (GAO, U.S. Government Accountability Office 2010)

Some CCRC's incorporate a further fourth layer of care extending to palliative care (Masterpiece Living 2018).

4.6.7 Summary

These examples show a range of models of aged care that incorporate aspects of community integration as defined for this study. They vary in the scale of facilities and the types of service delivery offered, but all have the common theme of integration and interaction within and outside a community in a socially supportive as well as physically adaptive environment that encourages active ageing. These community-based schemes reflect salutogenic theory, incorporating concepts of *continuing care*, through integration with local communities, active ageing principles, and the respect and accommodation of individual care needs and lifestyle preferences. Some were initiated by a visionary, as in the case of Humanitas, or a group of individuals finding a solution to an increasingly emerging need of extending a positive ageing paradigm to the highest category of the ageing care sector.

These five examples demonstrate community integration as a core principle providing better health and wellbeing outcomes for the higher needs care ageing sector, through their care models. These models of care, though based in vastly different social and political contexts, all incorporate aspects of community connectivity, lifestyle choices, independence and autonomy. They seek to provide a non-institutional 'homely' environment promoting a normalised life and activity, and ability to remain in the same environment with increasing care needs via the provision of progression to suitable accommodation and care needs within the same community. They represent community integration of aged care, incorporating the notions of salutogenic theory, stipulating focus on wellness rather than illness. As Lui et note, social integration emphasises the importance of maintaining social and community connections psychologically, as well as the correlation of activity and better health and wellbeing outcomes (Lee et al. 2007). The noted exemplars are based on keeping residents active, healthy and engaged through their concepts of care provision, particularly for those with advancing care needs and frailty, including the provision of continuing care, intergenerational activity, community building, and normalised activity, to name a few.

Significant to this research, in all examples presented above, location is important for enhancing community connections. Proximity to family and friends by aged care communities being developed within local neighbourhoods is also an important aspect of location. The importance of integration of dementia care in a continuing care model, is also demonstrated in their models and delivery of care. Additionally, the ecological aspects, such as proximity to services and infrastructure, for higher care needs, is an important aspect of socio-physical design

demonstrated through these international and local exemplars. But equally significantly, this discussion demonstrates that the delivery of a supportive aged care environment aligned with salutogenic principles include a wide range of features, not just those relating to the built environment of the facility, but also reflecting the organisational philosophy and delivery model of the agency and the social environment that supports the desired social and personal outcomes. These factors will be developed further in the CI-RAC model presented the next section.

4.7 A conceptual model of community integrated residential aged care

Drawing on developments in gerontological theory, culminating in salutogenic theory and PSD, which is translated in the policy context by the Active Ageing paradigm, and the innovative practice precedents discussed in Section 4.6 above, a model for community integrated residential aged care (CI-RAC) is proposed (see Figure 4.1).

Level 1: The drivers of the CI-RAC model

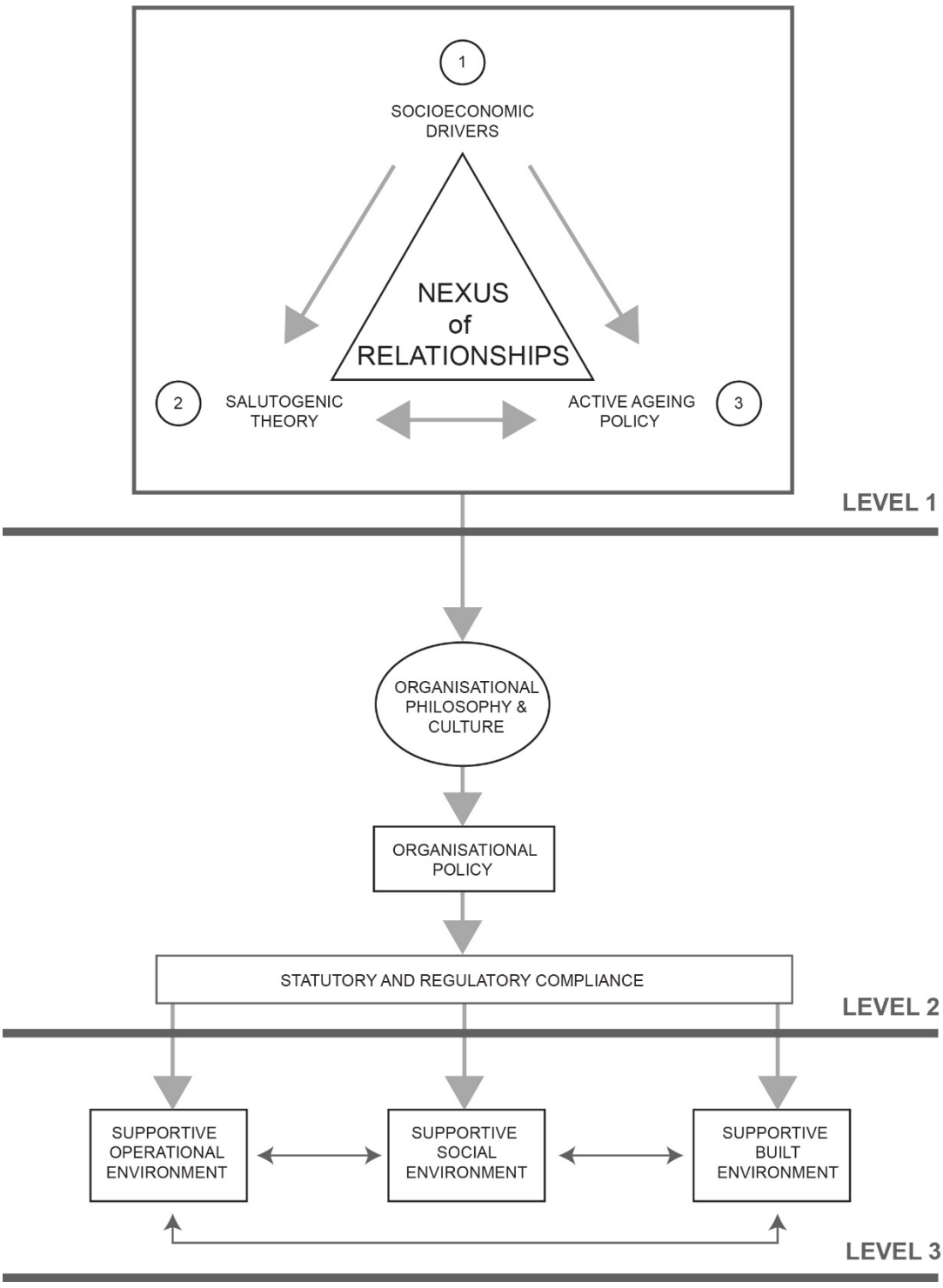
From the literature review, as a first step the model proposes a nexus of relationships which is critical in informing the conceptualisation of community integrated residential aged care. These three components are;

a. The principles of salutogenic theory,
b. The active ageing policy paradigm, and
c. Socio-demographic change.

This tripartite nexus of relationships, expanded on later in this section, is identified as the core driver of an organisational philosophy and culture of community integrated residential aged care adopted by a provider which is then expressed in their organisational policy. The organisational policy is in turn, necessarily filtered through the applicable statutory and regulatory framework which can constrain or enable the feasibility and delivery of aged care to recipients. The resulting delivery of care is then implemented via three important, yet interdependent, domains; a supportive operational environment, a supportive social environment and a supportive built environment. It is argued that the characteristics of each of these domains is consistent with the principles of salutogenic theory, active ageing policy and the socio-demographic changes influencing the demand for residential aged care. This identifies community integrated residential aged care as distinct from traditional prevailing segregated models and better geared to the health and wellbeing outcomes of their increasingly high care residents.

The model of community integrated aged care illustrated here will then be assessed against the evidence from the four case studies selected for this research that have been identified as exhibiting aspects of community integrated care, to ascertain its applicability as an appropriate model for future residential aged care that promotes the health and wellbeing of residents.

Figure 4.1: A conceptual model of community integrated residential aged care



The three core elements of the nexus of relationships at Level 1 in the model are as described below:

i) Socio demographic drivers; influence the operational context for the care provider and play a significant role in the development of organisational philosophy, shaping the nature of the care it provides. As discussed in Section 4.2, a paradigm shift has been signalled in the public discourse on ageing over the past decade (Lui et al. 2009). As Powell and Edwards note, the traditional viewpoint of older individuals disengaging from society has been replaced with one that recognises their participation and valuable contribution to society (Powell and Edwards 2002). Stenner et al notes that this notion of older individuals as active participants in society engaging in their communities has influenced the policy discourse (Stenner et al. 2011).

Not only do older individuals seek independence but also the ability to function and remain active in a location of their choice and to continue to enjoy their desired level of support and interaction with other people (Bruhn 2011). As noted in Section 4.4, the desire for more independent life-style preferences and increased financial flexibility to choose living options to suit their desired lifestyles, are a characteristic of the Baby Boomer generation now entering retirement age (Quine and Carter 2006; Bridge and Kendig 2005b; Pinnegar et al 2012).

In addition to these generational attitudinal changes, is the increased recognition in global policy of the rights of older individuals to continue to be integrated into their communities as valuable contributors, irrespective of decreasing cognitive or physical abilities. These socio-demographic changes are being experienced in most developed countries, including Australia influencing changes in policy as outlined in iii below.

Although the percentage of the older population entering into residential aged care is decreasing, due to population ageing, the number of persons needing residential aged care environment is actually increasing. This includes an increasing number suffering from dementia and other cognitive decline primarily due to the higher number of people living longer well into the old-old age group of 85 years and older. An active lifestyle, particularly with decreasing physical and mental ability levels afflicting the older population, is known to enhance a person's quality of life.

The five exemplars discussed in this chapter represent innovative responses to such socio-demographic change for older people with higher care needs by keeping them active and integrated in the local community, enabling them to age in place in the same environment for life, providing control over privacy and lifecycle choices, and offering a wide range of social

opportunities both with and outside the facility in a non-institutional normalised physical environment.

ii) Salutogenic theory; is identified for this study as its foundational theoretical construct for understanding community integration of higher care needs. Salutogenic theory explains the reasons people remain healthy, rather than how they get sick. This theoretical construct demonstrates the factors contributing to the suitability of the physical and social environment supporting a positive ageing paradigm. Therefore, it has a close link to the active ageing policy paradigm, as discussed in point iii below. As this study addresses the operationalisation of community integration for residential aged care, the theoretical construct of salutogenic theory based on a persons' Sense of Coherence (SOC) addressing three principles; *comprehensibility, manageability, and meaningfulness* is discussed with consideration of the social and psychological needs of a person alongside their clinical needs.

This study demonstrates that, salutogenic theory is a common thread that binds diverse models of aged care provision with a focus on fostering and enabling an active ageing model through community engagement. As discussed in Chapter 2. 4, Antonovsky describes this theory as "a global health protective life orientation" (Kroninger-Jungaberle and Grevenstein 2013, p. 2; Antonovsky 1979). In a context where residential aged care is moving towards an increasingly frail older population, the three constituents of sense of coherence, *Comprehensibility, manageability* and *meaningfulness* become increasingly important to incorporate into the delivery of community integrated care. According to Antonovsky (1987, p 19) *comprehensibility* refers to 'a feeling of confidence that the stimuli deriving from ones internal and external environments are structured, predictable and comprehensible', *Manageability* is the perception that 'the resources are available to one to meet the demands posed by these stimuli' and *meaningfulness* is the extent to which they find the 'demands and challenges, worthy of investment and engagement'. In a salutogenic aged care environment, one would expect these to be evident in across the philosophy, policies, care model, social activities and design of the physical environment of a community integrated aged care facility.

iii) Active ageing policy; As discussed in Chapter 3, incorporating the active ageing agenda, was a direct response to an international awakening to human rights including those of older people by international organisations such as the UN and WHO (United Nations Madrid 2002; WHO 2016). This was further underpinned in recognition of the health and wellbeing of older individuals, and changing needs brought on by population ageing (WHO 2007). In turn the active ageing agenda has filtered through to the policy framework of most developed economies

including that of Australia (NSW Government 2016; Bishop 2000). As discussed in Chapter 3.3.1, the 2002 Intergenerational Report highlighting the impact of the baby boomer generation entering retirement, highlighted the need for change in policy in response to financial implications of population ageing. Further, the Living Longer Living Better aged care reforms introduced in 2012, incorporated policy frameworks in support of an active ageing agenda which required aged care providers to align with its directives by 2015. However, the recent Royal Commission into Aged Care Quality and Safety established on 08 October 2018, is a landmark inquiry for Australian residential and in-home care, aimed at improving the lifetime wellbeing of people and families in Australia. This inquiry has noted that "Despite ongoing reform, systematic failures leading to poor quality of care for older Australians continue. Statistics show the number of serious risk notices issued to aged care providers jumped 170 per cent in the past year and significant non-compliance leapt 292 per cent" (National Seniors Australia 2019) . Therefore, government policy inclusive of regulatory frameworks are an important aspect of setting the agenda for active ageing, in line with salutogenic theory, and operationalising those aspects. As an initial step, an active ageing policy paradigm has a major impact on the care philosophy of aged care providers, which then set the standard for the formulation of specific care models.

This discussion demonstrates the nexus of relationships between socio-demographic drivers influencing the foundational theoretical framework selected for this study, salutogenic theory, and its corresponding interrelationship expressed in the policy paradigm through active ageing. In turn, as demonstrated through Level 2 of the proposed CI-RAC model, the influence of this nexus of relationships influences the organisational philosophy and policy, subject to regulatory frameworks in its delivery of care.

Level 2: Organisational Philosophy and Policy, subject to Regulatory and Statutory framework

It is evident from the review of the international and local examples above that innovation is driven by the philosophy and culture of the individual provider organisations. This is demonstrated in the Humanitas Model, as well as De Hogeweyk Dementia Care Village, where the care model is a response to the conviction and dedication of an individual or a group. These providers implemented a belief that community integration is an enabler for positive ageing irrespective of the need for more intensive levels of care (Section 4.6.2).

The nature of government policy also strongly influences nature of care-provision, through impacting on the operational policy (McNamee et al. 2017). Hugo et al. note that a reduction in

government funding will also affect catering budgets and aged care staffing levels (Hugo et al. 2018). This is of note in relation to informing the operational philosophy of aged care providers and, in turn, the nature and parameters of aged care delivery. Land use planning policy, as discussed in Section 3.9, is also of major impact on the model of care provision, especially in terms of its location, built design and physical connectivity with the local community. Therefore, government policy can be seen to major impact on the delivery of an accessible community integrated care model which is not restricted to only those who can afford it.

With reference to the elements of the organisational philosophy and operational models of the international exemplars discussed in this study (Section 4.6), both the De Hogeweyk and Humanitas models are framed within northern European social-democratic political values Such governance systems historically provide a more socially equitable society marked by higher taxes of the general population but allowing more social support for marginalised groups including the older population. This may not be achievable in a more market driven policy structure such as in Australia. Likewise, in the United Kingdom, extra care housing, although originally based on a social rent model, has now transitioned into a largely private ownership model, with more consideration of the position of self-funders. In the United States, the Continuing Care Retirement Communities, which are now increasingly incorporating higher needs care provision, have from their inception been based entirely on a private funding model. This can be seen as reflective of the heavily market driven governance structure of the United States

The international cases reviewed earlier demonstrate organisational policies which recognises the unique needs of each individual in keeping with the diverse and non-linear nature of ageing, including:

- person centred care and consumer directed care approaches;
- ability to age in familiar surroundings incorporated into communities including physical proximity and integration of aged care facilities into existing communities;
- normalisation of both the external and internal scale and design of the facility;
- in the case of specialised dementia, integrating residents with different care levels and clustering according to lifestyle preferences;
- whole of life education of residents to maintain a mentally stimulating environment to supporting active ageing, of care workers to implement the care model, and of communities (e.g. residents and businesses) about the needs and behavioural aspects of facility residents , including those with dementia, to facilitate their access to and acceptance within the local community.

Such organisational policies support the salutogenic notion of sense of coherence and its component principles of *comprehensibility, manageability and meaningfulness* for their residents. However, in the Australian context the application of many of these organisational philosophies and policies may be constrained by *The Single Quality Framework* governing all levels of aged care provision in Australia. discussed in Chapter 3, Section 3.3.2. In the model, this is represented as a filter of statutory and regulatory compliance by which the philosophical and organisational policy ideals must pass and may be constrained or compromised before becoming operationalised as described in the following section.

Level 3: Practice and Delivery – Three components that inform the delivery of a successful community integrated model of care:

Drawing again on salutogenic theory discussed in detail in Chapter 2.4, a person's wellness in stressful or challenging circumstances is enhanced by a Sense of Coherence through the three elements of *comprehensibility, manageability, and meaningfulness.* In a context of increasingly higher care needs in residential aged care, a person's Sense of Coherence which focus on their wellness rather than illness is of critical importance. Milberg et al note "the lack of studies using SOC within the palliative research field is a bit unexpected, because the theory of SOC seems of such high relevance within this context where there is no cure or prevention of the ultimate threat, that is death" (Milberg and Strang 2004, p. 607). Lee et al (2007) in their study of three aged care facilities in Sweden, note the community integration of aged care facilities largely as a result of its location within established communities contributes to better health and wellbeing outcomes.

The CI_CRC model proposes three domains at the operational Level 3 which reflect the drivers identified at Level 1 and their translation in organisational philosophy, culture and policy filtered through the regulatory and statutory framework at Level 2. These are:

1. A supportive operational environment;
2. A supportive social environment; and
3. A supportive built environment.

These three components are presented as interdependent environments which must be embedded in a salutogenic model of community integrated care to support a resident's sense of coherence incorporating the three principles of *comprehensibility, manageability* and *meaningfulness*. A supportive social environment must coexist alongside a supportive operational environment as well as a supportive built environment as illustrated in the

exemplars. The three aspects of a supportive operational, social and built environment for a salutogenic model of residential aged care are discussed in more detail below;

1. It is evident from the literature review and examples of practice that a *supportive operational environment* is the deciding factor in fostering and translating into practice the many elements needed for a community integrated care model. Those elements may include the nature of dissemination of funding with emphasis on quality of care for residents rather than of a profit focused care-model. As discussed in all five exemplars, this may incorporate operational elements such as a staff-resident ratio that enable residents to be more active and engaged, the provision of a continuum of care built into the care-plan, and a funding model in alignment with the care model in prioritising resident health and well-being. In keeping with the principles of salutogenic theory, elements such as staff-resident ratio, and the provision of a continuum of care enabling an Active Ageing agenda, incorporate all three elements of manageability, meaningfulness and comprehensibility of a persons living environment in residential aged care. Due to higher cognitive decline, staff support in not only daily personal care, but also in providing assistance for participation in social activities, and exercise activities such as walking which may not be possible without that assistance, makes those activities more manageable and enables a resident to have a meaningful life (As noted in Sections 4.6.2, 4.6.3, 4.6.5).
2. The nature of a *supportive social environment* is also a central aspect of community integration. As demonstrated in the De Hogeweyk model, careful attention must be paid to forming the social environments of the living units. Their data base was employed to permit residents to continue a familiar lifestyle, demonstrating the concept of *comprehensibility* as theorised in salutogenic theory. This means that a comprehensible and manageable task adds value to a person's own life by being meaningful to their individual person (Milberg and Strang 2004). Antonovsky expresses *meaningfulness* as the activities or community engagement that are "challenges worthy of investment and engagement" (Antonovsky 1987b, p. 19). In the case of Humanitas, demonstrating the concept of *meaningfulness* the social environment is deliberately diverse, even incorporating intergenerational elements by mixing student and aged-care housing. This aspect of *meaningfulness* is again seen in the case of Extra Care Housing and Continuing Care retirement villages, where the similar economic capabilities of persons buying into the mostly privately-owned housing, brings a degree of uniformity in the social structure that facilitates the formation of a likeminded community. All examples, however, exhibit the characteristic of incorporating a structure of care-provision to include normalised social activity, while enabling familiar social links to be maintained, demonstrating both *meaningfulness* and *comprehensibility*. The ability of all

the discussed models of care to incorporate advancing care needs can also be seen as fostering a sense of belonging, promoting community integration. As discussed in Section 4.6, the interventions inherent in the social environments of the exemplars were supportive of all three elements of *comprehensibility, manageability* and *meaningfulness*.

3. A *supportive built environment* incorporating both the locational position of the facility in its wider neighbourhood as well as the architectural design of the facility, with age-friendly features and universal design principles and spaces that are conducive to social integration facilitate an Active Ageing environment. This aspect is particularly relevant in supporting the component of *manageability* as theorised through salutogenic theory and Psychosocially Supportive Design. Ecological theories discussed in Chapter 2 such as Lawton's environmental press model, further reinforce the validity of *manageability* and *meaningfulness* by demonstrating the crucial importance of the physical environment in providing adequate support in an environment that is designed for physical comfort and accessibility but offers an adequate amount of challenge to induce activity. Community areas, landscaped gardens, and outdoor areas linking the local community and the facility are therefore also features noted to be of importance in facilitating an Active Ageing model. The location of the facility within an established community in close proximity to health care and accessible to various modes of transport as well as recreational areas such as, clubs, open spaces and parks are also conducive to integration with the neighbouring community. Such an environment is present in all the described examples, through the promotion of normal activity within a community environment while having the support and care needed to perform and meet challenges brought on by increased frailty. In turn, all these elements support not only the aspect of manageability, but by incorporating *manageability* also contribute to a person's *comprehensibility* and leading a *meaningful* life. Therefore, parallels can be drawn between these exemplars and the principles of psychosocially supportive design informed by the salutogenic theory discussed in Chapter 2. The emphasis of the design of the built environment based on a wellness model rather than an illness model, as demonstrated in psychosocially supportive design, is evident in all the models of care adopted in the reviewed cases serving higher needs care. Further, Lee et al, present four strongly built-environment related factors in alignment with Psychosocially Supportive Design underpinned by salutogenic principles, to support health and well-being for older people, in their analysis of three aged care homes in Sweden. These are;

   "1. Community integration: These elderly care homes are generally placed close to a residential area, or a city centre. Services are often shared between residents and community members at large, consequently there is a flow of "visitors" of all ages connecting with the facility on a daily basis.

2. Homelike environment: A noteworthy aspect of Swedish elderly care homes is keeping the facility appearance as homelike as possible. The associations with home may be explored through the appearance and configuration of both the exterior and interior of the building. These homes seemed to be designed with a conscious aim to create a homelike setting.
3. Small scale approach: Clustering of resident rooms is one method through which the small-scale approach can be achieved in larger facilities. With unit clusters, the facility can foster opportunities for social interactions among resident.
4. Accessibility to garden and nature: The courtyard is a well-developed concept in planning elderly care homes in Sweden. They are generally safe and easily accessible to the residents". (Lee et al. 2007, p. 9)

Lee et al. (2007) note that the aged care homes in their study demonstrate the physical building, the community, and services provided as a single entity, in its expression of community integration. Here, one can infer the aspect of *comprehensibility* and *meaningful*ness to residents, as theorised by salutogenic theory. Similarly, *comprehensibility* and *meaningfulness* are demonstrated through the 'homelike environment' by not only the external appearance of the facility to reflect that of a person's home, but also within the home. They note the use of incorporating residents' own furniture and personal belongings in their private flats a desirable solution to providing a sense of familiarity and comfort. The small-scale approach enabling the opportunity for unit clusters even in large scale facilities further address the factors of *meaningfulness, manageability* and *comprehensibility* through fostering informal social interactions among residents. Manageability is further demonstrated in this study, by accessibility to garden and nature, which Lee et al. note provide easily accessible, safe outdoor spaces creating contact with nature. This study by Lee et al. provides an important reference to the role and features of the built environment based on salutogenic principles. However, the CI-RAC model proposed here demonstrates that a supportive built environment is only one factor of the three pronged interdependent variables of community integrated aged care, which, it is argued, must coexist with supportive operational and social environments aligned to the salutogenic principles of *comprehensibility, manageability, and meaningfulness.*

The aspects of community integration are layered into the three levels of the conceptual model of community integrated aged care (CI_RAC) developed for this study (Figure 4.1). At the operational level (Level 3) it identifies the three aspects of a supportive operational environment, a supportive social environment, and a supportive built environment as the key components that together deliver a community integrated model of aged-care provision. This conceptual model provides the framework that will be explored in depth through the

perspectives and lived experience of those who work and live in the facilities that comprise the field work for the research, presented in Chapters 6 to 9.

4.8 Conclusion

This chapter has demonstrated the importance of 'community' in enabling older people to stay engaged in society. Given the increasing levels of dementia and other cognitive decline combined with an increase in numbers of older people requiring formal continuous care, the concept of community and nature of integration of this sector have become critical issues in enabling older individuals to stay connected and active in order to lead a meaningful life with dignity. To be able to do so with advanced frailty is particularly important. Hence this chapter has explored firstly, the concept of community, and the meaning of integration for people with higher needs care. Through this discussion, elements of community integration were drawn as applicable to community integrated residential aged care taking into account the Australian policy context. The extension of an active ageing framework enables older individuals to stay connected and age within communities as active participants. How such care has been implemented in practice has been illustrated by brief descriptions of a range of residential aged care schemes that exemplify aspects of community integration.

Drawing on the literature and policy reviews and the five international exemplars discussed in this chapter, a conceptual model is proposed of how community integration can be applied in a residential aged care setting. The nexus of relationships forming the first tier of the proposed CI-RAC model includes socio demographic change which together with the dynamic relationship between salutogenic theory and the concept of Psychosocially Supportive Environments, and Active Ageing policy comprise the key drivers. Thus, while this nexus of relationships is described as the driver of the development of community integrated aged care, it flows down to the organisational philosophy and culture as the primary enabler of a community integrated model of residential aged care. It was clear from the exemplar cases discussed in this chapter that this was the key catalyst in the provision of a care model supportive of community integration. All had their origins in the particular vision and philosophy of these organisations in providing quality of life and health and wellbeing to those in their care. The organisational philosophy is then critical in the shaping the organisational policy of the aged care facility. which is then filtered through the layer of statutory and regulatory compliance frameworks that can constrain or compromise g the feasibility and delivery of a community integrated care approach.

The delivery of aged care, in the CI-RAC model is represented in the third and lowest tier through the three interdependent domains of a supportive operational environment, a

supportive social environment, and a supportive built environment. In order to deliver such a model, all three tiers of the model should actively embody wellness factors rather than illness factors as theorised in salutogenic theory and its central concept of addressing a person's Sense of Coherence (SOC) and its constituent factors of *comprehensibility, manageability* and *meaningfulness* as discussed in Chapter 2. This should be evident in all the three domains of a supportive operational environment, a supportive social environment and a supportive built environment.

The proposed model offers a conceptual framework to explore the four detailed case studies chosen for the empirical research for this thesis presented in the following chapters. The value of this model in understanding the delivery of community integrated residential care is further discussed and refined in the light of the empirical findings in the discussion chapter of the thesis (Chapter 10). The next chapter sets out how the research methodology was developed, using the three-component CI-RAC model outlined above.

Chapter 5: Methods

5.1 Research approach

This research investigates the relevance and viability of achieving greater community integration of residential aged care facilities given the increase of numbers in the population demographic requiring more intensive care. The methodology aims to explore how elements of the CI-RAC model (Figure 4.1) are exemplified in the four case studies chosen for the research. The focus is on the three components – social, operational and built environment, selected for addressing community integration of residential aged care. The research was undertaken using a case study approach incorporating four case studies in New South Wales, Australia, as described below and in more detail in Appendix 7. Following the identification of research gaps and the definition of the CI-RAC model in Chapter 4, the empirical stages of the study was conducted using an in-depth interviewed questionnaire format for each of the two categories of stakeholders and residents or their families. The research method was designed to address the following research questions:

1. How have residential aged care delivery models in NSW incorporated the principles of community integration?
2. How do care receivers perceive the value of community integration?
3. How well are the needs of high-care residents accommodated in the practice of community integration principles?

A mixed method framework has been used which included seeking the views of residents and management of aged care facilities, aged care providers and facility designers, to capture the different perspectives of the many different 'actors' in the aged care system in Australia. Methods used included initial exploratory discussions to ascertain the relevance and viability of the research, followed by selection and documentation of four cases, an interviewed survey of key stakeholders and residents or their families. The researcher's observations for each case study are included in Appendix 1. The following steps were followed in this research.

Stage 1: Exploration

An initial ground-truthing exploration was carried out to establish relevance of the research topic. It involved three steps:

1. Initial discussions with industry experts to discuss relevance of research;
2. A literature review (incorporated into Chapters 1, 2, and 3) to establish the basis of the research and evaluative model;
3. Identification of research gaps to be addressed (Chapter 3).

Stage 2: Execution

Identifying and selecting approaches to the research involved:

1. Identification of research methodology;
2. Development of a conceptual model of community integrated residential aged care 'CI-RAC', based on the literature review (Chapter 3);
3. Identification of case studies;
4. Identification of interviewee groups; and
5. Ethics approval.

Stage 3: Design and documentation

1. Documentation of case studies;
2. Design of interviewed questionnaire of stakeholders;
3. Design of interviewed questionnaire of residents or their families; and
4. Conducting the interviews.

Stage 4: Conclusion

1. Assessing results; and
2. Presenting the Permeability/ Porosity/ Propinquity (PPP) schema of the operational, social and built environment of CI-RAC.

Stage 5: Reflection

1. Reflections on methods.

5.2 Stage 1: Exploration

The aim of Stage 1 of this research was to explore the relevance and viability of the topic of community integration of residential aged care, inclusive of past, present, and future directions. This exploration was based on discussions with my supervisors Professor Bill Randolph and Professor Emeritus Bruce Judd. A literature review of policy and practice of residential aged care, as well as relevant theoretical fields, were conducted next. The literature review was conducted through a key word selection, as well as information gained in the following Stage 2 of exploratory discussions with industry leaders.

The resulting peer reviewed journals, publications using the UNSW data base and access to international academic publications, UNSW library resources, internet searches on Google Scholar, and searches for Australian federal and state government reports, as well as public documents on global policy, reports and standards on ageing and aged care, such as from the

World Health Organisation and United Nations. This led to the identification and validation of the research gap.

5.2.1 Exploratory discussions

The purpose of the exploratory discussions was to broadly orientate the researcher regarding the issues in the CI-RAC and the consequent need for this research, as well as to help identify potential case studies, and inform the design of the questionnaire. These initial exploratory discussions included inquiry about the current state of residential aged care, and the impacts of current policy, funding and practice of residential aged care and likely future trends. These informal exploratory discussions, coupled with a literature review informed the research questions and selection of case studies, for in-depth analysis. The steps undertaken for the initial informal discussions were as below:

1. Identification of broad categories of stakeholders to represent the views of a cross section of participants in the aged care industry;
2. Identification of participants within those categories;
3. Obtaining written permission for participation in the exploratory discussions;
4. Conducting the face-to-face exploratory discussions.

The exploratory discussions were undertaken between November 2013 and February 2014, with four categories of participants:

1. Government policy makers;
2. Aged care sector senior professionals;
3. Aged care peak body representatives;
4. Aged care facility designers;
5. Academics.

While these exploratory discussions formed the initial phase of this research in ascertaining its direction and content, two further discussions were undertaken at a later stage of the research following the in-depth interviews. These two interviews were conducted with industry experts who were introduced to the researcher throughout the course of the in-depth interviews. These industry experts had specialised knowledge of the development of aged care delivery and practice in Australia, as well as detailed knowledge of the selected case studies.

Selection of participants

Identification of key industry stakeholders was undertaken following the literature review and conversations with industry leaders. Through the literature review it was identified that sixty percent of aged care providers in Australia were within the not-for-profit sector (AIHW 2015). Therefore, interviews were secured with several leading aged care providers in that sector identified through a web search. Under the 1996 aged care policy reforms of the Australian Government, all capital funding for aged care fell under the umbrella and jurisdiction of the

Australian Government (Nolte and McKee 2008). It was therefore relevant to seek the views of a senior Australian Government policy maker to obtain a government perspective on the current state of residential aged care as well as future policy development.

As this research has focus on the role of the built environment in CI-RAC, leading architects and designers of repute responsible for the design of innovative aged care facilities were also identified and approached for participation in the exploratory discussions. Finally, in order to obtain an independent opinion of the state of residential aged care within the Australian context, well known academic experts were also identified and approached. Additional participants were also identified during the course of the exploratory discussions using a snowballing technique. The interviews were limited to NSW, due to the researcher's location in NSW, as well as NSW being the location of the head offices of the aged care providers approached for this research. The discussion with the senior Australian government policy officer, based in ACT, took place via phone conversation.

Table 5.1 Exploratory discussion schedule

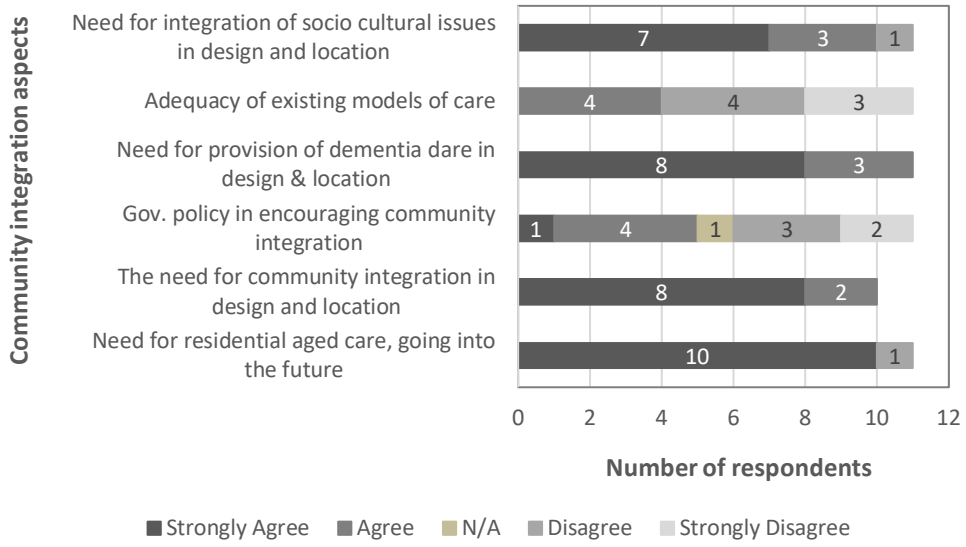
Exploratory discussion schedule	**Type**	**Date**
John Flower. Director, Calder Flower Architects.	Architect	8 Nov 2013
Barbara Squires. Head of Research and Advocacy, IRT Group.	Aged Care provider/ Industry Expert	19 Nov 2013
Diane Jones. Executive director, PTW Architects, Adjunct Professor, UNSW.	Architect	29 Nov 2013
Dr John G. Kelly AM, Chief Executive Officer, Aged and Community Services, Australia.	Aged Care Peak Body	02 Dec 2013
Senior Policy Officer, Department of Social Services, Australian Government, Canberra (not identified by request)	Australian Government Policy maker	05 Dec 2013
Rev. Nicholas Stavropoulos. Chief Executive Officer, St. Basils Homes	Aged Care Provider	11 Dec2013
Dr. Stephen Judd. Chief Executive Officer, Hammond Care.	Aged Care Provider	12 Dec 2014
Chris Lawlor. Director of Development and Asset Management, Uniting Care Ageing	Aged Care Provider	13 Dec 2013
Professor. Richard Fleming. Director NSW/ ACT Dementia Training Study Centre, University of Wollongong	Academic/ Industry Expert	10 Jan2014
Professor Henry Brodaty AO MB BS MD DSc FRACP FRANZCP. Scientia Professor of Ageing and Mental Health, University of New South Wales; Consultant Psychogeriatrician, Aged Care Psychiatry and Head of the Memory Disorders Clinic, Prince of Wales Hospital. Director of the Dementia Collaborative Research Centre (Assessment and Better Care) and Co-Director of the Centre for Healthy Brain Ageing, UNSW.	Academic/ Industry and Dementia Expert	01 Apr 2014
Tamar Krebbs. Founder and Director, Group Homes Australia.	Aged Care Provider	
Further coping interviews following the selection of case studies		
Gillian McFee. Director, Gillian McFee& Associates	Industry Expert	11 May 2015
Steve Tuelan. Director, Uniting Care Ageing NSW.ACT	Aged Care Provider	18 June 2015

The informal exploratory discussions were based on the following themes:

- The need for residential aged care going into the future;
- The need for community integration in terms of design and location;
- Government policy in encouraging community integration;
- The need for provision of dementia care in the design and location of residential aged care;
- The adequacy of existing models of care/financial models;
- The need for integration of socio-cultural issues in design and location of residential aged care.

Figure 5.1 below demonstrates the views of the stakeholders interviewed about aspects of community integration.

Figure 5.1 Exploratory discussions: Community integration aspects



As indicated, the exploratory discussions demonstrated a broad overview of the nature of aged care delivery and practice through the eyes of providers, academics and designers. There was a strong congruence in opinion from all sectors interviewed that there was an overwhelming need for greater community integration of residential aged care into the future. At the same time, there was agreement that government policy supportive of CI-RAC and accompanying care and practice models was not yet sufficiently represented within the Australian aged care system. This gap is addressed by this research.

Following these initial exploratory discussions with industry leaders and drawing on the theoretical discussion in Chapter 2 and literature review and international exemplars in Chapter 4, the following broad institutional policies and practices to support the

implementation of community integration in a residential aged care setting were deduced. These are;

1. Interaction with the local community visiting the home
2. Choice and independence
3. Promotion of healthy lifestyles
4. Age-friendly building and design
5. Seniors educational programs
6. Interaction with the public in the local community.

These were included in the stakeholder questionnaire interviews used to validate the key features of care models incorporating community integration.

5.3. Stage 2: Execution

As noted in Chapter 1 Introduction, for the purpose of this research, community integration of residential aged care will be referred to as "CI-RAC", a term unique to this study. A conceptual model of CI-RAC, was developed through the literature review, to be tested against the case studies selected for this research (Chapter 3). This conceptualisation culminated in a three-component approach to operationalising community integrated aged care in a holistic delivery model which comprised: semis etc

1. A supportive operational environment;
2. A supportive social environment;
3. A supportive built environment.

The identification of these three components through exploratory discussions and literature review, led to the selection of the four case studies as good practice examples demonstrating aspects of the three components providing provided for community integration.

Informed by the exploratory discussions with the key industry stakeholders and the literature review, four good practice examples of community integrated aged care facilities were selected varying in built form and scale, location, care model and financial model. In-depth interviews were then conducted using questionnaire format, which included stakeholders of the facilities, and the residents (or alternatively a family member in the case of incapacity to participate). The stakeholders consisted of four groups including care workers, management, the provider/owner and the designer of the facility.

5.3.1Case studies

The case study approach adopted for this research is a widely recommended approach that allows the in-depth examination of a social phenomenon (Babbie 2013). As discussed in the

Introduction Chapter, population ageing is a pervasive social phenomenon, affecting every man, woman and child, in societies across the globe (Population Division, DESA, United Nations 2000). Klein points out:

> Case studies emphasise detailed contextual analysis of a limited number of events or conditions and their relationships. Researchers have used the case study research method for many years across a variety of disciplines. Social scientists, in particular, have made wide use of this qualitative research method to examine contemporary real life situations and provide the basis for the application of ideas and extension of methods (Klein 2012, p. 70)

The case study research method is described by Yin as "an empirical inquiry that investigates a contemporary phenomenon within its real life context, when the boundaries between phenomenon and context are not clearly evident, and in which multiple sources of evidence are used" (Yin 2008, p. 23). Grbich summarises the many well-known case study researchers such as Robert E. Stake, Helen Simons, and Robert K. Yin, suggesting that techniques for successfully organizing and conducting the research fall into six steps: semis etc

- Determine and define the research questions
- Select the cases and determine data gathering and analysis techniques
- Prepare to collect the data
- Collect data in the field
- Evaluate and analyse the data
- Prepare the report (Grbich 2012)

Case study selection

The case studies were selected through the scoping interviews from examples given by key industry leaders interviewed, of facilities they believed exhibited community integration characteristics. The cases were not evaluated for their expertise or extent of community integration, but rather selected for their variation of location, size (number of residents), and one facility for its specificity on dementia care. Details of these case studies are provided in Appendix 1. Keeping in mind the large diversity of the ageing population in Australia who reside in residential aged care, choosing case studies that vary as much as possible on a range of criteria demonstrating aspects of community integration of residential aged care, allowed the researcher to investigate the particularities of each case as well as patterns shared across all four cases.

Importantly, it should be stressed that this research did not attempt a comparative analysis of facilities deemed to exemplify 'best practice' in community integration against facilities that

deemed to be weak in this respect as this was not within the scope of the research.. The focus was on the need for and nature of community integrated residential aged care facilities in Australia. It also concentrated on facilities catering for higher need residents, aligning their needs with salutogenic theory and contemporary views on the need for community integration of older people.

Although the initial inclination was to select five case studies from around Australia, it culminated in the selection of four, all located in NSW. As the researcher was based in NSW, local case studies facilitated the data gathering process. This is a limitation of the research.

The reduction of case studies from five to four was decided upon as the criteria considered for the maximising the variation of facilities yielded the necessary aspects across the first four selected case studies and a fifth case study was not deemed to be of added benefit.

All the selected case study subjects provided letters of permission on their willingness to participate in this study, and to make available the necessary information and access to management staff and residents.

The four case studies of residential aged care facilities identified by the initial discussions with industry leaders with good practice in community integration were used to test the utility of the CI-RAC model. These four case studies served as the lenses through which the CI-RAC model is given expression in understanding community integration of residential aged care and its theoretical and philosophical underpinnings. The cases vary in the geographical location and the neighbourhood type in which they are located, their degree of connectivity to the neighbourhood surroundings, their scale and form, and the care model used as well as the resident profile. The purpose of this section is to describe the case studies to position their differences and similarities in approaching their unique interpretation on the nature of community integration. Detailed descriptions of the four case studies are provided in Appendix 1. The case studies are listed below:

1. Dougherty Apartments, Chatswood;
2. Sir Moses Montefiore Jewish Home, Randwick;
3. Group Homes Australia, St. Ives;
4. Elanora, Shellharbour.

The information pertaining to these case studies was obtained from the following sources:

- Published information on the aged care facility from the provider of the facility;
- Online published information on the aged care facility website, and local and federal government websites;

- Information received through in-depth interviews conducted for this research with managerial personnel of the facility as well as management of the provider of the facility; and
- The researcher's personal observations of each facility. These observations are offered to enrich an understanding of the facilities.

The selection criteria considered for selection of the four case studies, were;

- Geographical location: within the Sydney/ Illawarra area;
- Connectivity: the availability of public transport options and proximity of road networks, and access routes;
- Care model: distinguishing features of care provision;
- Built form and scale of the facility: the relation of the built form of the facility to the surrounding neighbourhood inclusive of number of residents, floor area, and height; and Innovation: inclusive of mission statement, of the provider and how this reflects in the management model facilitating community integration.

Dougherty Apartments is a multi-story facility at the heart of the Chatswood commercial centre, with opportunities for visitors to come into the facility as well as for residents to access the neighbourhood. Opportunities for residents of varying care-levels to interact together are incorporated into the care model. It demonstrated ease of access for both residents to access the neighbourhood as well as the external community to access the facility.

In contrast, *Montefiore*, which has a capacity for 300 residents, demonstrates community integration within a secure compound. High level security access controls who enters the facility by virtue of the importance of security placed within the Jewish community. Planned community and family interaction is a focal point built into the management model. Montefiore is a self-reliant community with many essential services located within the facility.

Group Homes Australia, in contrast to Montefiore, is a small domestic scale facility with only 6 residents. This facility is a high-care facility for residents with dementia related diseases. Its approach to community integration is much like a regular domestic environment. Strangers cannot access the facility from the community unless invited, although family members of residents are free to access the facility at any time of day, exactly as in a domestic home environment. The residents also access the village centre and shops with their carers located a short walking distance from the facility.

The Elanora aged care facility is part of a new town centre development. Elanora therefore demonstrates how community integration can be incorporated into urban planning, thereby increasing opportunities for aged and impaired residents to be integrated into the local community by virtue of its proximity and to the main new town centre of Shellharbour. The

residents' individuality, personal preferences and autonomy are a focal aspect of the care philosophy of the aged care provider 'Uniting'. 'Uniting' are also responsible for the now widely accepted 'person centred care' approach in aged care, and now integrated into the Australian policy context.

A summary of the nature of the facilities is provided in Table 5.2. Following this summary table, Figures 5.2 to 5.5 presents a further descriptive summary of the four case studies. Detailed descriptions of the case studies are included in Appendix 1.

Table 5.2 Aged care facility profiles

Name & Address	Geographical location	Connectivity	Provider	Form of facility	Scale of facility		Innovation
					No. of Rooms	GFA	
Dougherty Apartments Chatswood. NSW 2067	Major Urban Centre	Bus, Rail, Private Vehicle	Dougherty Apartments Retirement village. Private NFP	Multi storey residential apartments	68: Hostel 44 self-care 44 Dept of Housing	10,289 m2	Community integration Multicultural integration Dementia Care urban integration
Sir Moses Montefiore Jewish Home 36 Dangar Street Randwick. NSW 2031	Inner City Suburban	Private vehicle	Sir Moses Montefiore Jewish Homes. Private, NFP	High density Residential Institution Resort	109: Nursing home 60: Dementia Care 107: Hostel Care:	27,400 m2	Faith based principles of care Community integration Prestige and reputation Neighbourhood model of care Day care & respite care Dementia specific care Intergenerational Integration
135 Killeaton Street Group Home St Ives. NSW 2075	Suburban	Bus, Private vehicle	Group Homes Australia	6-bedroom residential dwelling specialising in catering for dementia care housing for 6-8 residents.	6 beds	300m2	Dementia Specific Care Home Environment: Functions, looks, smells like a 'home' Focuses on life choice and relationships Community integration through scale and appearance of home
Elanora. 7-23 Wallaroo Drive Shellharbour City Centre NSW 2529	Regional Fringe	Bus, Private vehicle	Uniting Care Ageing	Medium density Residential Institution	100 beds	6696 m2	Ageing in place: low care and on-site high-care Inspired care model Public transport connectivity Pastoral care

Case Study 1: Dougherty Apartments, Chatswood. NSW

This description of the Dougherty Apartments begins with a summary of its nature and then proceeds to a point by point description of the community integration characteristics.

Name: Dougherty Apartments.

Provider: Dougherty Apartments Pty. Ltd

Provider type: Private, Not for profit

Location: 1 Victor Street, Chatswood. NSW

Neighbourhood type: Major urban centre

Connectivity: Major railway transit station, bus transit terminal, major highway, primary and secondary arterial road network.

Scale: 9 storey high rise 'Vertical Village' containing 148 residential units:

- 22 x Resident funded 1bedroom self-care units
- 19 x Resident funded 2bedroom self-care units
- 1 x Resident funded 3bedroom self-care units
- 38 x Public funded 1bedroom self-care units
- 68 x Residential care units.

Philosophy: To promote and encourage residents to maintain their independence and links to their community.

Resident demography: Self-care, residential aged care, dementia care, with a combination of public funded, private funded, and concessional.

History: Built in 1989, in partnership with Willoughby Council, Department of Housing, and Uniting Care Ageing. It is now under the sole management of Dougherty Apartments.

Architect: PTW Architects (architects of new refurbishment)

Commencement of operations: 1989

Cost: Original cost is not available

Cost of Refurb: AUS $ 14.6 million (Approximate)

GFA: 10289 Square metres

Dougherty Apartments. Source:(Dougherty Apartments 2009)

Location Map, Dougherty. Source (Google Maps 2017a)

Figure 5.2 Case Study 1: Dougherty Apartments summary description

Case Study 2: Sir Moses Montefiore Jewish Home, Randwick. NSW

The following is a summary description of the nature of Montefiore, and then proceeds to a point by point description of the characteristics

Name: Sir Moses Montefiore Jewish Home, Randwick

Provider: Sir Moses Montefiore Jewish Homes

Provider Type: Private, Not for Profit

Location: 36 Dangar Street, Randwick NSW

Neighbourhood Type: Inner Suburban

Connectivity: Primary and secondary arterial road network. On-site parking.

Montefiore Home, External view. (Source: (Montefiore Jewish Home 2017)

Scale: 3 Storey multi-development

- 107 Hostel (or low level care) beds for residents who require some assistance with daily activities
- 109x Nursing Home (or high level care) beds for frail or physically dependant residents requiring higher level of nursing care
- 60 High and low special care beds for residents with dementia and other cognitive impairment requiring specialised care in a secure and caring environment
- Respite care for short term accommodation and provision of care in times of need

Philosophy: "To enhance the quality of life of older persons, by providing an exceptional standard of service and care, embracing the richness of Jewish religion, culture & tradition" (Montefiore 2018)

Architect: Calder Flower Architects

Cost: AUS$ 95 million (Approx.)

Commencement of Operations: 2006

GFA: 27, 400 Square metre

Immediate surroundings of Montefiore Jewish home

Figure 5.3 Case Study 2: Montefiore Jewish Home summary description

Case Study 3: Group Homes Australia. St Ives, NSW

The following is a summary description of the nature of Montefiore, and then proceeds to a point by point description of characteristics.

Name: Group Homes Killeaton Street, St Ives

Provider: Group Homes Australia

Provider Type: Private, Dementia Specific

GFA: 300 Square metres

Location: 135 Killeaton Street, St Ives

Neighbourhood Type: Suburban

Connectivity: Primary and secondary arterial road network. Connection to major Highway.

Scale: 6bedroom Residential Dwelling

Philosophy: Supporting older people with dementia to live independently, in a home environment, with an active engagement in the local community.

Resident Demography: Dementia care specific, 6 Dementia residents.

History:

Group Homes, Home 1: Origin Nov 2012, Killeaton Street, St Ives

Designer: Tamar Krebbs

Cost of Renovation Home 1: $400,000 renovation plus fit out (Killeaton Street, St Ives)

Commencement of Operations: 2011

Group Homes Australia. (Source: (Tamar Krebbs 2017, 2017)

Location Map: Group Homes Australia. St Ives. Source: (Google Maps 2017b)

Figure 5.4 Case Study 3: Group Homes Australia, summary description

Case Study 4: Elanora, Shell Harbour. NSW

Name: Elanora, Shell Harbour

Provider: Uniting Care Ageing

Provider Type: Private, Not for Profit

GFA: 6696 Square metres

Location: 7 Wallaroo Drive, Shell Harbour City Centre

Neighbourhood Type: Peri-Urban

Connectivity: Public transport by Bus (Bus transport to Railway station, connecting to Sydney City CBD, and Wollongong CBD). Primary and secondary arterial road network. On-site parking. Connection to major Highway.

Scale: 80 x Bedroom Residential Care Facility

Philosophy: "Inspired Care" designed to enable the well-being of residents offering a service of care with courage, Integrity, compassion and respect, maintaining and encouraging their links to the local community, within a non-clinical environment.

Resident Demography: 100 Residential care

History: Developed by Uniting care as part of a strategic development plan of the New Shell Harbour Town Centre precinct.

Architect: Calder Flower Architects

Commencement of operations: Dec, 2011

Cost: AUS$ 21,000,000.00 (Approx)

Figure 5.35 Elanora Shellharbour. Source(Calder Flower Architects 2017)

Location Map, Elanora. (Source: Calder Flower Architects, 2017)

Figure 5.5 Case Study 4: Elanora Shellharbour summary description

5.4 Stage 3: Design and documentation

Design of the in-depth interviews and documentation of case studies both followed Stage 2 and was intertwined with both Stage 1 and 2 since it was not a linear process. An ongoing cross referencing of the literature review as well as keeping informed of industry publications, government reports and publications, new academic literature and discussions with industry experts influenced the ongoing process of development of this stage. The questionnaires took two forms: stakeholder interviews, and resident or family member interviews.

5.4.1 Part 1: Stakeholder perspectives

The operational environment

Aspects of the operational environment that were examined through the four case studies of this research were the key contextual features identifying particular challenges and issues relevant to the service and delivery of CI-RAC for each facility. These questions were specifically aimed at the stakeholder group of participants rather than residents, given that operational structure and business drivers of the facility are pre-eminent.

Primary to this research was the definition of 'who' comprises the community in the perspective of stakeholders as well as for the residents or their families, using two questionnaires designed for the stakeholders and residents respectively. These questionnaires are discussed in more detail in Section 4.5. Seven groups of actors were identified as forming a 'community':

- The community of residents within the home;
- Staff of the home;
- People in the local community;
- Visitors to the home;
- Visiting family and friends;
- Visitors to the home providing a service;
- Other.

The seventh category of "other' was included to capture groups that may not have been identified through the literature review and initial exploratory discussions.

The operational environment also included the external and internal policy factors influencing the delivery of the residential aged care model in question. External policy was seen as both in terms of the operational policy as well as specific government policy, with the questionnaire addressing both fields of policy influences in operationalising CI-RAC. The findings were captured in a table identifying the operational drivers of CI-RAC and their respective influences on the *operational environment.*

Given the unique challenges brought on by an increasingly frail population in residential aged care, the impact of the internal operational environment focused on the day-to-day management model, executed through a care model of the facility incorporating the following elements:

- Positive profile of home;
- Financial viability;
- Staffing;
- Safety and security;
- Emotional wellbeing;
- Disturbance in care routines;
- Noise and disruption.

In the above identified elements of the operational environment derived from the literature review and exploratory interviews, the elements of a community integrated care model included the perception of the facility as one that projected a positive image to the general community as well as to residents and families, as one that was integrated into the community. The element of financial viability of providing a positive experience to residents, included elements such as adequate numbers as of general as well as specialised staff, provision of safety and security both physical and emotional wellbeing. The possible negative aspects of disturbance in care routines, and noise or disruption brought on by a community integrated approach, are also noted to be important elements in considering a community integrated care model.

The social environment

In acknowledging the increasing number of older individuals in society with higher care needs resulting in an increasingly frail demographic of residents entering into residential aged care, developing a social environment geared to CI-RAC was just as important from the perspective of the stakeholders as it was for the residents. In many ways, it is the management model that enables the degree and nature of social integration. The social environment was viewed by the stakeholders through the lenses of institutional policy enabling a social environment to be embedded within the CI-RAC model. The elements chosen to examine the stakeholder perspective for this component were as follows:

- Interaction with the local community within the facility;
- Choice and independence (to residents);
- Promotion of healthy lifestyle;
- Seniors educational programmes;
- Interaction with the public in the local community;
- Other.

In examining the above, entertainment and organised activities were also investigated, including educational programmes and the integration of dementia care was also examined as a component of operationalising an effective social environment in CI-RAC.

The built environment

The aspects of the built environment in enabling CI-RAC were examined through the analysis of the physical characteristics of the facility and its surrounds as well as the more qualitative aspects (such as what constitutes a desirable atmosphere to aid in the community integration of a facility) in the four elements below:

- Location of the facility;
- Age friendly building and design;
- Architectural design;
- Size of facility;
- Familiar atmosphere of facility.

In assessing the built environment, the implications of local government planning controls were also broadly discussed in their role in enabling or inhibiting a CI-RAC model.

5.4.2 Part 2: Resident and family perspectives

The second part of the findings is exclusively dedicated to the examination of CI-RAC and its relevance to residents and their families.

Social environment

As with the stakeholders, the residents were first asked to identify the important groups of community in their lives using the same 6 identified categories (noted above in Section 5.3.1), the aim being to identify the nature and degree of community integration in their lives.

Factors facilitating community integration within the facility were examined through 6 categories of:

- Choice and independence;
- Personal care;
- Health care;
- Entertainment;
- Staff.

Resident engagement in the wider community was examined through the ranking of importance for residents in the following areas:

- Parks;
- Recreational shopping;
- Shopping centre;
- Coffee Shop;
- Visiting family;
- Recreational walks;
- Corner shop;
- Organised trips;
- Movies and theatre;
- Neighbourhood destinations;
- Recreational clubs such as Returned Services Leagues (RSL) clubs;
- Restaurants.

Operational environment

It was also important to examine if any features demonstrating CI-RAC were reasons for residents to choose a facility for their care provision, in consideration of the importance of CI-RAC in their choice of entering the facility, based on the following elements:

- Cost/affordability semis;
- Religious specificity;
- Cultural specificity;
- Community engagement;
- Activities available;
- Care model;
- Facilities provided.

Built environment

- Location of the facility;
- Architectural design;
- Size of facility;
- Familiar atmosphere of facility.

Considering the frailty of the highest need care residents interviewed for this study, it was important for the residents to identify the areas that may influence or impact on their social life. The findings of the stakeholder interviews and the findings of the resident interviews are addressed separately. Viewing these two categories with separate lenses was important in teasing out issues relating to the operational and social matters. Both were relevant to operational viability from stakeholders' perspectives, and through an experiential perspective in the resident category.

5.4.3 In-depth 'questionnaire and interview' method

With the view of obtaining qualitative data, this research adopted a 'questionnaire and interview' method. Babbie describes this type of instrument as a "data collection encounter in which one person (an interviewer) asks questions of another (a respondent)" (Babbie 2013, p. 274). He goes on to say that an interview "is an alternative method of collecting survey data. Rather than asking respondents to read questionnaires and enter their own answers, researchers send interviewers to ask the questions orally and record respondents answers" (Babbie 2013, p. 274). This was relevant for this research as the respondents were older residents in residential aged care facilities with varying degrees of cognitive and mental capacity, making it potentially difficult for surveys to be self-administered. The questionnaire and interview approach included both closed and open questions.

The closed questions, in most instances also produced valuable data of qualitative significance through the interview format, prompted in conversation. 'Probing' was incorporated into the interviews, which was seen to be useful when respondents gave vague, tangential or incomplete answers, in guiding the respondent back to the substance of the question in order for the answers to be sufficiently informative for analysis. Probing was also used in the closed questions relating to satisfaction rating or frequency rating to arrive at an accurate response and provide a more nuanced understanding of interviewees' choice. Babbie proposes the technique of 'probing' as a request for elaboration and advises the interviewer to use neutral probes which do not encourage a biased answer from the respondent. He recommends silence as the most effective probe which encourages the respondent to elaborate on their own accord. He also recommends neutral probes such as "how is that", "in what ways", or "anything else" which were used in this research (Babbie 2013). Abbas et al. argue that "the advantage of interviews compared to self-administered questionnaires, is that in the latter, probing is not possible", and important data could neglect to be missed (Abbas Tashakkori and Charles Teddlie 1998, p. 305). For this research, the data was recorded both in written notes by the interviewer, as well as digitally so that information that might have been overlooked in the written record would be captured at the time of the interview.

All but two of the interviews were conducted in the field or location of the respondent workplace in the case of stakeholders, and place of residence in the case of residents. As Babbie describes, going directly to the social phenomenon under study, allowing study in the respondents' natural environment, can create a more relaxed atmosphere and a deeper, fuller understanding of the respondent's views (Babbie 2013).

The interview format also allowed the researcher to further explain the questions where there was difficulty in language or comprehension due to the varying ability levels of the older residents who took part in this study. As all data gathering was undertaken by the researcher, it also allowed the researcher to refine the questionnaire during the early stages of the interviews. In this respect, there were three changes to the resident questionnaire. The first was the deletion of a question referring to the inclusion of *Marshall's principles of design for dementia care*, in the design of the aged care facility, which was initially thought to be relevant (Marshall 1996). It was soon noted however, that these principles explicitly related to the specific design of the interior of the facility, and therefore were not particularly relevant to the broader focus of this research. The second change in the resident questionnaire was the addition of a question concerning the geographical nature and extent of community integration by asking the resident to mark their regular destinations to and from the facility on a map of the local area as well as and determining the frequency of those visits (see Appendix 1 and Appendix 2 for copies of the questionnaires. The questionnaire for residents contained questions specifically targeted on the experience of community integration offered by the facility to residents. The stakeholder survey questionnaire contained operational, policy, and management questions as well their perception of community integration and views of community integration pertaining to the facility.

5.4.4 Selection of participants

For this research, interviewees for each case consisted of five groups of respondents across the four selected case studies. Each group included eleven or twelve interviewees, with a total of forty-six interviews for all four case studies. The interviews included the following groups together with the number of interviews for each case study:

- Aged care facility provider: One interview;
- Residents (or family member) of aged care facility: Five interviews;
- Aged care facility management: One interview;
- Aged care facility care workers: Three interviews;
- Architect/ Designer of aged care facility; One interview.

All but one of the interviews with the aged care provider, was with the CEO or member of the senior executive management of the organisation. Similarly, the management interviews were conducted in all facilities with the general manager or a senior executive manager. The interviews with the architect/designer of the facilities were with the principal designer/director of the architectural firm responsible for the design of the facility. The case study with the lowest numbers of residents and care workers consisted of five and three respectively. This sampling number complies with the recommended total number of interviewees as stated above (Sandelowski 1995).

The purposive 'sampling frame' shown in Table 4.2, was provided to the aged care facility management, to identify residents or their families for the in-depth interviews. The rationale behind the gender split is reflective of the far higher percentage of female than male residents in residential aged care facilities. In all but one of the case studies, the residents were directly interviewed by the researcher. On the advice of the CEO of Group Homes, the daughters of the five female residents, were interviewed rather than the resident directly since the latter were all suffering from advanced levels of dementia-related illnesses. The resident was present at the interview in all five interviews which took place in the age care facility.

Table 5.3 Purposive sampling frame for resident selection

	74 years and younger	75 years and older
Male	1	0
Female	0	3
+ 1 in any category of age and gender		

Requests for participation in this research did not encounter any obstacles, rather the participants were generous in offering their time and willingness to participate. As a token of appreciation for their generosity, a combination of gift vouchers and boxes of chocolates were given to respondents after checking with the aged care facility management for any medical conditions with dietary restrictions.

5.4.5 Interviewee abbreviations

Stakeholder interviews:

The abbreviation system used to identify stakeholders following quotations in the findings chapters of this thesis consists of three elements as outlined below.

- Two letters identifying the name of the case study, a letter and number identifying interviewee category, followed by the initials of the participating stakeholder. i.e. (DA, P1, XX)

Table 5.4 Stakeholder interviewee abbreviation

Case study	Interviewee category	Stakeholder initials
DA (Daugherty Apartments) MF (Montefiore Jewish Home) GH (Group Homes Australia) EL (Elanora, Shellharbour)	P1 (Provider) M1 (Management 1) M2 (Management 2) C1 (Care worker 1) C2 (Care worker 2) C3 (Care worker 3) D1 (Designer/Architect)	XX (First and second name initials)

The abbreviations used for resident interviewees following quotations consists of four elements as outlined below.

- Two letters identifying the case study, a three-letter abbreviation for resident category, the interview number and gender of resident, followed by the age of the resident. i.e. (DA,Res,3F,94).

Table 5.5 Resident/family interviewee abbreviation

Case study	Resident category	Number & gender	Resident age
DA (Dougherty Apartments)	Res	1F (Resident 1, Female) 1M (Resident 1, Male)	XX (Age of resident)

It should be noted that all participating stakeholders taking part in the in-depth interviews, including the residents and their families, consented to being identified. The abbreviations used by the researcher, were used for differentiating stakeholder groups and the case studies they represented, rather than for de-identification. However, identification of residents is avoided in this thesis by using age and gender only.

5.4.6 Case study documentation

As this research relied more upon a qualitative method of data analysis, documentation of the four case studies was particularly important as the research was focused on the design and planning of the built environment, making it necessary to document the characteristics of the design and location of the facility. As Marshall and Rossman point out, "qualitative researchers typically rely on four methods of data collection: (a) participating in the setting, (b) observing directly, (c) interviewing in-depth and (d) analysing documents and material culture" (Marshall and Rossman 2010, p. 97). The researcher's subjective observations were applied to all four case studies by visiting the facilities in their urban context. The researcher travelled to the case studies using public transport, which enabled her to form a view of the degree of connectivity and ease of travel to the locations from the Sydney CBD, as well as their local town/village centres.

Documentation of the case studies was undertaken for this research to obtain demographic and historical data on the four localities in which the case studies were situated, as well as the characteristics of the built environment and the physical built form of the facility, that might support community integration. One of the variables used in the maximum variation selection process of the four case studies was the type of neighbourhood and locality, for which historical and demographic data was derived, to help identify the level of community integration of the residential aged care facility. Data was also sourced from online transport and local council

sources, on the level of availability of public transport such as access to bus, rail and road networks to determine the degree of connectivity of the aged care facility to local services such as a village centre and public transport. Proximity to parks and other recreational activities and aspects of safety were also important information that could impact on community integration of the facility and was sourced from online local Council databases. As (Marshall and Rossman 2010, p. 107)point out "archival data are the routinely gathered records of a society, community or organisation and may further supplement other qualitative methods" . Documentation was also seen to be an unobtrusive and nonreactive mode of data collection as it could be conducted without disturbance to the setting (Marshall, 2006, p108). This is convenient for the researcher, where the researcher determines where the emphasis lies after the data have been gathered, as well as providing relative clarity to the reader (Marshall and Rossman 2010, p. 108). The documentation of the case studies is contained in Appendix 7.

For the purpose of this research, 'secondary data' such as documented details of the particular facilities were also sought, in order to assess the level of community integration afforded by the design and location of the facility, as follows:

1. A map of local neighbourhood showing the distance to the furthest destination visited on a regular basis by interviewed residents of the facility. This information acted as the facility's boundary and was sought through Google Maps, and architectural drawings.

2. Architectural plans, sections and elevations and other relevant drawings of the facility, to determine the design features supporting community integration. This information was supplied by the architect and/or designer of the facility.

3. Photographs of the facility and surrounding area to determine its capacity for community integration. This information was sought both from the aged care provider, management, the architect/designer of the facility, and from photographs taken by the researcher.

5.4.7 Ethics approval

Ethics approval for this research was twofold. The initial ethics approval was obtained for the purpose of conducting exploratory discussions, on 24 October 2013 (approval reference: 135098). This was followed by the second application for ethics approval for the purpose of conducting the in-depth interviewed questionnaire survey, on 5 June 2014 (approval reference: 145055). Appendix 3 and 4 contain copies of the Ethics Approval.

The Participants Information Statement, and Consent and Revoking of Consent forms, emailed to each participant at the time of invitation to participate, as included in the ethics approval process, are as attached as Appendix 5 and 6.

5.5 Stage 4: Conclusion

The three components of the operational, social and built environment formed the framework for exploring the operational care models of the four case studies in detail, as well as informing the design of the questionnaire and subsequent data analysis. The data analysis was divided into two segments: Findings Part 1, which analyses the stakeholder perspectives, and Findings Part 2, which explored the perspectives of the residents and their families. Part 1 approaches community integration from the lens of management and its operational needs as well as the policy implications. Part 2 discusses community integration from a residents' perspective of experiencing the operational and policy interventions.

The mixed method data analysis that was used for this research is as follows;

1. Provider/Management/ Care worker/ Designer interviewed questionnaire;
2. Resident/ Family Interviewed questionnaire;
3. Documentation of data on the case study aged care facilities;
4. Researcher observational schema.

The data collection was undertaken across the four selected case studies with a selected group of participants. According to Atkinson et al. (2004, p. 311) "the qualitative method investigates the *why* and *how* of decision making, not just *what*, *where*, *when*. Hence, smaller but focused samples are more often used than large samples" . The questionnaires used both closed and open-ended questions combined with probing to obtain elaboration of answers by the participants, as described by Patton, below:

> Interviews with open ended questions and probes yield in-depth responses about people's experiences, perceptions, opinions, feelings, and knowledge. Observations consist of people's activities, behaviours, actions, and the full range of interpersonal interactions and operational processes that are observable human experience. Document analysis includes studying excerpts, quotations…official publications and reports…and open ended written responses to questionnaires and surveys (Patton 2005, p. 4)

The mixed method approach enabled this research to be undertaken with the participation of many different groups of stakeholders, allowing gathering of data under the one umbrella. Using this framework, the first contribution of this thesis was the identification of three components of the operational, social and built environments which form the basis for community integration. This rational is demonstrated in a hypothetical model in Chapter 3 of this thesis. Following the formation of this model, the second contribution of this research is the development of a schema of CI-RAC to analyse performance in porosity, permeability and propinquity against the three operational, social and built environment elements, developed as presented in the discussion chapter of this thesis.

5.6 Stage 5: Reflections on the methods

In interviewing older people, one of the major considerations in this research was their level of ability to participate. It was found that, even in instances where residents with more than mild dementia were interviewed, that they could coherently articulate their preferences and thoughts. In the case of Group Homes, the management preferred to arrange interviews with residents' families. On their recommendation, five women who were the daughters of the five female residents were interviewed. The accuracy of data obtained from residents was cross checked with management, and it was found that the data could largely be substantiated, including those given by residents with dementia. There were a few minor discrepancies of facts relating to accuracy of age, dates, and questions relating to length of time and duration of stay. In general, it was found that the interview process was a success in obtaining the collaboration of participants.

At the stage of data analysis, a thematic data analysis approach was implemented. The focus was the three components of community integration demonstrated through the CI-RAC model; operational environment, the social environment, and the built environment. The stakeholder views and resident views were analysed separately, using a thematic approach.

The methodology undertaken for this research therefore was found to be efficient, with the anticipated challenges of residents with dementia and other cognitive decline not appearing to be a problem. Although there was considerable variation in the time taken to complete each interview depending on the ability level of the participant, none of these challenges compromised the integrity of the interviews in any way.

Findings Part 1: Stakeholder perspectives

The research findings are presented in Chapters 6, 7, 8, and 9 which are framed around the three components of the *operational environment, the social environment*, and the *built environment* as applicable to community integration with reference to salutogenic principles. These findings are presented from the perspective of stakeholders associated with the four case study facilities and residents or, in one case, their family members.

Part 1 of the Findings reports on the views of the case study stakeholders relevant to the research questions. As indicated in the Methodology Chapter, a total of twenty-four stakeholders were interviewed for this research, including five from each of the four case studies:, Dougherty Apartments, Chatswood (hereafter referred to as Dougherty); the Sir Moses Montefiore Jewish Home, Randwick (Hereafter referred to as Montefiore); Group Homes Australia (hereafter referred to as Group Homes);and Elanora Shell Harbour (hereafter referred to as Elanora). The stakeholder categories included interviews with one provider organisation, one manager, three care workers, and the designer/architect of each facility.

Chapters 6, 7, and 8, focus on the stakeholder perspectives using Level 3 of the CI-RAC model as a structuring framework. Chapter 6 is concerned with the *social environment*, first identifying the drivers they saw for an increasing emphasis on community integration, followed by their views of what constitutes 'community' in a CI-RAC facility and the perceived benefits to residents and staff.. Chapter 7 reports on the *operational environment*, examining their views concerning the practice of community integration in view of the increasingly high care needs of their residents, including those with dementia. Chapter 8 discusses their views on the role of the *built environment* in community integration based on their experience. Part 1 therefore provides a comprehensive view of stakeholders' views on community integration as an important precursor to the views and experiences of residents and their families which are covered in Part 2 of the findings, contained in Chapter 9.

Chapter 6: Stakeholder perspectives: Social environment

6.1 Introduction

Key contextual features informing the nature of residential aged care include social, operational and built environment factors which are often overlapping. This chapter seeks to identify the particular challenges and issues relevant to community integration relating to the *social environment* from the perspective of stakeholders. The factors influencing the *social environment* of CI-RAC will first be discussed by identifying the drivers, constraints and other features impacting upon community integration of residential aged care. The contextual features of the *social environment* of community integration were discussed in detail in Chapter 4. First, however, it is important to understand the definition of community (often a contested term) as viewed by the stakeholders, according to their approach and attitudes which shape the care model of the facility. Their understanding of community can be seen as a primary determinant of the *social environment* of community integrated residential aged care. This sets the scene for a discussion of the key factors seen by stakeholders as having a role in creating the social environment for community integration, followed by their perceptions of the benefits to residents and staff.

6.2 Factors Influencing the Social Environment of CI-RAC

Stakeholders were asked to identify the key elements influencing the emergence of CI-RAC. Table 6.1 summarises their views of the eight categories of drivers identified and their implications. These are explored in more detail in the following section using statements from the interviewees.

Table 6.1 Stakeholder views on social environment factors influencing community integration

Stakeholder perspectives: Social environment	
Drivers	**Implications**
Population ageing	• Increasing demand for residential aged care • Higher percentage of higher care needs • More single person older households • Changing family structures
Baby boomer demographic	• Increasing cognitive decline of residents • Consumer driven market • More financial power of residents • Demand for improved models of care

Increasing higher needs specialised care	• Carer stress • Inability to provide specialised care at home • Financial stress on families
Changing social expectations	• Families wanting loved ones to age in dignity • Increased financial power of the aged (particularly baby boomers), enables a consumer driven market in aged care
Religious and cultural values	• With an emphasis on the family home, migrant communities may show reluctance to sell up to enter residential care • Commitment of religious groups to community integrated care
Role of families as decision makers	• Demand for good care, easy access, and proximity to their own community
Emergence of new care models	• Choice in community integrated aged care to suit individual needs
Social affluence	• Enables variety and demand for new improved models of care

There were notable social drivers that contributed to the nature of residential aged care, and specifically to community integration. There was consensus among the participant stakeholders that the effects of an increasing number of older individuals in society with higher care needs resulted in an increasingly frail cohort of residents entering into residential aged care. This was seen to have significant impact on community integration initiatives:

> …so we now have people entering into residential aged care who are much sicker than they were even 12 months ago- now we get people who live for less than 2 months from entry, so we're becoming more palliative care. There are residents here who have been living here for 10 years, if they wanted to come in now they wouldn't get in because they are not sick enough (DA,P1,LB).

Baby boomers as a force of change were also noted as a social driver of community integrated aged care given the increase in numbers of this population group combined with their different attitudes and values in contrast to previous generations:

> Baby boomers are a strong force for social change. So, the voices of older people will be heard more, bringing about change in aged care delivery (EL,C1,AN).

In particular, the changing social and consumer expectations of the baby boomer generation were noted as a driving force for change in the nature of residential aged care provision:

> …the baby boomers who are coming into the aged care system- they expect to have a lot of things that older people now didn't expect (DA,M1,JG).

The Elanora General Manager also noted the incoming baby boomer generation as contributing to this impact significantly through their desire to be independent and self-sufficient:

> …so I think that's aligned with a greater demography of people wanting to be self-sufficient, particularly amongst baby boomers - so they probably will resist the option of going into residential care for as long as they can (EL,P1,CL).

Another changing social factor driving the delivery of residential aged care was considered to be the increasing influence of families of residents and their preferences rather than the needs and preferences of the residents themselves, as often the decision to enter into residential care is made by the families following a sudden life changing, health related event.

> People put off thinking about residential care as something for the last minute. It's often a move that has to be made after a sudden catastrophic event that requires entry into res[idential] care. Therefore, where you go is often decided by family. I've been in this role in this organisation and others, and I haven't seen anybody who has made that decision (EL,C2,LI).

The preferences of family were often seen to encourage community integration as they did not want their loved ones to be shut away in an isolated facility removed from regular society:

> Older people are living longer with very high needs that can't be looked after by family, so they are unable to stay at home, so residential care is very important. And integration into the community is very important as the families want to stay a part of their life and know that they're not shut away somewhere (EL,C3,SA).

The General Manager of Elanora noted the substantial percentage of the older population who suffer from age related health conditions which are difficult to be managed in one's home and can result in carer stress with little or no access to professional care. This was seen as a challenge for most individuals to maintain social connection:

> … Then there is loss of control such as [urinary] incontinence, which is easily manageable by wearing a pad, but most people can't cope with faecal incontinence. Faecal incontinence is quite high in the general population, and it's not related to diminution of cognitive capacity, it's just a physiological aspect of ageing in some people through sedentary lifestyles, and they have lost all muscular function. These people can still manage their hygiene, but those who have things like faecal incontinence affecting them due to cognitive decline, they are a section of the population whose families can't cope or deal with. That's when they need to come into residential aged care…where they can have more freedom to have a normalised lifestyle because of access to professional care (EL,M1,WD).

An Elanora Care worker also noted the need for family support for high care residents as a reason for adopting a community integrated approach to:

> The residents coming in are increasingly less and less able, with higher needs, so it is a challenge to keep them integrated with society or activities. So what's important is meeting their basic care needs, providing a sense of security and love and care, and encouraging family support (EL,C1,AN).

Another societal factor was changing family structures, and the resulting inability of a family member to take on the caring role for an older person:

> The primary force is purely economic and societal. Societal in that family structures have changed radically over time, so that it's not common to have a situation anymore where grandparents are living with their children or grandkids. Everyone is independent. The result being there is no one to look after [them] in a family setting if older people need to be looked after (EL,D1,JF).

The breakdown of traditional family structures was also noted as an important social factor for older individuals moving into residential aged care because they require professional care:

> For me, coming from Nepal, people over there have a logic of having their parents at home and caring for them, because often the husband would go out and work, and the wife would stay at home, so they could look after the parents and kids and so on, and it's considered really bad if you send your parents into aged care. But over here it's different, because everyone has to go out to work, and people can't afford to stay at home and be a carer. And for myself, if I had the choice of being looked after by my children or in an aged care facility, I would choose the aged care facility, because there are a lot more systems to look after older people - ways of lifting, lifters, medication, doctors' appointments and things like that (DA,C2,BI).

The Group Homes Care Manager also cited the need for social connection as a significant contributor to the integration of aged care into the community. She saw human beings as intrinsically social beings, many of whom may not support the idea of being by themselves, isolated from society:

> This [being isolated in one's own home] goes against the basic human need from a social aspect just to be able to be around other people, even though the frequency and nature of this interaction may differ from person to person (GH,M1,JO).

Dougherty was intrinsically conceived as part of the community, to serve the local community of Chatswood. As explained by its architect, current refurbishments which focus on increasing the community integrating features of the facility are consistent with Dougherty's philosophy for it to function as a not-for-profit community-based facility enabling residents to continue to maintain meaningful relationships with family and friends:

> …this is the trend specially in the not for profit sector, allowing people to maintain connection with family and friends, this is the overwhelming driver for incorporating community integration in aged care (DA,D1,DJ).

A Group Homes care worker noted the importance of close proximity to families. She noted the increased congestion in residential areas of Sydney which has resulted in aged care facilities receding to the peripheral areas. Given that families want to have their loved ones close by, and often not by choice but necessity of not being able to provide the level of care needed at home, she saw community integration of residential aged care as driven by this need:

> Sydney is very congested, but there is a need for residential aged care in every community, so they should not be located in isolated areas, because families need to have their loved ones close to them. But it's not possible to have them in their own homes because it's not economical or practical (GH,C3,MA).

For Montefiore, the driver of community integration was distinctly linked to the Jewish community given its location in the heart of the largest Jewish community in the eastern suburbs of Sydney, as well as the distinctive cultural and religious foci that were described as the foundation of Jewish values, by the interviewees. The 'continuum of care' central to the community integration initiative of Montefiore is based on the understanding of the local Jewish community taking responsibility for aged care for their own community members. As a Director of Montefiore described, the main community integration driver is a social one. This involves all generations in the community, through well managed outreach and education programs, taking part in the integration process:

> … there is awareness in the Jewish community of the continuum of care which falls under the umbrella of the Jewish communal group. …so, there is a continuity and affinity and familiarity through a continuous connection which is intimately interwoven at every stage of their life. Montefiore specifically has an intergenerational coordinator employed as they see intergenerational interaction as a key factor in building positive nurturing relationships and life outcomes (MF,M2,ML).

The General Manager of Elanora, while reiterating the increased demands on community care as a result of the policy focus on ageing in the community, also foresaw barriers for many people. He envisaged that the growing proportion of migrants in Australia would have barriers to entering into residential aged care due to lack of monetary assets as most saw their family home, if they had one, as a legacy to pass on to future generations. Therefore, this growing cohort, he mentioned, could be reticent to use their family home as their mode of entry into residential aged care and receiving appropriate care:

> At the moment, there's great focus in providing community-based care. The expectation is that people will expect to be cared at home particularly when entry into residential aged care requires assets. I think the reticence to come into residential aged care is many people see that asset which is often their family home as their legacy for their children or family. This is particularly evident in the migrant community who have come here for a better life and their focus on the family home, and their attachment to the family home is far greater than the average Australian population. And the migrant population will be disproportionately larger than the non-migrant going into the future (EL,M1,WD).

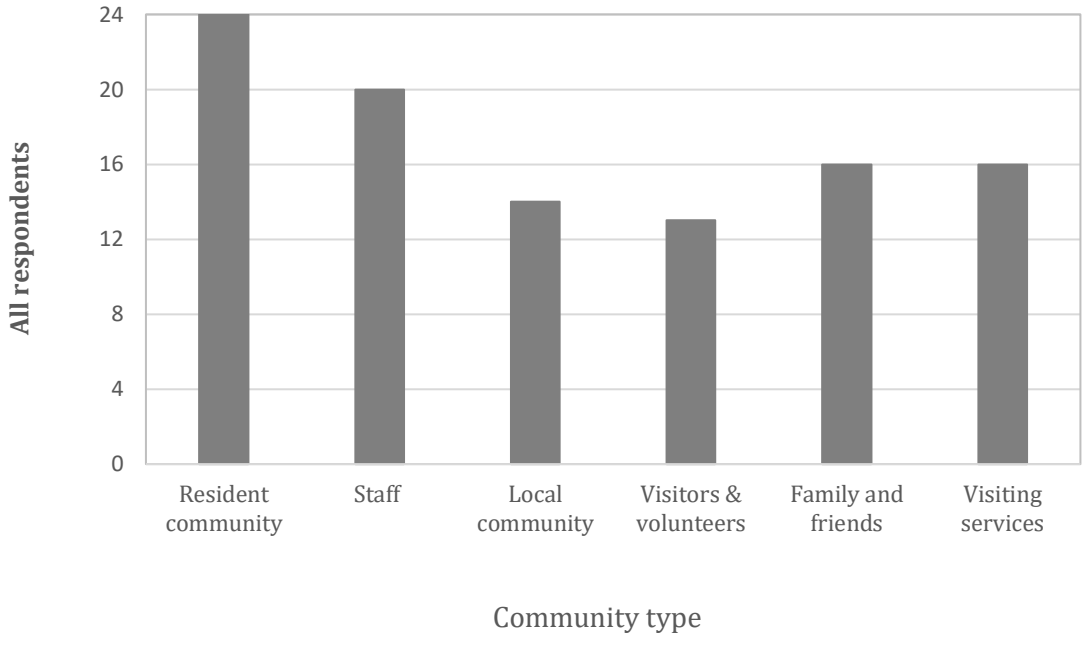
Therefore, the reticence to liquidate an existing residential property could be seen as an increasing challenge for the ageing demographic containing higher numbers of the migrant population. In turn, older people requiring professional care may not get the care needed due to inability to enter residential aged care which required significant financial assets to meet required payments for bonds.

As illustrated in Table 6.1 and the above statements, stakeholders saw the drivers toward a community integrated approach to residential aged care to be primarily socio-demographic forces arising from population ageing, including the baby boomer population entering older age with their changing attitudes and expectations, the increasingly high care needs of residents and family's desires to see their loved ones remain engaged with the community and within close proximity to them and their former community. This begs the question however as to what is meant by 'community' in a community integrated residential aged care setting, which is the subject of the following section.

6.3 Social environment: Who is community

Figure 6.1 below explains the variety of social groups who were seen by stakeholders as forming elements of the community of the care home. These groups were considered to include the residents within the home, the staff of the home, visiting family and friends, other visitors and professionals providing a service to the home, as well as the people in the local community. Figure 6.1 shows their responses to Question 9: "Which of the following do you regard as the 'community' in relation to this home?'

Figure 6.1 Stakeholder views on who constitutes community



All twenty-four stakeholders interviewed regarded the community of residents within the home to be the most important element of what constitutes community. The staff of the home were shown to be the second most important group, though somewhat less important than the resident community. Visitors to the home providing a service and visiting family and friends of

residents were the equal third most often mentioned groups. Other visitors to the home and people in the local community both constituted an equal fourth group, for a little over half of all respondents.

6.3.1 The residents as community

Regarding the importance of the resident community, the founder of Group Homes Australia held this view:

> Social integration is a very big component in each Group Home, so this [the residents] is the first community (GH,P1,TK).

The General Manager of the larger scale Dougherty Apartments also saw integration within the resident community as being intrinsically tied to its care services and the distribution of appropriate levels of care which facilitated an integrated community across the varying ability levels of its residents:

> We have residential aged care, dementia care as well as a retirement living community. They are all part of the community of Dougherty. And we're able to provide the necessary levels of care as needs progress or change in the same [internal] community. So this [the internal community] is the residents main community (DA,P1,LB).

These comments demonstrate that the intention of community integration is built into the care delivery to create a supportive social environment. At Group homes Australia, the six residents are viewed by management as a cohesive 'community' and care is taken to nurture the social environment within the community of residents as the primary community. By having a non-segregated community in terms of care levels, the management model of Dougherty Apartments demonstrates an emphasis on the resident community as the primary community in the delivery of support and care to enable social participation of dementia residents according to their varying ability levels.

6.3.2 Staff as community

The second most important group considered by stakeholders as part of community were the staff of the facility. As the primary care givers to the residents, staff were regarded as the first point of contact for residents. Therefore, the degree of contact and familiarity between staff and residents was important. As expressed by the Manager of Group Homes, staff played a crucial role in the daily lives of residents, and were therefore seen as an important part of their community:

> …the staff of this home [are an important community], because the staff are the immediate people the residents have contact with. And they are the ones who would initiate if they wanted to go to the shops or go for a walk (GH,M1,JO).

The Manager further explained why:

> …[In] a regular domestic scale housing environment, … you have more individualised care, where you get to know each person, much like in a family. So a smaller based model is so much more personalised (GH,M1,JO).

Diversity of staff was also seen as key by Dougherty, particularly given its location within a culturally diverse urban context and providing for their needs:

> We have a big Asian population in this community. So we have to provide for that and have staff who can speak the languages that we're accommodating, in order for community integration to be at its most efficient. So the staff are a big part of the community here (DA,P1,LB).

Given their critical role in providing a supportive social environment within an aged care facility, staff were thus seen by stakeholders to be important enablers for community integration of residents through their role of care giving and fulfilling residents' day to day needs, creating familiarity, regularity of contact and accommodating cultural and language diversity. .

6.3.3 The local community

The local community refers to the general population in the local neighbourhood of a facility. This community in the immediate surrounds was seen to include many different sub-groups of people. The Elanora General Manager identified some of the local community groups that were important to the facility such as:

> …religious groups and other community groups that develop a relationship with us, such as the local pre-school students who tended a vegetable patch at the facility grounds and other volunteer groups are elements of the larger 'community' of Elanora (EL,M1,WD).

The provider of Elanora, Uniting Care Ageing, noted the growing community connections between different levels of care which support a continuum of care services. This was seen to greatly facilitate the strengthening of community bonds:

> We also have a retirement village on site which we're expanding, so residents from the onsite retirement village could often be the residents who progress onto residential aged care home. So their friendships might span that locational change (EL,P1,CL).

The local community also included groups varying from religious services to school children providing intergenerational interaction. The interaction of residents with the local community and its importance are discussed through the eyes of residents in Chapter 9 of this thesis. The providers' perspectives of the local community were noted to be more related to the nature of organised activities rather than the more informal ones, between the community and the home.

6.3.4 Visiting family and friends

Visiting family and friends formed an important aspect of the care home community. These people were a conduit of familiarity and continuity with their previous life, as well as often being the decision makers in the admission of residents to residential aged care. Elanora architect, Flower, stated that this was significant as it is often the family who make the decision about the residents' living arrangements:

> Visiting family and friends must be taken into consideration as it's often the family][that] has got to be very comfortable in where their loved ones are living (EL,D1,JF).

A Manager at Group Homes Australia was of the view that visiting family and friends were important for continuity and familiarity reasons:

> …because family keep them connected to familiarity and events that are important to the resident and keeps a continuity alive for the resident (GH,M1,JO).

Therefore, family and friends were noted by stakeholders to be of significance in implementing a community integrated aged care model, noted as the primary group for forging familiarity and connection to the wider community and the residents.

6.3.5 Other visitors and professionals

There were also other visitors who may or may not come from the immediate local community who were considered to form part of the community of the home, including health professionals:

> Doctors are important because they come in every week, the residents do not go out to doctor (DA,C1,AN).

The involvement of volunteers from the community was also seen as a significant contributor to the promotion of community integration. These could be of a religious or intergenerational nature, involving school children and members of the local community:

> [There are] a high number of volunteers from the community who come in and do programs with the residents which are very valuable. Visiting Rabbis to take care of emotional and spiritual needs. Student programs with schools coming in, where the students are integrated with residents and they have art programs, debates, music programs, intergenerational interaction. Pre-school on premises, and lot of integrated programs including the Sabbath program every Friday where the kids come in, Jewish holiday programs, and also residents going to the pre-school to read to the kids (MF,M1,JG).

Others were visitors of a cultural nature.

> We have a high Spanish population, so the Spanish society does a lot of volunteer work, with entertainers and entertainment shows brought into the home. (EL_C1_AN)

This group could include volunteers, entertainers and professionals, and particularly health professionals. Given residents' higher care needs, medical practitioners and other and health related professionals such as podiatrists were regarded as particularly important resources to support residents health and wellbeing. The religious, cultural, artist and entertainment visitors to a facility can assist in maintaining meaningful cultural, religious and creative connections for residents.

6.3.6 Spiritual community

It was apparent in some of the interviews that a further element of what constituted the facility's community was derived from the spiritual community associated with the affiliated faith-based organisation responsible for the home. For example, the spiritual community was particularly noted to play a key role in Montefiore. A Director noted this to be the umbrella for all volunteer and community integration activities:

> The spiritual community is the larger Jewish community. All of the above [integration activities] would comprise the Jewish community. Therefore this is the number one community at Montefiore (MF,M2,ML).

In addition, this manager noted the provision of 'Kosher food' specific to the Jewish community and other cultural and religious activities that play an integral role in the concept of community.

Elanora and Dougherty on the other hand catered to a diversity in spiritual needs as required by the residents. At Elanora, a dedicated room within the facility served as a prayer space which was shared by visiting pastors to serve the resident community who wished to participate in services. At Dougherty, residents who wished to participate in religious activities were taken out to church services at churches in the local community. The management did not note a requirement by residents for religious services that were not available in the local community. Group Homes Australia similarly did not have an emphasis on faith-based care, or a regular requirement by their high care needs dementia residents to express a need for regular spiritual activity. However, the CEO of Group Homes noted that there were a number of Synagogues and churches in the community which the residents could be taken to for services should they require the need.

6.4 The benefits of social integration to residents, their families and the surrounding community.

The stakeholders stated a variety of social benefits for residents and their families which represented their motivation in incorporating a community integrated model of care while moving towards higher care needs. A director of Montefiore noted:

> It is vitally important, as it enhances the quality of the life of the resident, and it normalises their experience, so they're not snatched out in their life time and taken out of their familiar surroundings, even in high care, it's very important to normalise their life as much as possible (MF,M2,ML).

Social integration even in high care was emphasised by a care worker at Montefiore who also noted that it was important to residents irrespective of ability levels:

> Even high care-residents need integration into the community. For this facility, the community is the be all and end all for the residents, and they very much want to stay connected and thrive on it, in whatever capacity (MF,C3,CR).

Social integration was again seen to prevent isolation, encouraging a resident to stay connected to society. This was noted by the Montefiore CEO as the main benefit to residents as well as their families:

> One of the biggest pitfalls that people are worried about entering into aged care is the risk of social isolation. Therefore, from the residents and the family's perspective, it is very important to know that the social connection is maintained. Community integration is important to the notion and idea of wellbeing and quality of life from the residents as well as the family's perspective (MF,P1,RO).

A continuation of 'normalcy' in a resident's life was also noted as a benefit of community integration which in the case of Montefiore supported a resident continuing to use the same services they were used to, such as their own community doctor and other support structures:

> Feeling of living in their community and not being isolated. Strive to maintain individual connections to community. Residents can use their own doctors and give that support as much as possible. Keep things as normal as possible for residents (MF,M1,JG).

Normalcy and elimination of the risk of isolation were noted as important benefits to families even for high-care dementia residents:

> From a family's perspective, the families want their loved ones to be part of society, and not shut away, that they are active and happy. And from a resident's point of view, it empowers them to have a say in their daily lives, in going about their normal daily routines as part of a community. Get the hair cut they want, and shop for their own things and so on (GH,M1,JO).

A socially integrated approach to design was also noted as providing opportunities to exercise a person's choice and independence:

> People like choice and independence in the type of space they use. People are resistant to change, with the planned upgrades, but hopefully they will see the benefits of the upgrades. And make the facility as normal part of the community as possible (DA,D1,DJ).
>
> From a residents perspective, they are able to feel purposeful and a part of the community, and that they are a needed part of the community, I think too often they feel forgotten and locked up, and that's not something we want (GH,P1,TK).

As noted by the Manager of Dougherty Apartments, the social benefits of a community integrated care policy were seen to be the direct impacts on health and wellbeing irrespective of ability levels, including for residents in dementia care:

> It keeps their mind active. If you're able to take a resident down to the shops or for a coffee as easily as we can (due to location) they feel like they're still a part of the community- even our dementia residents go out nearly every day. It keeps part of their personality alive, and know what's happening around them (DA,P1,LB).

An active and engaged lifestyle was noted to have positive impact on the psychological health of residents, mitigating physical illness:

> When residents are not happy they get sick. When they are active and alert, they are not withdrawn and depressed (DA,C3,DO).

A Dougherty care worker noted the positive impact on health and behaviour of the resident, by remaining in, or having a sense of connection to, the outside world through community integration:

> When residents are happier, their behaviour is better and easier to manage. They are happy when they have interaction with the outside world, makes them feel a part of it all (DA,C3,DO).

This care worker also noted that this was seen to be the case even for residents who were physically not able to interact. As a Dougherty Apartments care worker stated:

> …residents have better health and wellbeing by being active and a part of the community even if they can't physically participate, because just getting a sense that they are remaining a part of it is very important (DA,C1,AN).

The provision of continuity of care, where provided, was also cited as a benefit of community integration in order to maintain and develop a sense of belonging and stability through advancing stages of ageing, allowing people to remain in the same care facility:

> People don't want to move, so there needs to be a continuum of care as needs increase, and the facility should be designed incorporating these needs, so that people don't need to physically move from what they regard as their home, for instance from hostel to higher care facilities (DA,D1,DJ).

For the founder of Group Homes Australia, the social impacts of community integration were seen to provide measurable improvements in quality of life, health and well-being of their dementia care residents. However, she saw community integration as having three main beneficiaries, the resident, the family, and the local community:

> For the residents, it's human flourishing, and enhancing their quality of life. I see longevity in residents in terms of slower deterioration, less BPSDs [behavioural challenges]. It is definitely a different experience for the family to see their loved one here as opposed to an aged care facility, and you see that from the amount of times

> people visit, to what they do when they come to visit. For instance, they can come and take their mum out for a cup of coffee, because we're role modelling that for them, so they see the normalcy of just coming and sitting and visiting. It is also about educating the community, so when we go to Woollies or the coffee shops, it educates the community that people with dementia are part of society, and there is a normalcy to it. So, there are three elements; 1. Resident, 2. Family, 3. Community (GH,P1,TK).
>
> When the facility is more integrated into the community, there is a change in behaviour of the resident, because they are happier and calmer when they are in a normalised home environment with the appropriate care. So the care is easier (GH,C2,FA).

A Group Homes care worker also confirmed that a community integrated care model was not only beneficial for the resident, but it also educated the community concerning the needs of the ageing population:

> It's educational for the community as well as healthier for the resident. So, there is a positive impact on care models when it's part of the community (GH,C3,MA).
>
> Community is more aware of the need to accommodate the needs of the ageing population, which has influence on the care models in residential aged care (GH,C1,CR).

The small scale of the Group Homes facility was noted to facilitate community integration, by catering for no more than six residents. This allowed for greater familiarity between the resident, care workers and the community, necessary for building more meaningful relationships:

> When you are integrated into society in a regular domestic scale housing environment, you're not institutionalised since you have more individualised care, where you get to know each person, much like in a family. So, a smaller based model is so much more personalised (GH,M1,JO).
>
> And that contribution is twofold, because it's the resident contributing to the community, but it's the community learning about people with dementia and having that tolerance and the inclusiveness. So, it's a two way street (GH,P1,TK).

The founder of Group Homes stated that community integration contributed to the peace of mind of the families of residents knowing their loved ones were well looked after:

> …and for the families, they feel that their parents have contributed all these years in their earlier years and it's important to keep that connection in their later years according to their capacity (GH,P1,TK).

A Montefiore Care worker noted that it was the view of most families of residents that residents tended to be more active and engaged when they entered into residential care with a community integrated model such as Montefiore, rather than being in their own homes:

> What family tell us is that when the resident was at home, nothing was happening at home, but in residential aged care here, they are more alert and active because a lot of things happen (MF,C2,SA).

Manageable challenges in daily life were also seen as an important aspect of maintaining health and wellbeing. This was noted by a care worker at Montefiore who described community integration as providing that challenge which made a resident's life more meaningful:

> Gives them a sense of belonging and identity. Still have a meaningful life. They're encouraged to participate in activities which challenges them to be involved, and that challenge is important in maintaining health and wellbeing (MF,C3,CR).

The architect of Montefiore noted the very personal experience of his own mother entering residential care, and subsequent concerns of the family which were ameliorated by the community integrated model of care of a Uniting Care Ageing facility. He noted that being a charitable organisation, the attitudes to care differed greatly from a corporate provider of aged care:

> [My] very personal point of view, having been through the process of looking for a facility for my own mother, is that I was terrified of mum sitting twenty-four-seven in the same place. Family visits break that cycle, but knowing the facility have a proactive program of incorporation, which breaks the cycle is important. The charities try to incorporate that, but not corporates. For instance, charities have a bus to take residents out, but not the corporates, because for them it's an added cost (MF,D1,JF).

The small scale of Group Homes enables minimal restrictions to be applied to residents and their families allowing a resident to maintain their own rhythm of preferences and lifestyle. This model of care according to the families of residents was seen to be far superior to that of a larger institution, in terms of the benefits to health and wellbeing:

> From the feedback, we get from the families, they love it that their loved one is here at Group Homes. Sometimes it's because they were in another facility which was a large institution and they can see the difference in the resident being happier and living a normalised life here. Here there are no visiting hours, and no rules and regulations. They can come any time. It's peaceful, and cheerful, and there's nothing to hide. We have got feedback to say that they almost don't recognise the resident because they seem so happy compared to what they were at home or in another facility. So, they have a better quality of life, with the Group Homes Model, which is a very community integrated model of care. One of the residents said to me "I love this house, I love this house, because it's so peaceful" (GH,C3,MA).

The architect of Elanora noted a key benefit of community integration being the transparency of the spaces designed for high-care residents, such as dementia care which is not hidden away in the facility but located right at the front with visual access to the shopping centre.:

> People go to great lengths to hide [away from public view] components that say a person is less well. So, for example high behaviour problems are hidden away. But in Elanora, they are right at the front door. So, the people who are deeply affected by dementia have their courtyard at the front door where everyone comes in. Most places hide it (EL,D1,JF).

It was noted that the sense of community need not necessarily come from the residents' own connection with their previous residential community. In the case of Group Homes Australia, these connections were developed with the local community of the home irrespective of the resident's previous location of living. These bonds were seen to be meaningfully developed even in the latter stages in life of dementia care residents. The peace of mind this brings to families of residents was described as vitally important:

> It [community integrated care model] benefits the resident's family a lot. Peace of mind that their loved one is not isolated and being taken care of well, as well as we have a lot of residents who have family living in the community so they have ease of access to visit their loved one (GH,C1,CR).

The feeling of belonging that a resident develops with the local community was also seen as a positive aspect by the families of residents:

> The residents don't feel isolated. They feel they can go outside and see familiar faces and feel safe and secure. And the family like the feeling of belonging a resident has with the community, as their lives are normalised as much as possible (GH,C2,FA).

A sense of self-worth was noted as a benefit of a community integrated approach to residential aged care as even in increasing cognitive decline a resident could engage in activities such as intergenerational initiatives where they would feel that they are contributing to the education of younger generations:

> Sense of self-worth. Sense of connection. Keeping a normalised attitude to the world and maintain a level of integration. You keep levels of interest in people higher which is important to health and wellbeing - whether it be through the arts, activities, children, mentoring; using their age in a productive manner rather than feeling they're not needed any more (EL,P1,CL).

The sense of 'home' created by a community integrated model, according to the Manager of Elanora, provided the physical and emotional safety and security of knowing that they were 'safe' with access to professional care:

> The benefits of community integration is their perception that this is their "home", and irrespective of the location of the home, they feel a sense of community, both in a physical sense and an emotional sense (EL,M1,WD).

The General Manager of Elanora also commented on the benefit to families of a socially integrated care model which could help to improve fractured relationships between generations brought on by the strain of caregiving which he described in most instances resulted in a role reversal between parents and children, sometimes causing family breakdown:

> For families, it completely changes their relationships with their parents. Before they went into residential aged care, it is very much a functional, daily routine based on necessities such as delivering the groceries or checking up on them. Many of the children

> are baby boomers who had children late, so they still have teenage children, and elderly parents, and it is not possible to look after both. When they come into residential aged care, it's much more functional and caring relationship that they're able to have with their parents, and they're very appreciative of that (EL,M1,WD).

A reduction of carer stress on families was also noted as a benefit to families of residents, resulting from entry into residential aged care:

> For the family, the main benefit when it comes to someone requiring high-care, is that it helps to share the load, and releases the pressure off family, to deliver high-needs care, which is often stressful (EL,C1,AN).

A socially integrated model also was seen as providing a home where residents' families are very much a part of their loved one's lives while getting the necessary care:

> For the resident, this is home. So, we are mindful and respectful that we're in somebody's home, although it's our place of work. For the family, they can feel that they are still a part of the residents life and they can come and go and visit as they wish, and know that their loved ones are cared for and looked after well here (EL,C2,LI).

Creation of new ties and communities with other likeminded residents in similar situations was also noted as a benefit to the residents, resulting in a resident's sense of belonging, health and wellbeing:

> The resident gets a feeling of still being connected to society which is important to their mental and physical wellbeing. They don't get the feeling that they've come here to die. They are still living and have to be treated as such. The residents also make new connections and form a new community with likeminded people who can relate to each other, and this is important to them. Family knows that they are well looked after - peace of mind (EL,C3,SA).

The overwhelming consensus from stakeholders was that a socially integrated approach to residential aged care was a largely positive one. They emphasised the increase in quality of life for residents noting that even in higher needs care, an active social environment led to wellness, keeping their mind active as well a sense of purpose by engendering a sense of belonging and identity. They noted that the creation of the internal communities with shared life experiences and likeminded people, breaks down the social isolation often experienced by residents if they were to be in their own homes. The resident community's' interactions with their local communities and other external groups also included intergenerational interaction. The ability of residents to exercise choice and independence as a result of residing in a community environment was also seen to be important. In addition, the benefits to family were discussed in terms of eliminating carer stress if a resident was to age in their own homes with inadequate support and the specialised training. Residents requiring higher needs care, were noted to take a toll on the social and emotional life of families. Therefore, formal residential aged care

providing consistent and appropriate levels of care and support not only benefitted the resident but also their families.

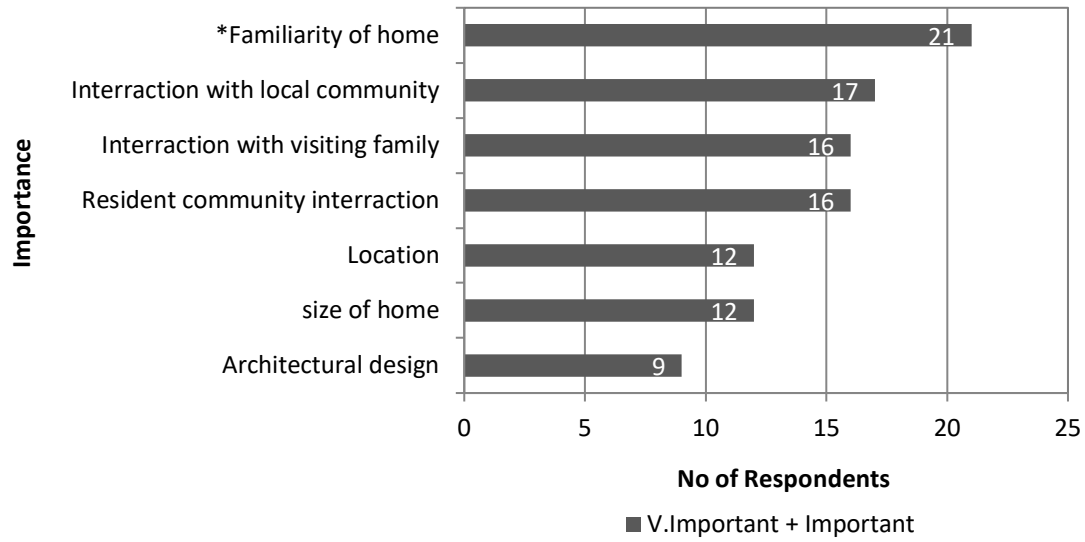
6.5 Benefits to staff and the facility

The staff of the facility enable the extent to which a resident can take part in social activity and interaction, given their higher care needs. These higher care needs often incorporate a high level of physical impairment as well as deterioration of mental faculties such as those suffering from dementia. Therefore, the staff of the facility form an integral component of the social environment. Figure 6.2 indicates the importance to staff of the quality of the social environment of the care facility

Three of the four designers of the selected four case studies did not take part in responding to this question as it chiefly concerned the management and staff of the facility. One designer took part, as he had spent extensive time with the workers of the facility during the design development phase, which gave him knowledge of the importance of the various elements to its staff. Therefore, the total number of stakeholder participants responding to this question was twenty-one.

The home-like atmosphere of the facility (referred to in the table as 'familiarity of home') was noted to be of primary importance to stakeholders, with the agreement of twenty-one respondents.

Figure 6.2 Importance of community integration elements to staff and management



*Note: 'Home-like' was not considered to be an appropriate term by the respondents, who stated that 'familiarity of home' was the preferred term.

Interaction with members of the local community was considered of secondary importance with the agreement of seventeen. Interaction with visiting family and the resident community were next in importance with an agreement of sixteen respondents each. Significantly, the locational and design aspects of the facility were considered to be of lesser importance than the capacity to facilitate social interactions. While overall, care providers saw the familiarity (or home-like) environment of the facility as the most important reason they were working in the home, second to this was interaction with the local community and equal third were interactions with the family and the internal community . As suggested earlier regarding benefits for residents and families, the notion of familiarity, or home-like, may include aspects of the internal and external physical environment.

For Group Homes care workers, the familiarity of the home was seen to play a key role in facilitating community integration with non-institutional surroundings providing a pleasant working environment:

> The home must feel like a home, everyone's home is different, but it has to have the feeling of and look like a home, that is important, as I wouldn't like to work in an institution environment (GH,M1,JO).

This was confirmed by the one participating architect.

Designing an atmosphere of familiarity for those who lived and worked [staff and residents] in the home was very important (EL,D1,JF).In the architect's view, the way in which the care model addressed the size of Elanora was also seen as facilitating inter-personal relationships between residents and staff, in creating a sense of community:

> Elanora is about small communities within a big facility. This helps in creating a sense of intimacy and community between residents as well as staff (EL,D1,JF).

These findings suggest that from the perspective of stakeholders, it was the internal character of the home incorporating a "home-like atmosphere" that was seen to be the most important facilitator of the socially integrated environment, but also interaction with the local community. While of the built environment aspects of location, size of home, and architecture, appear less important than the social aspects, a familiar or home like external environment may also incorporate some of these factors (see Chapter ?? for further discussion)..

6.6 Conclusion

An initial finding from the stakeholder cohort was that their definition of what constitutes the community. From the stakeholders' perspective, the primarily, 'community' was defined as the residents and staff of the facility. This was followed by external visitors – family, friends and other professional service providers, the local community and other visitors were rated lowest.

In other words, their strongest focus was on the internal community rather than the external one. This is significant and may be explainable by the stakeholders' more immediate concern about the importance of the social environment they were responsible for creating within the facility. However, these findings also demonstrate that a majority of stakeholders accepted each of these groups as constituting part of what community means in a community integrated aged care facility.

An additional component of community, noted particularly by the faith-based provider Montefiore, was the cultural/spiritual community, as the basis of its care-model was based on the principles of Jewish faith and culture which influenced daily life for residents, with provision of specific foods and religious activities. At Dougherty, by virtue of the cultural demography of Chatswood, the CEO of Dougherty noted an increasingly higher percentage of Chinese residents entering the facility. In response, the facility employed care workers with relevant language skills to facilitate familiarity for residents, and ease communication.

Stakeholders revealed a wide range of factors that influence their approach to providing a supportive social environment within a facility. For example, residential aged care facilities are increasingly catering to the aspirations of the families of residents rather than solely to the residents themselves. Stakeholders perceived a clear preference of the families of residents for the facility to be integrated into the community. Community integration of residential aged care facilities not only addresses the demand for this type of support.

Similarly, in the context of a population with higher care needs, the cohort entering into residential aged care is increasingly at an advanced age and therefore in poorer health. As a result, some residents will require formal care for shorter lengths of stay. But even for these limited stays, demand from families of residents was for residents to be connected to society. Also, the primary carer role is perceived by stakeholders to have become more complex due to higher levels of divorce, merged families, single parent households, childless couples and individuals limiting their ability to provide care and thereby increasing the demand for high care accommodation. Baby boomers as a force of societal change were also noted as a significant factor in influencing more socially integrated aged care, being a generation, which is noted to be active, assertive and demanding in maintaining independence and continuation of a familiar lifestyle.

The stakeholders expressed that one of the primary benefits to the families of residents, and residents themselves, of a community integrated care approach is that a resident does not feel isolated and lonely. Therefore, from the residents' and their families' perspective, the maintenance of wider social connectivity was important. This connectivity was also noted to

enhance the quality of life of the resident, and significantly 'normalise' a resident's lived-in experience in a care facility. The stakeholders further noted that social connectivity helped to keep a resident's mind active, by making a resident feel that they are still a part of the community, as well as impacting on a resident's mental health and wellbeing and in turn on their physical wellbeing.

Another benefit to residents was the stakeholders' perception that a community integrated care model assisted residents to lead a more purposeful life by being included in the wider community. This was emphasised as particularly important as it was thought to give the residents a sense of belonging and identity, rather than being isolated and socially inactive.

The stakeholders also perceived that it was the way the facility created a non-institutional atmosphere which they described as 'familiar' that was the primary catalyst in supporting a beneficial social environment: in other words, the way they ran the facility. This aspect was also noted as a benefit to staff, as the stakeholders perceived a homely character of the facility to also be a more conducive work environment. Considering that care giving, particularly in higher needs care, can be stressful, due to behavioural issues of residents suffering from dementia and other illnesses, the mental wellbeing of staff is also important.

Another benefit to staff expressed by the stakeholders was the proximity to transport that is often tied to a community integrated facility. They noted that most care workers travelled to their workplaces via public transport. Therefore, the location of a facility played a significant role for staff. However, the physical locational and design aspects were perceived to be of somewhat lesser importance overall.

Evolving social expectations and the very real financial power of the more affluent elder community create a financial incentive for a local community to embrace an inclusive approach incorporating the needs of the ever-growing elder population. However, in contrast, there was a perception among some stakeholders that the cultural values and expectations of migrant communities who comprise of an increasingly larger proportion of the incoming older cohort into residential aged care may not have established financial resources or wish to liquidate family assets, which often comprises the family home, to fund residential care.

It can be observed from these findings that the there is considerable resonance between salutogenic principles and the views of stakeholders about the nature of community; the ideals, values and principles that underpin their care models; and the benefits they see to the residents and staff of their facilities They each, sometimes in different ways, seek to provide a Sense of Coherence amongst their residents by providing a care environment where they can be

confident that their world is “structured, predictable and explicable” (comprehensibility), that the necessary “resources are available“ to support choice and a sense of control over their lives (manageability), and that supports motivation for activity which is “worthy of investment and engagement” (meaningfulness) (Antonovsky, 1987, p.9). This will be further elaborated in the Discussion chapter.

Having dealt with the views of stakeholders on the social environment of community integrated aged care, Chapter 7 will continue to explore their views of the role of the operational environment in delivering community integrated residential aged care.

Chapter 7: Stakeholder perspectives: Operational environment

7.1 Introduction

Given that residential aged care is moving increasingly toward serving higher care needs (see Chapters 1, 3.3.1, 4.5), the question of the rationale behind community integration involving residents of increasingly higher cognitive decline is a challenge for the *operational environment*. The term operational environment embraces both the internal management of the facility itself as well as the broader policy environment. This chapter discusses stakeholders' views on the relevance of community integration to the *operational environment* given the impact upon residential aged care delivery methods in the face of the increasing demographic of high care needs residents. Table 7.1 shows a summary of key drivers impacting on the operational environment and their consequent implications, in the view of stakeholders.

Table 7.1 A summary of key factors identified in the operational environment

Stakeholder perspectives: Operational Environment	
Drivers	**Implications**
Inadequacy of government policy structures supporting funding for residential aged care	• Residential aged care moving towards palliative care • Eligibility for residential aged care, if not at palliative care stage • Increased number of older individuals requiring specialised formal care unable to qualify for residential aged care • Gap in addressing needs of residents at risk of not qualifying for residential aged care, but are unable to age in their own homes
Appropriateness of government policy	• Viability of successful community integration by providers • Inability of providers to direct targeted and needs based care.
Over-regulation	• Health and Safety policies constrain community integration
Institutional policy	• Largely dependent on institutional philosophy reflected in the model of care • Care philosophy of not-for-profit vs profit-based organisations
Continuum of care policy	• Supports ageing in same environment • More conducive for community integration • Enables maintaining social ties • Enables familiarity of place
Higher care needs of residents	• Increased costs of specialised medical equipment and services.

Cost of professional care in the home	• Lower cost of residential aged care vs home care
Inflexible government funding	• Standardisation of resident fees
Inadequate government funding	• Privatisation of aged care • Need for and reliance on volunteers • 100% privately funded models of care • Reliance on cross-subsidy model for provision of care
Monetising assets for entry into aged care	• Dependence on varying asset values • Impact of intergenerational wealth transfer
Increasing home-care costs	• Financial inability for families to support high needs care at home
Privatisation of aged care	• Affordability for those on low incomes

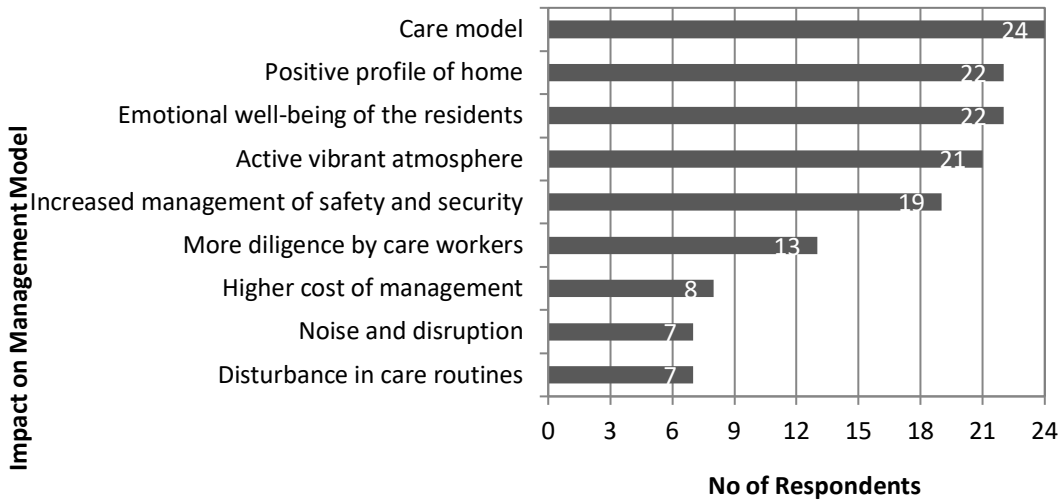
Source: Interviewed survey of stakeholders

The points in the above table 7.1 are discussed in detail in the following sections below.

7.2 Impact of community integration on the operational environment

The stakeholder views on the drivers influencing a community integrated approach and their impacts on the operational environment are based on responses to Question 02: What is the impact of community integration on aged care delivery models and practice?

Figure 7.1 Impact of community integration methods on the management model



This chart shows that the biggest impact of adopting a community integrated approach is on the overall care model of the facility with all twenty-four respondents identifying this as a key factor. It was also agreed by a substantial majority of twenty-two respondents that a community integrated facility increased the positive profile of the home, with an equal number of respondents agreeing that this model of care aids in the emotional wellbeing of residents. Twenty-one respondents agreed that community integration of the home leads to an active and vibrant atmosphere of the home. Following closely behind were nineteen respondents who were of the view that community integration impacted on the need for increased management diligence in safety and security. Approximately half of the respondents were of the view that a community integrated model of care impacted on the need for more diligence by care workers due to the higher visibility and transparency of activities within the care home by visitors.

Regarding the impact of adopting a community integrated approach on the care model, most stakeholders agreed that an effective management model was responsible for the subsequent degree of positive or adverse outcomes. The term 'care model' means the guiding principles with which care is provided which embodies the founding values of the organisation. The differentiation of profit organisations and not for profit operational philosophies are important considering that the majority of aged care providers in Australia are within the not for profit sector. This implies that their primary motivation is focused on resident wellbeing and on care incorporating community integration rather than profitability.

The founder of Group Homes noted the different challenges for management models depending on the location of facilities, as some communities were more conducive to acceptance of those needing care, than others, with greater opposition in some of the more affluent areas of Sydney:

> We've now just purchased our fourth property which is located in the Northern beaches, and it's not as easy cruising as this was, as the three in St. Ives were not easy, but easier. But in the Northern Beaches, we've come up against Nimbys [Not In My Backyard] for the first time, who are saying, "we don't want people with dementia running up and down the street…", and I wouldn't want people with dementia running up and down the street either, but that's not the case here. And because there's such a perception that people with dementia need to be locked up in dementia care units, this is re-educating people about how dementia care can be and how people with dementia can be integrated into the community (GH,P1,TK).

Most respondents did not think that encouraging visitors to the facility led to higher cost of management, with only eight of the twenty-four interviewed responding in the affirmative, and fourteen stating that it did not result in higher costs, and hence negatively impact on the financial model. An effective management policy was seen as key in mitigating higher costs:

> It's not necessarily cost, but increase in diligence and good management (GH,P1,TK).

The founder of Group Homes further mentioned that a community integrated care model can be a bridge in building a positive relationship between the resident and their families, by educating families on dementia:

> We have people coming in and out and we use that as an opportunity to educate the families, so if someone comes in here and they don't have an understanding about dementia, we'll take the time to explain to them how to visit and what to do (GH,P1,TK).

The provider of Elanora mentioned the importance of risk management in adopting a community integrated care model:

> You have to implement 'risk management', we structure community integration around care routines (EL,P1,CL).

It was noted that careful management was needed to maintain and sustain community integration even though the facility may be physically located within a community. This was mainly achieved through the participation of volunteers from the outside community.

> In our model of care, we encourage volunteers. A lot of people come from the community for interaction and provide entertainment to the residents. These events or interaction must be built into the care model (EL,C1,AN).

A Montefiore care worker emphasised the increased impact on the management model of the need to manage a large volunteer base who were the main providers of integration with the community and needed access to the facility:

> Volunteer base needs to be managed, and [therefore] we have volunteer manager to specifically to oversee and manage them (MF,C1,AN).

Overall, as the General Manager of Dougherty noted:

> It does require a different system of management as you are managing not only for the residents, but also for the people coming in (DA,P1,LB).

Policies incorporating successful community integration principles into the care model were seen by stakeholders as having a positive impact on residents' health and wellbeing:

> …human interaction is important for people even in advanced stages of palliative care, so it's best that facilities are integrated into the community (DA,C2,BI).

A care worker at Group Homes further pointed out that policies of community integration were:

> …very important as it helps them [residents] a lot to feel protected and secure (GH,C2,FA).

An overwhelming majority agreed that increased visitor numbers to the facility led to an improvement in the positive profile of the home. However, the Director of Community Relations at Montefiore also cautioned that "the reverse can also be true as one unhappy customer can

spread the word around the whole community, as well as the press, and the Department of Social Services!" (MF,M2,ML).

The importance of the management model and facility design were noted in mitigating possible noise and disruption to care routines through a community integrated approach:

> It's possible that community integration initiatives could lead to some noise and disruption, but it's something that needs to be managed. (EL,P1,CL).

The General Manager of Elanora noted that "it creates a pleasant cacophony of sound". (EL,M1,WD) He further stated the importance of the vibrant atmosphere created as it reflected a normal community ambiance. She explained:

> People love to chat and love to look. And that's why having the hairdresser and the café at the entrance creates a friendly congestion. If you go past a shop and there are lots of people, as opposed to a shop where there's nobody there, you won't go in it (EL,M1,WD).

Likewise, the founder of Group Homes, while agreeing that a community integrated approach could sometimes lead to disruption, mentioned the significance of implementing the management model while staying true to its care philosophy of respecting the wishes of the residents:

> We had a family member who used to visit at 11:00 PM in the night. And the mum would be in bed, and they would crawl into bed with their mum, and initially I thought it was really disruptive, but she said to me, no I've done this for the past 55 years since I was a little girl, so I guess it's a compliment in a way that she still feels that she can do that here because I don't know anyone in an aged care facility that can go into the facility and crawl into bed with their mum! So, is it disruptive, yes, but if we go back to our model of care, and residents' choice, this is what they did for the past 50 + years, so who are we to say don't do it…. I think if we are true to our values about normalcy and choice, we can't be judgmental towards how people interact with their parents, and so with this lady, when her daughters come to visit, they all crawl into her bed and this could be at 7:00am in the morning, or 11:00pm at night. So, I had to realise that it's "different strokes for different folks" (GH,P1,TK).

Those who agreed that it might cause disruption qualified their response mostly by stating that it is an aspect that needs to be well managed in order to create a balance:

> Community integration between residents and visitors can create disturbance to care routines, that's why you have to be more mindful of it (MF,P1,RO).

Many of the participants also noted the increased safety and security requirements, which went hand in hand with more visitors from the community entering the facility:

> …it requires increased management diligence in safety and security, because you need to get family consent (DA,C3,DO).

The architect of Montefiore noted the inherent vigilance that needed to be maintained for their Jewish facility, which required high levels of safety and security:

> It requires increased management diligence in safety and security. The Jewish community is particularly concerned with security, given past and present global conditions (MF,D1,JF).

However, there were also responses which indicated that safety and security was an aspect of the management plan that needed to be incorporated irrespective of community integration. As a care worker at Elanora noted:

> …we have to provide the security regardless (EL,C2,LI).

As the CEO of Montefiore stated, it required a "…keener focus on residents, and [being] more mindful of who is accessing the home"(MF,P1,RO). He stated the duty of care in providing safety for residents by the organisation meant that risk assessment and management aspects of community integration were important.

Opinion was divided as to whether community integration had an impact on the care model in terms of more diligent care by care workers:

> Yes, it aids in more diligent care by care workers because under the eye all the time (MF,M2,ML).
>
> …we provide good care anyway, but I think when there are people around it might make a care worker more conscious of providing good or more diligent care (DA,C3,DO).

Those who answered in the negative thought that care workers were diligent irrespective of whether they were being watched or more visible to outsiders:

> Care workers need to be diligent anyway (DA,P1,LB).
>
> No because we provide care based on our operational philosophy of 'person-centred care' anyway (EL,C2,LI).

Among other impacts brought on by a community integrated model of care mentioned by stakeholders were increased job satisfaction and maintaining a higher standard of care. As a care worker of Dougherty noted her increased job satisfaction as a carer resulting from a community integrated care approach:

> As a care worker, we get to meet and chat with family members of residents when they come to visit, and getting information from family & friends about residents' preferences is important in facilitating community interaction and activities (DA,C3,DO).

Community expectations were also regarded as a contributor in maintaining a high standard of integration of the facility with the community:

> The community expectation is great with regard to Montefiore. This sets the bar very high for the care and delivery models at Montefiore. This expectation is the same in the preschools, the day schools. So, they expect a standard of care which is consistent with the way they've lived and other facilities and services provided by the Jewish community for the Jewish community (MF,M2,ML).

It is evident that adopting a community integrated approach made a significant impact on the management models of residential aged care. Whilst many challenges were discussed, particularly taking into consideration higher-care needs of residents, the benefits were seen to be of greater value.

7.2.1 Government policy

As a result of the increased numbers of the eighty-five and above age group with higher cognitive decline, palliative care residents were seen to increasingly be entering into residential aged care. Palliative care, due to the need for higher specialisation of staff as well as specialised equipment, requires increased funding. However, it was the view of the stakeholders that current government policy did not adequately fund residential aged care in view of the increased costs incurred by aged care facilities:

> The thing we really need to get funding in is palliative care. Because if you are not operating palliative care, from the first of July you need to fund palliative care as you cannot just be a low care provider, and providing registered nurses on every shift is a cost - but you have to do it (DA,P1,LB).

The increase in palliative care residents, was also seen as crucial to the manner in which residential aged care could be integrated into society. The Dougherty Care Manager saw the impact of the policy drive towards ageing in one's own home as an inadequate solution for many who require formal and specialised care. She also noted carer stress and its adverse impact particularly on female family members who often took on the carer role. Alternatively, those who did not have their own home to age in or family to take on the carer role, as well as those suffering with dementia, were also among those who required formal care. She noted that this represented a growing percentage in society for which the government will not be adequately able to fund to age in place at home:

> Big impact! There is not going to be any such thing as low care, all residential care is going to be end of life and palliative care. …but low care is not just people who can't manage to look after themselves, it's people out on the street, who don't have relatives, or funds to enter residential care, who will not get cared for. Having someone with mild dementia in their own home may work, but they still need constant care, and it's the women family members particularly who become the carers, and having to give up work to care for them, and we are not looking at carer stress. This is the main reason most dementia people come into Residential aged care, it's having someone to look after them, and reducing that burden from family. Someone coming into the house for two or three hours a day is not going to look after the dementia. So I don't think community

> care is fully thought through…. The current policy emphasis on ageing in place as in their own home is not the answer for all (DA,M1,JG).

Funding was identified as a major factor influencing aged care policy both at governmental level as well as its subsequent effect on institutional policy, particularly with regards to the nature and extent of community integration. It was noted that although there was an emphasis in government policy supporting community integration, the intention was often not carried through, due to lack of government funding:

> I think politically the government would like to [support policies in support of community integration] but they are not putting [in] the funding needed to make it happen. We have more and more people missing out on getting into residential aged care because they are not old enough or unwell enough to get into residential care but they're in the community needing home care but missing out on home care. So, we're actually having a problem where people are missing out on the care that is needed, and there's not enough funding in home care to provide them with that level of care that they can receive in residential aged care (DA,P1,LB).

The Care Manager of Montefiore also reiterated the lack of government policy to encourage upon community integration initiatives. Lack of funding was identified as the primary issue undermining community integration:

> The economic climate is difficult. From a residential care perspective, the dementia care supplement has been taken away, and that's had a huge impact on the residential care staffing levels, which then has an impact on the level of resources that we can allocate into integration into the community. So, activity officers, and carers to assist with bus outings for communal places, concerts, shopping, is reduced, because when funding is cut, your staffing reduces, so it has a direct impact. This funding was taken away overnight, effective as of the 31st July [2015] with no indication of how that funding would be supplemented in any other way (MF,M1,JG).

The care manager of Montefiore, stated that the government policy focus of ageing in one's own home as advocated in the *Living longer Living Better* reforms had resulted in a much frailer resident demographic. This altered significantly the nature of care, requiring much more specialised staffing and equipment at a much higher cost, as well as shorter lengths of residency:

> *Living Longer Living Better* reform has an impact. That's what I've seen as the biggest shift in my twenty-five years in aged care as a force which encourages people to stay in their homes for longer, and the people who are coming into care now are very much more debilitated than when I first started twenty-five years ago. That has an impact on the services, as the average stay in residential care is shorter and the equipment that we need for the resident's care has escalated, and the staffing levels have had to increase as the level of needs of residents have increased (MF,C1,AN).

A positive aspect in local government policy, however, was noted to be their policies providing a degree of support for older residents:

> The local government Council has a lot of programs for older residents, and we take our residents to them. In terms of the policy of this home, there is a lot of community integration, as social integration is part of the care model of the Group Homes concept (GH,C2,FA).

With regards to positive government support, Montefiore CEO noted the federal government program brokered through local government, the Community Visitors Scheme (Australian Government 2018) , had contributed to the facilitation of community integration:

> The CVS [Community Visitors Scheme] supported by government is a good initiative. And for instance, if bus is not affordable for the organisation, the local council in some cases provide bus services to the home (MF,P1,RO).

It was noted by a care worker at Group Homes that there was still a need for better policy to support the move towards community integration:

> Ageing should not be seen as a disease, but part of normal life. Therefore, government should have more policy to have aged care homes within every community (GH,C3,MA).

A director of Uniting Care Ageing (the Elanora provider) noted the influence of the *Living Longer Living Better* aged care reforms of 2015 affecting the move towards community integration from the perspective of a provider. He noted that it was too early to determine the consequences of this policy reform but noted the emphasis of ageing in one's own home and reflected on the reduced length of time spent in residential care, depending on the residents' care needs. This policy therefore had economic consequences for providers as it also increased monthly payments by residents rather than large lump sum bonds, and thus required providers to put up more upfront costs for the development of residential aged care facilities:

> …*Living Longer Living Better* policy, well it's about encouraging people to stay at home. Also looking at funding of aged care to reduce cost to government, and hence to tax payer[s]. You can charge bonds for high care, earlier you couldn't. Now you can pay a weekly charge equivalent to value of [the] bond, so it's changing funding policy of residential care homes for accommodation. It's too early to understand consequences, but it will depend on the person's needs, for instance if a person was to stay in residential care for only a week or a month, it's better to have a system in place where you could pay weekly instead of a big lump sum. But all this is influenced by the tax system and pension system. It may mean that providers need to put up more upfront cost, because they don't have the flexibility of investing lump sum moneys for use in new building work or other aspects of care (EL,P1,CL).

The general manager of Dougherty pointed out that policy and funding was not necessarily supportive of community integration in a practical sense, because of gaps in the system which may leave many not receiving the levels of care that they require. The *Living Longer Living Better* reforms were regarded by him as an underfunded policy tool which may not necessarily achieve its intentions due to the large increase in the number of older individuals with serious health and cognitive decline including those suffering from dementia:

> *Living Longer Living Better* has been there for a long while in one guise or another, but it hasn't facilitated the funding into areas that are needed even in community care. It comes back to what the government thinks is happening and what the reality is. The reality is, even when we had community care, it was easier then to give care to more people [and] spread the funding across extra people because the money could be spent according to the amount of care packages funding you got, you could spread that money across more people by judging needs. In my previous role, we funded three to four extra people with the funding we got say for 350 care packages. But now, under new legislation, the packages are coming under the new Consumer Directed Care, we're not going to be able to do that anymore. So, people are missing out there. With the Living Longer Living Better, I believe that more people are missing out, and I honestly believe that regardless of what the government says, there is going to be more and more high level residential aged care-high level palliative and dementia care in a residential aged care context, and they really need to then fund the community care (DA,P1,LB).

The General Manager of Dougherty also noted the short-lived policy initiative of the Dementia Care Supplement, which she saw as economically unsustainable from its outset:

> The Dementia Care Supplement that was introduced last year by the previous government was taken away this year, wasn't that a farce! - and none of us who runs aged care ever depended on that supplement as we knew it was unsustainable, so we're not particularly affected by it, because the reality is we didn't budget around it, although it was nice. The government spent a five-year budget in six months with this supplement! (DA,P1,LB).

A manager of Montefiore cited the withdrawal of the government funded Dementia Care Supplement as an example of inadequate government support for implementing community integration initiatives, resulting in facilities needing to rely on volunteer support to meet these needs, not seen as ideal due to lack of training and professionalism:

> …the deletion of the Dementia Care Supplement, which then means we have to rely more on volunteers, which isn't ideal as volunteers are not trained to understand dementia care or even to understand the ageing process, and volunteers are not often reliable because they often do volunteer work for their own feeling of satisfaction or benefit, and they can't be relied on to keep to an appointment or punctuality or regularity. It's not a solution, but without funding from government and donations from the community it is difficult (MF,M1,JG).

Community integration of the older population being viewed and encouraged in one's own home, as current policy dictates, was seen as flawed in many respects. This was not seen as favourable considering the growing numbers of the older population requiring a high level of constant care, who cannot be managed through part-time community programs:

> … even with community care, people with dementia have all kinds of security requirements, for instance if they're in their own home, how do carers get into the home to provide care and all sorts of things that are connected with safety & security for the resident as well as the providers. Currently in aged care there needs to be more community support, transport options, integration options that need to be in place to integrate residents. Getting out into the community is a great idea and we do it as often as

> possible. The residents are noticeably aggravated and behaviour is much more challenging if they don't have the opportunities to go out (DA,M1,JG).

The general manager of Elanora saw the government policy push towards a user pays system, which requires the resident or their family to use up their assets, adversely affecting a resident's ability to enter into a residential care facility able to provide the required levels of care for higher needs:

> In the socio-political sense, there isn't enough funding to support the numbers in the ageing demography, and consequence of that are the recent policy changes in Government towards a user pays model. The user pays model defines a person's needs and monetises assets in order to pay for their care. Mostly that asset is their house or property of some sort (EL,M1,WD).

Caution was expressed by some providers regarding the promotion of current policy concerning *CDC* packages, aimed at affording greater choice and independence to residents, as this was not seen as a viable approach to providing the best care needed to all residents:

> CDCs don't really give increased choice and independence to residents. If you are not already doing that, there's something that you seriously shouldn't be doing. The problem with CDCs is a lot of people can't make informed decisions. We already give choice and independence to residents in where they wished to go, or if they want to come down to breakfast in their pyjamas, but if we were to offer meals at any time they wanted, it becomes an impossible task. So, you have to be careful in how you offer CDCs (DA,P1,LB).

Over-regulation of the industry was also seen as a deterrent to community integration resulting from policy:

> They [Aged Care Regulations] are so worried about the safety of residents that you're never going to get CDC's going if you're regulated so much that you can't do anything. The regulations say that if someone goes out and doesn't come back when they say they would we are told to report them missing! So, the two things don't match - the rules and regulation that we have to abide by and the paperwork is exhaustive. I could give the paperwork to one area of the department and the next day another area of the department would ring for the same information two weeks later. It's government bureaucracy and rules and regulation that impedes people being able to provide the kinds of services that people want (DA,P1,LB).

Such policy limitations were also noted as being precipitated by fear of litigation rather than being driven by humanitarian principles:

> I think that government thinks they're supporting ageing in place, but I'd have to say that current government policy doesn't support ageing in place. Because if they are accredited and as long as there are limitations with risk mitigation, infection control, OH &S issues, the management want to make sure from a legal perspective that they are covered because they're scared and we're not encouraged to take risk, we're encouraged to minimise it, and in the process, we're eliminating the human component. So, we have these great human warehouses where everything is very much risk is minimal, infection

> control is very controlled, but forgetting that we're in a human industry, not just about legislation. So we have to find that fine balance (GH,P1,TK).

The founder of Group Homes also noted the lack of interest from government in recognising new models of care such as the Group Homes model, as a deterrent to the emergence of alternative and effective models of care for the increasingly higher needs of the older population. More importantly, it was further stated that current policy not only was unresponsive to such new models of care but discouraged innovative community integrated models:

> At this point, there's been no interest from government to look at our model, and we've tried. We've engaged them many times in saying that this is a replicable community model used internationally very successfully. It is a model that's not ethno-specific, you can use it in the gay and lesbian community and different cultural groups. We've tried to engage government in a lot of ways, but they're very risk averse, and I think the government is just not interested as if you can fund your own retirement, they don't want to be involved. The sad part of that is, these kinds of models of care then does not become accessible to the entire Australian ageing community. …This model keeps people in their local community. It gives residents a sense of purpose because they are able to live in a regular home. And it gives people much more individualised care because of the intimate scale of it (GH,P1,TK).

As noted by a care worker at Elanora, increasing scrutiny brought on by policy with regards to the well-being of residents' health and safety in a community integrated model of care is justifiable as long as the emphasis is on the needs of the individual receiving care:

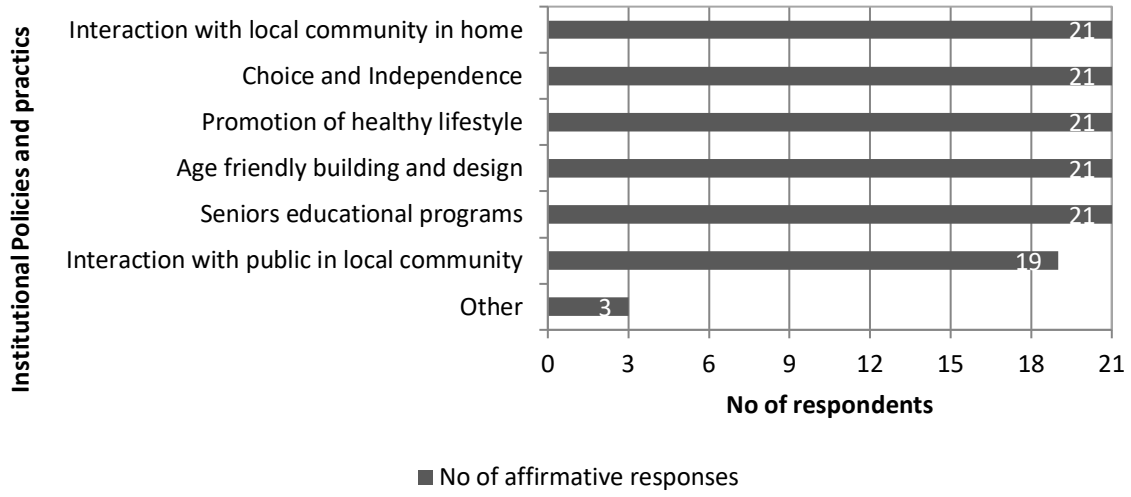
> Working in aged care, we are increasingly open to scrutiny and it's justifiable because we're looking after increasingly frail people. So, we need to see the person before the disease, and recognise the need to keep them engaged in the community even when they are frail (EL,C2,LI).

In summary, government policy was seen to be primarily affected by an increasingly frail population entering residential aged care. Consequently, funding becomes a primary challenge in serving higher needs care, requiring specialised care, equipment and staff. Considering the increasingly higher care needs, the current trend of government policy encouraging older people to age in their own home was not seen as a suitable solution, particularly when dementia care was involved. Though there were government sponsored programs such as the *Community Visitors Scheme* which could be a facilitator of community integration, greater consideration was needed for increased Government funding of community integrated care models for higher care needs residents, as well as ensuring that older people generally requiring specialised care had access to the appropriate levels of care. Government policy, therefore, was regarded as having a negative impact on institutional policy which is discussed in the following section.

7.2.2 Institutional policy

This research is focused on the four different care models of the four case studies, which have adopted community integration principles as a model of care to promote better health and wellbeing for their residents. The specific characteristics of these four case studies are dealt with in the Case Studies chapter. As the institutional policy was seen to define the various care models, the specific aspects pertaining to the four case studies and their care models is investigated in this section. Figure 6.2 shows community integration principles adopted in the care home policies in response to the following question: Question 14: Which of the following policies and principles does this home have that encourage community integration?

Figure 7.2 Institutional policies and practices supporting community integration



In discussing the policies and practices that encourage community integration that were defined following the initial exploratory discussions (see Chapter 4.2), three of the architects did not participate as they were not privy to institutional policies. Therefore, the total number of respondents was twenty-one. There was a high level of unanimity in their responses with all twenty-one respondents expressed that in their view, five of the community integration characteristics noted in the questionnaire were reflected in the policies and practices of their respective facility. These were: interaction with the local community in the home; choice and independence for residents; promotion of healthy lifestyle; age-friendly building and design; and seniors' educational programs. Policies encouraging interaction with the public in the local community were only slightly less commonly cited. Given the opportunity to suggest other key polices, few did so.

It was noted that the institutional policy of the provider organisation impacted on its core principles, reflecting on the care philosophy and subsequent care policy which was supportive of a community integrated model of care:

> It is part of the mission of Uniting Care, as a church-based organisation. The purpose of a church-based organisation is to do good work. The corporate structure is a good conduit for public funds that needs to be accounted for. So, it's an immediate community integration strategy to get people [in the local community] to be part of the organisation. Then you need to get people to be purposefully engaged in the organisation. … A social inclusion model (EL,M1,WD).

The CEO of Montefiore expressed that a continuum of services was central to the Montefiore community integration model. Therefore, at the first point of contact with residents their community outreach programs sought to build a relationship with potential residents and their families, where possible, to assist the residents in making timely decisions regarding their entry into residential aged care:

> … in order to optimise better outcomes for the older person, you have to be able to provide a continuum of services. That is, ageing isn't a linear process. For instance, they have a fall, go into respite care, go back home, come back again and so on. By providing a continuum of services, the provider can 'case manage'. The outreach service provided by Montefiore, allows the provider to assess the needs of the older person and help in timely transition to appropriate levels of aged care. Monte is situated in the Eastern suburbs heartland of the Jewish community, so it is intimately integrated into the community (MF,P1,RO).

Training staff for cultural understanding as well as community integration was also seen as very important, particularly within the religious and cultural context at Montefiore:

> Staff integration and understanding the culture in which they work. For instance, training in Jewish culture, and ageing issues associated with holocaust survivors are specifically very important in terms of community integration at Montefiore (MF,M1,JG).

The Elanora General Manager stated that in terms of community integration the culture of the home is one that is intrinsically embedded in institutional policy:

> …it's the confidence in care received, and trust in the individuals who provide that care. That is very much based on the policies and principles of the organisation. And that's, compassion, honesty, integrity, trust, courage, love. Unless you have an organisation providing aged care that is values driven [and] embedded in its policies, it becomes soulless. No matter how competent you are in what you do, if you don't do that in a way that has purpose, compassion, and feeling, for that individual, if you ask that person how they're going, they'll say, I'm terrible (EL,M1,WD).

Elanora, being part of the largest aged care provider in Australia, Uniting Care Ageing, was located within a wider framework of institutional policy which encouraged community participation. Because of its status as a not for profit organisation, the health and wellbeing of the resident was seen as the primary focus rather than the financial profit model of a commercial provider. This had an impact on the motivation of the organisation to provide a community integrated care model to support the health and wellbeing of the residents.

Uniting Care, promotes the concept of providing a continuum of care which gives the ability through its flexibility to convey individuals on to appropriate levels of care through the one provider in their ageing journey. The provider of Elanora saw the continuum of care as an important aspect of community integration given the growing number of older residents with cognitive decline:

> We have to be much more conscious of providing a 'continuum' of care from the time they make inquiries to the time they come into residential care. They might go through forms of healthy ageing, where they get access to gyms and dietary advice through to more clinical interventions where people support them in their homes, with more domestic support, they might then move into independent living where they have access to that level of support, so if they progress through a single organisation, there is a seamless transition or move from one type of support to another. So a provider would have a well-developed CRM [Customer Relations Management] system which can track an individual through their journey (EL,P1,CL).

Institutional policy which incorporated choice and independence for residents via their model of care, was noted to be an important aspect of a community integrated care model. Moreover, the degree of success of residents participating in integration and interaction was dependent on an individual's interest, ability, willingness and enthusiasm for such involvement:

> We provide choice and independence to residents by giving them a choice of meals, activity program outlines all activities available for the residents to choose from (MF,M2,ML).
>
> It's very much the residents choice if they want to integrate, how much they want to integrate and how they want to integrate (GH,P1,TK).

The CEO of Montefiore also emphasised the importance of providing a broader spectrum of services for better community integrated outcomes, which was encouraged through its policies and principles embedded in the care model:

> It's about having a broader view. The philosophy of Montefiore is if you can provide a broader spectrum of services, you can provide a better outcome. A number of aged care providers have now got into the 'home care' space as a result of the government's emphasis on ageing in their own home, as this supports their business model better by initiating a connection with the older person and when the time comes to move into residential care, the connection is already made (MF,P1,RO).

He further stated with regards to the provision of a continuum of care in the care model:

> As a first stage of need for older people, we have home care. Montefiore also has the Burgess Centre which is the Day Centre. There is also Respite Care offered by Monte. In addition, personal companions can be provided prior to admission, so this is more a social engagement role of the facility (MF,C1,AN).

The founder of Group Homes Australia expressed that the concept of community integration while a socially driven one, was intrinsically tied to the Group Homes care model, as residents

performed better in a community integrated setting directly affecting their ability and disability levels in a positive way. Familiarity and sense of purpose and meaning in life, therefore were seen to be integral to the quality of life of the advanced dementia care residents:

> Social trends would be to keep people involved and active in their communities for as long as possible and to explore best ways in doing that. Being guided by the principles that people want to feel purposeful and meaningful, the Group Homes model is a care model not so much an integration model, but that care model incorporates keeping people involved and connected to their local community and services. So, if they're used to going to a specific hair dresser or coffee shop or supermarket, it's providing the care so that they keep those connections in keeping with their ability or disability levels (GH,P1,TK).

Catering to cultural and ethnic diversity was noted as a factor affecting subsequent policy and principles of the care provider. As a director of Montefiore expressed, even communities of the same faith came from different cultural backgrounds. These different groups then tended to congregate together, which Montefiore handled through its policy of providing by locating them in groups in their different facilities according to their cultural preferences:

> We have another facility in Hunters Hill, in the North Shore, and when we built this, I thought we will have to close that one, but an interesting thing happened, in that, a lot of Russian Jewish immigrants were in the Hunters Hill facility, and consequently in spite of this facility being available the Russian Jewish community preferred to go into Hunters Hill, as that's where their community was. People want to stay close to their communities that they identify with. Over here in Randwick, it's more the holocaust survivors. A single person or a couple who've come to Australia and created their wealth, and it's more Hungarian, Polish, Viennese, Australian, a few South Africans from the Eastern Suburbs South African community. The demographic will keep changing as it's all very fluid. (MF,M2,ML).

Montefiore CEO also pointed out their sense of responsibility for delivery of services such as advocacy through their policy and entitlements:

> With the advent of *Consumer Directed Care* (CDC), there is an advocacy aspect/role which needs to be taken on by the provider in helping the resident choose best options and outcomes. For this purpose, Montefiore employs social workers for that advocacy role (MF,P1,RO).

At Dougherty, their policy if catering for a wide variety of socio-economic groups including social housing residents allocated from the Department of Housing, the integration of different socio-economic groups was reflected in the management model. However, this was applied less in the residential aged care component than in the lower levels of care:

> …the other part is our housing for concessionals. We have people paying big money to live here, but we also have Housing Commission, full rent assisted, full concessionals living here in the self-care units. So there is a mix of people, which is a challenge because if someone is paying big money to live here and next door there is someone who's paying nothing, from a totally different socio economic background, it can be

> challenging. This is not so in residential aged care, because people are facing the same health challenges and so things like socio economic differences don't matter. We have about thirty-five units for housing commission, and about fifty fee paying units, in self-care (DA,P1,LB).

The Elanora General Manager stressed the importance of creating a socially inclusive care environment in their policies and principles regarding community integration:

> To be purposeful in being part of the community is very important. To provide LGBTI friendly service. That's about looking after marginalised people in the community. This creates a socially inclusive environment. That's what I'm working towards (EL,M1,WD).

The Group Homes manager mentioned educational programs to raise awareness of dementia in the local shopping village in the neighbourhood. It was offered as part of their care policy and philosophy of providing education to both the community as well as families of residents to facilitate better integration of residents with the community:

> …training the St. Ives shopping centre to be dementia- friendly is part of Group Homes policy of educating the community and residents families on Dementia awareness (GH,M1,JO).

All case studies promoted Community integration through interaction with the local community taking place in the local area. At Montefiore, a large proportion of this integration was facilitated through its volunteer program:

> Policies and principles of Montefiore that encourage community integration are significant. A lot of this is done through the volunteer program (MF,P1,RO).

As the CEO of Montefiore further stated:

> Policies and principles of Montefiore that encourage community integration is one of the Key goals in strategic planning is as we call it, to optimise community engagement and involvement (MF,P1,RO).

The Manager of Group Homes stated that it was the Group Homes model of care policy to encourage community interaction through regular day to day activities between residents and the community:

> In terms of the Group Homes model, we get the residents involved in the community with community outings and opportunities for interaction and integration like shopping trips or walks in the neighbourhood, or attending appropriate community events, as there are a lot of elderly people in St. Ives. So, it's important for the residents to feel part of the community (GH,M1,JO).

The Group Homes care philosophy also organised the home itself to be run like a regular domestic household:

> This is a home, exactly as with someone's home, so you don't have people just walking into your garden or premises off the street, and it is the same here. There is no difference (GH,P1,TK).

Facilitating the integration of staff with the resident community was also seen as crucial for community integration policies and principles at Dougherty Apartments. It was their policy to incorporate input from the residents themselves on matters relating to the home, with resident management meetings held on a regular basis. For example, resident views on staff attire were incorporated into the management policy resulting in the preference of regular work wear instead of care worker uniforms:

> … we don't have any uniforms here. If you walk through our care levels, you won't see any uniforms. This is because the residents didn't want staffing uniforms, and we took that on board. The residents here have a significant voice. We have a regular monthly residents meeting for both self-care and residential care, so all that is incorporated into our care model and the way we run the place (DA,P1,LB).

Management involvement as well as individualised care were mentioned as inherent characteristics of a community integrated care model incorporating residents' contact with the larger community:

> …Encouraging the community to come into facility to visit. We also have a fabulous recreation team, whose job is to bring the community in, from school children to various groups, volunteers, volunteer bus drivers, shopping trips and things like that (EL,C2,LI).

It was noted that with higher care needs, individual choice in the nature of interaction and individualised care becomes important:

> Community integration becomes more one on one care when it gets to higher care needs. Residents are taken out on organised trips, taken out to the shopping centre, to keep them engaged (EL,C3,SA).

However, it should be noted that there is a close intertwining relationship between institutional policy and government policy discussed in the previous section 7.2.1. In the view of the stakeholders, aspects of the broader operational environment of the facility relevant to community integration of residential aged care included both government as well as institutional policy. These two aspects of policy were in many instances intertwined in the delivery of residential aged care and practice. Government policy was seen as a broad framework within which institutional policy was adapted by each provider to suit their own care model. Therefore, government policy had a strong influence on supporting or inhibiting institutional policy regarding community integration. Government policy was seen to incorporate the two major areas of funding and standards of care. Government funding dictated the nature and extent of financial support both to individuals as care recipients and institutions as the care providers. The standards of care which were set by government policy, were seen to be concerned with responsibility (or duty) of care to residents, safety of residents, and legal

responsibilities. The direction of government policy was noted to have more of a focus on community integration as a healthier ageing paradigm, however it was regarded as premature to assess the results of the recent policy changes:

> We are at a transition state now. We have a very broad view about where residential care is going. The whole thinking is changing, because community integration is the way to go, seen as benefitting residents' health and wellbeing. But, it's too early to assess the outcomes of current policy (EL,C2,LI).

The providers were found to overcome government policy shortcomings through their own institutional policy in support of community integration founded on their care philosophy.

In summary, there was very strong agreement amongst stakeholders about institutional policies and practices that support community integration. These included interaction within the local community within the home; choice and independence, promotion of healthy lifestyle, age-friendly buildings and design, education and interaction with the public in the local community. This justifies the selection of the four case studies of this research, chosen for their strong community integrated care models.

7.2.3 Economic factors

The economic context of the adoption of community integrated care models, was found to be influential in the development of both the operational environment of the facilities as well as impacting on broader policy issues. Consequently, there is significant overlap in the discussion of the economic context with social and policy impacts discussed earlier in this chapter.

The emergence of the Federal Government's *Living Longer Living Better* aged care reform with its emphasis on policy encouraging ageing in one's own home, resulted in those who entered residential aged care being at more advanced stages in ageing and cognitive decline, often with serious health conditions. This was noted to have caused a significant increase in the cost of care, medical equipment, and specialised services:

> …like I said, it's all around the fact that older people are coming into residential aged care older with more immobility and higher needs, often end of life care- so the cost of care is higher for staffing, and care model staffing is more costly. Equipment is more costly- lifters etc. If you're an average ACFI [The Aged Care Funding Instrument] is sitting on Medium-low-low, your funding is probably averaging around $28.00 a day, you can't provide care for that. My average here right now is High-Medium-High for ACFI. And that's what we intend to maintain it at. So, you have to be conscious of your model of care and how you do your financial modelling around that (DA,P1,LB).

The Group Homes Care Manager saw the economic aspects driving community integration tied very much to societal affluence and the ability to choose the type of aged care the family would often want their family member to be in:

> In terms of economic forces, depending on the person, many people just have the option of going into a large institutionalised aged care system or facility, which are geared very much on money and budgets and so on, and not necessarily the human aspect. Now, as people are having more resources they are looking more towards quality of care, and they are looking for places which are not so profit driven, and more focused on maintaining the same lifestyle that they've always had, and having their care needs met (GH,M1,JO).

The economic factors influencing community integration of aged care were likewise stated by a care worker of Group Homes as being driven by the resident's family, as it was more an economic decision for the families to seek professional care required for their family member which could not be provided by them in the home:

> …for the families, it is more economical and practical to have their loved ones being cared for in a residential aged care facility rather than at home, when they are at a stage of needing 24-hour care (GH,C1,CR).

However, a Montefiore care worker pointed out that means testing was making good care services financially unattainable for most people:

> There has been a push to providing home care, so residents are familiar with Monte and the staff, so when they eventually move in, it's familiar to them. This is something that government policy is pushing towards, and now there's a means test, whereby you have to have a certain amount of money to get into a place like this. And a majority of people can't afford it (MF,C3,CR).

Economic factors were also mentioned as being behind the government's reticence in encouraging community integrated residential aged care facilities. At the same time, while ageing at home is emphasised, it may not be the most efficient community integration method for older individuals with higher cognitive decline:

> … when you concentrate a lot of them [residents of residential aged care] in a care facility, then you only need a few carers to look after a lot of them. If they're in their own homes or separate homes, you need more carers and more nurses to look after as they are spread out and the nurses can only respond to an emergency call, or a timed regular call. So, the reasons for not having aged care facilities [Residential aged care facilities as a whole, in favour of ageing in a person's own home] is purely economic as the government can't afford them (EL,D1,JF).

In the reforms, elimination of the distinction between high-care and low-care was seen to have made a significant impact on the financial models of aged care home who are encouraged more and more to provide care for higher needs in order to qualify for adequate funding:

> … there is no such thing as low care now, so that management model disappears within a couple of years. So financially taking care of people within the facility becomes much more expensive. Of course, you get paid higher by the government to look after people with higher care, but the set-up costs for the facility are quite enormous, and you also have to make sure you train up your staff. We've got eighteen months more to bring [in] registered nurses twenty-four hours a day, and we've already done it, because you can't

> now have proper ageing in place without registered nurses. We've budgeted close to $100,000 just in set up costs - lifters, water chairs, oxygen and so on (DA,M1,JG).

The CEO of Montefiore suggested that the financial model was about striking a balance between a user-pays system and government funding. For a charitable organisation, funding was distributed in a way that benefitted all residents according to their level of need in providing the best care for all, and not with the aim of profitability for the organisation:

> Funding is a combination of user pays and government funding. There is a limit to both, and it is trying to understand and get the best balance to provide and meet the critical levels [of] care a person needs. Through our cross-subsidy model, people who can afford to pay to a limit of what you're allowed to under the government framework, pay a full commercial rate to be with Monte which gives the provider the ability to cross-subsidise those who cannot afford the levels of care needed. For that reason, profitability is much less than a commercial provider, as being a charitable organisation. Every year, as funding arrangements change, fluctuations in the economy take place, it requires the funding model to be modified. For example, the refundable bond is used to generate more income by investing according to our investment strategy (MF,P1,RO).

The positive development of policy was acknowledged by the Director of Community Relations of Montefiore, who noted that there was no flexibility around government aged care funding regulations which was seen to effectively implement transparency and standardisation in the charging of fees to residents:

> Under the Department of Social Services guidelines, the way funding works for aged care is very standardised. It is very transparent, and there is no grey area. In years gone by [pre 1997], providers could charge what they wanted where an admissions manager of the facility made the decision (MF,M2,ML).

This director at Montefiore therefore stated that the financial model followed the strict guidelines set out by the national Department of Human Services. However, in order to achieve the necessary standard of care, as well as functioning as a care facility intrinsically integrated into the community, Montefiore engages a cross-subsidy model which distributes funds across all residents to ensure the high standard of care and services are offered to all residents:

> … there is an understanding in the community that whoever is approved for care or requires care, would be accepted at Montefiore no matter what. So, the financial model for Monte is by the book according to the guidelines set by the Department of Social services, but some are bond payers, and some are fully subsidised, and at Monte the subsidies are achieved with a cross subsidy model (MF,M2,ML).

Fund raising was similarly mentioned as an essential aspect of the financial model at Montefiore, by virtue of it being community integrated:

> …fundraising is a big part of the financial model. What has happened historically is that over 40% of the current residents at Monte are holocaust survivors. They came to Australia with nothing and in some cases went on to build huge empires and accumulated vast wealth, most lived frugally and saved a lot of their money (MF,M2,ML).

Charitable donations were described to form the original financial basis of Montefiore. This was noted to be solely due to it being a community based, community integrated charitable organisation in a community which regarded Montefiore as "their own". A director of Montefiore explained that most Jewish immigrants who first came to Australia often never had families due to the horrors experienced in concentration camps, and never had any affinity or involvement with the Jewish faith or community due to disillusionment and feelings of abandonment by God. Therefore, their wealth was often left to charity upon their passing, as they came to Australia either as a couple or on their own with no extended family or community connections. Being closely integrated into the community, these older individuals it was explained, had the knowledge that when they grew old, widowed or circumstances dictated that they could not manage in their own homes, they would one day progress to Montefiore, and it would provide them with the care that they needed:

> When it came to building Montefiore, there were huge bequeaths by deceased estates that still continue to benefit the cause of Montefiore and have significant impact on the level of care and services offered by Montefiore. This is a reason that Montefiore was able to be built, but having said that, this model of funding needs to be changed as the youngest members of this generation of holocaust survivors are now in their late 70s or 80s (MF,M2,ML).

It was noted though, that the structure and nature of community was one that was subject to change. The financial model therefore could not be sustained on the assumption of large charitable donations in the current and coming generations. Therefore, a dynamic approach to the funding model was seen to be necessary in keeping with the changing dynamics of society:

> … Montefiore cannot depend on bequeaths of large sums of money to continue to provide the level of care expected and needed by the community. And the fund-raising model needs to be dramatically different. So, the funding model is currently based on a very strong spiritual commitment to the Jewish faith to look after their own. It is written in the Torah. It's very much ingrained that charity is a part of their life. So, the new model for fundraising will have to be based on this spiritual model where members of the community are approached for a commitment to monthly donations that are at a comfortable level for them (MF,M2,ML).

The shift in policy towards a user pays system was noted by the care manager of Montefiore as one which may render the provision of adequate care unreachable for many, even as a community integrated facility which was formerly very heavily subsidised by an eager and interested community:

> CDCs are not fully implemented as yet, but there is definitely a bigger financial burden on people to pay for their services. And once it's more formalised, it will very much be a user pays system (MF,C1,AN).

The Group Homes model of care being the first of its kind in Australia, is for the moment completely privately funded with no government subsidy. As the founder of Group Homes Australia stated, the existence of the newly available CDC packages did not necessarily mean they were easily accessible or adequate in number for the growing proportion of high-care needs in the older population.

> People are entitled to bring community care packages, so that impacts the financial model in terms of what the care costs for the individual, so the more care packages are available, that adjusts the fees, but there aren't many available [CDCs]. The process is so complex for the family of the residents to navigate in order to get the care packages, and the ACAT teams often don't know how to compartmentalise us [the Group Homes concept] (GH,P1,TK).

A Group Homes care worker noted that it was more economical to have one care worker looking after multiple residents in a professional care environment equipped to handle care needs, than one carer for each ageing individual. This was due to the increasing ageing population with higher cognitive decline. Another reason was the increase in skills shortages, with fewer people in the workforce qualified as care workers to look after the ageing:

> It is more economical to have residents in residential aged care rather than having an individual carer for their loved ones because older people now have higher needs with living longer with more cognitive decline (GH,C1,CR).

It was also pointed out that volunteers were an integral aspect of a community integrated aged care model. Fundraising through volunteer activities was identified as an important aspect which influenced the financial and management models:

> Uniting Care relies on volunteers to provide activities for residents. The volunteer base is also crucial in fund raising for Aged Care delivery (EL,C1,AN).

It was noted that the increasing entry of higher needs residents required more funding for a viable business model:

> Aged care is interesting from the point of view that we are caring for people who are frail and aged, but there needs to be a business model which is viable. So, there can be a conflict sometimes of the care needed and the funding available. We're seeing even younger people coming into res care who are dying, so for me it's a challenge (EL,C2,LI).

It was also considered that the policy initiatives with the focus on ageing in one's own home was moving residential aged care toward privatisation, which consequently has financial bearing on the cost of care:

> The government is cutting funding to residential care, so that they are leaving wide open for private developers to create residential care because its private, it's generally expensive, so it's not available to everyone, and that leaves a class of people at home. And those people can't get the same environmental outputs that they can get in a care

> facility. When they are at home on their own, they can't afford to have a well-designed environment which is capable of meeting individual needs (EL,D1,JF).

A contrary view stating that community integration per se did not need to escalate financial costs, as community integration was noted to have a positive impact on residents. Indeed, a care worker at Dougherty suggested that care giving was easier as residents were happier:

> It impacts in a positive way- integration doesn't need to be expensive. Makes it easier for us because residents are happy (DA,C3,DO).

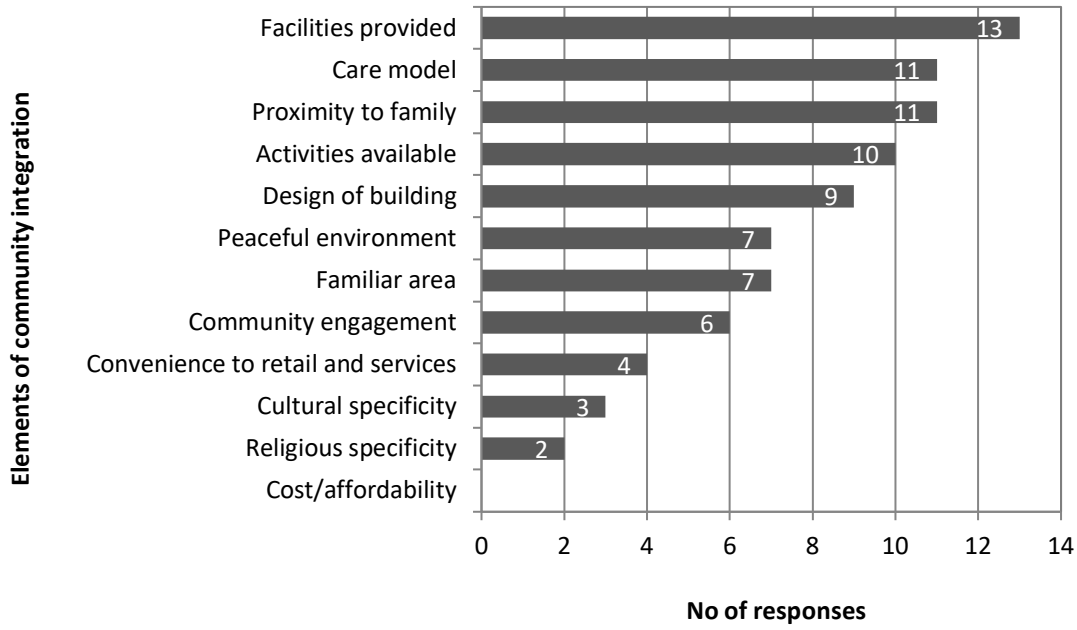
This discussion on the economic impacts on the social environment of a facility demonstrate that there is a significant effect on the overall care model of the facility. It was noted that a community integrated approach of the care model contributed to the positive profile of the home. In a market driven economic context, this could be a positive generator of customers (families of residents choosing the facility for their loved ones based on its positive profile). It was agreed that a community integrated environment contributed to a resident's emotional wellbeing. This could contribute greatly to the positive profile of a home, in turn more likely for family members to choose a particular facility. However, it was also noted that a community integrated approach, does require increased management diligence. This may or may not require additional financial burden on the operational environment, but it is certainly a factor that requires integration into the care model in delivering a community integrated care approach.

7.3 Reasons for resident choosing the facility

The reasons why residents choose a facility are an important determinant in the *operational environment* in that facility. This is primarily driven by the increasing demographic of the older population as discussed in Chapter 2, who have significant financial power and increased expectations, leading to the residents' ability to choose the care facility that offers care giving of their choice. In the case of residential aged care, it is likely to be a family member making a decision of entry into the facility following a sudden health event leading to incapacitation of the resident or higher needs care stage in the residents life rendering them unable to make the decision themselves, In such a situation, the family members likely do not wish their loved ones to be in an undesirable institutionalised setting. Therefore, it is important for this research to explore if aspects of community integration play a role in resident's choice of facility. It should be noted that aspects of all three components of *social, operational* and *built environment*, are included in this section as these are often interrelated but are viewed through their impact on the *operational environment* from the perspective of stakeholders working in the operational environment.

Figure 7.3 demonstrates stakeholders' perceptions of how the various elements of the community integration model influence the decisions made by residents and their families. Figure 7.3 summarises their answer to the question '*Which of the following reasons do residents give for moving to this home from another home?*'.

Figure 7.3 Reasons residents choose the facility



Note: Multiple answer question

A total of twenty respondents were included in this question, excluding the designers of the facilities who are not directly involved in operation of the facilities. Respondents noted multiple reasons why residents would enter the facility. Cost and affordability were not seen as reasons for any of the residents to choose the care home, as all four case studies selected required higher bond payments than most facilities. However, three of the four case studies catered for concessional residents where fees were subsidised by government rebates or through the financial model of the home. The facilities provided by the home were seen to be the most important reason for a resident or their families to choose the home, according to management interviewees. This was followed by proximity to family as well as the care model as equally second reasons. It is interesting to note that although facilities provided were the primary reason for transferring or choosing the facility, the activities available were seen by ten out of thirteen respondents to be a reason for a resident or their family to choose the facility. The design of the facility was also noted as valuable by nine respondents. Peaceful environment and familiarity of the area were noted by an equal seven respondents, while community engagement was seen to score slightly less with the agreement of six respondents. Convenience to retail and

services likewise were noted as reasons by only four respondents. Both cultural specificity and religious specificity were rarely given as reasons by only three and two respondents respectively.

Open ended response to the question gave a more nuanced explanation of stakeholders perceptions of reasons for choice. The care model was seen as important specifically with regards to higher needs care. As in Dougherty Apartments, the availability of specialised care for higher needs care residents, as well as dementia care were often reasons given for why residents transferred from another facility:

> …high care and dementia specific care are reasons that residents give to move to Dougherty from another facility (DA,C1,AN).

Quality of care was also noted to be a reason for resident transfer, as in the following case:

> The main reason for transfer is because they weren't looked after well in previous facility, for instance when one of the residents who recently transferred here had a fall in her previous facility, the family were not informed (DA,C3,DO).

It was noted in Montefiore that the care model which included a community integrated approach to behaviour management, was responsible for transfers from other facilities:

> A lot of people transfer here because of the interventions we have in behaviour management. We have been able to take people off drugs with a care model that integrates the resident in an active lifestyle (MF,C1,AN).

Similarly, at Montefiore, a care facility intimately related to the larger Jewish community, the care model and service provision which incorporated active community integration of residents was noted to be a reason for transfer or choice of home:

> …the main reasons to transfer here or choose this particular facility is mostly around services. It's activities and services, facilities, and community engagement (MF,P1,RO).

The founder of Group Homes noted the care philosophy which was linked with the size and design of the home and environment as the reasons people transferred to and chose their facility:

> It's our care philosophy, the Group Homes model incorporating the care model, and the design of the home which is part of the care model. This is the reason people have transferred to this home. So, it's the type of care, and the type of environment. So, the size of the home is important which is inclusive in the design, that it's a regular sized home, and it looks like a regular home not an institution (GH,P1,TK).

The manager of Group Homes also commented it was the care model combined with the small scale of the home which were reasons dementia residents transferred to or chose Group Homes:

> Good care model is the no.1 reason. We have residents here who could not be managed in large institutions, because staff wasn't well trained, and residents were unhappy in a large institution. Dementia cannot be managed in large institutions, and residents were calling their family all the time because they did not want to be there (GH,C3,MA).

In the case of Group Homes, this facilitated provision of a normalised home environment. Activities available also ranked as significant after the care model and proximity to family:

> The way activities are defined in this home is getting people involved in normal activities that they would do if they were in their own home, which this is for them. So we don't play Bingo and have sing-a-longs. And I say to people, if your bringing your mum along for that, then don't, but if you want your mum to be involved in the cooking and baking, and shopping and gardening, and all of that, then this is her home. So, they do come to this home for the activities, because they're real activities (GH,P1,TK).

Religious and cultural specificity were also noted as reasons for choice by only a few stakeholders from facilities which had a majority resident population belonging to a specific religious or cultural group. For example, Elanora was initially designed with the Italian population in the area as a potential resident demography, but later changed to a majority Spanish resident community, as a result of Spanish advocacy groups promoting the facility to their community. The resulting cultural profile has sometimes resulted in residents transferring from other facilities to Elanora:

> Although [our] organisation is not culturally specific, there is a high Spanish population in the area, and twenty five percent of residents are from a Spanish background. The Spanish advocacy groups 'CAPAH' & 'SALCO' work closely with us. The colour scheme of the facility was also chosen to reflect a Mediterranean theme by the previous manager as when this was built, the focus was the Italian community according to demographics, but now it's become a majority Spanish community (EL_M1_WD).

Similarly, Chatswood is a suburb with a high concentration of Chinese residents which has increased within the past fifteen years. This has resulted in the increased entry of residents with a Chinese background into Dougherty Apartments in recent years:

> Chatswood has a big Asian population, so we are having a lot of Asian older people as residents coming in. So, we have staff who are able to speak in Mandarin/Cantonese as well (DA,P1,LB).

The reputation of the facility was also a feature noted for transfer to Montefiore, as well as Elanora. The Elanora General Manager further stated that "most residents who come here now, are actually on the waiting list, and those who have no place to go, they generally get priority" (EL,M1,WD). This was seen as largely due to the reputation of the facility.

7.4 Implementation of community integration

Stakeholders views about the relative importance of various methods of community integration adopted by the four case studies of this research are detailed in Figure 6.4. It shows a very high

level of agreement about methods adopted. Among those with an aggregated score of important and very important, five responses were given by all stakeholders. These were interaction with visiting family and friends within the home, the architectural design of the home, the location of the home, and community integration as a strategy for residential aged care. Interaction with friends and family in the local community, and with the community, were also considered important along with residents' interaction within the home, for all but one of the respondents. Interaction with a church or spiritual community outside the home was viewed as equally important as having that interaction within the home by 22 stakeholders. Finally, interaction with members of the local community within the home ranked higher than interaction with the surrounding community, but still by a majority of 20 and 19 respondents respectively.

Figure 7.4 Implementation of community integration features according to importance

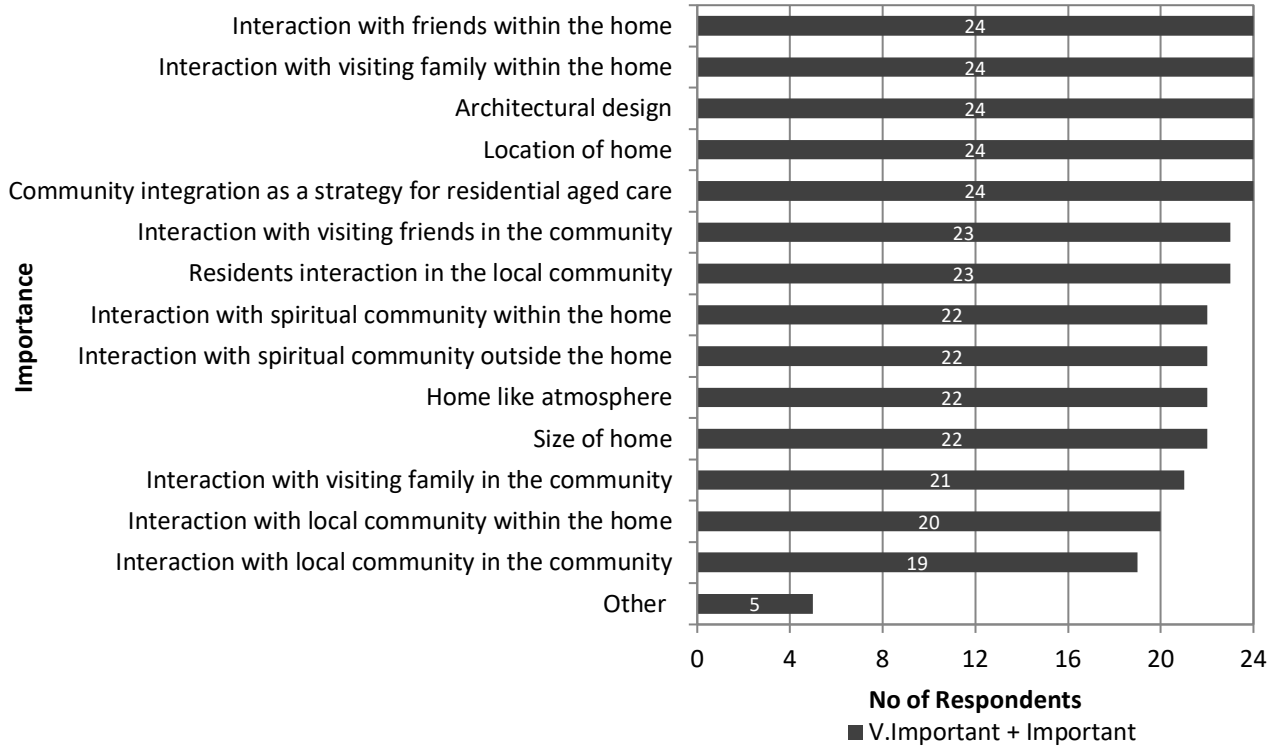


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Figure 7.4 demonstrated that there were some interesting differences between what the stakeholders regarded as important and what community integration activities were implemented in the care homes. This may indicate that the strategies adopted were easier to implement or lesser costly.

Organised entertainment activities within the home

All case studies were seen to promote community integration through interaction with the local community taking place within the age care home. Inviting entertainers and performers to the home was a common form of integration:

> We invite performers and so forth on occasion (GH,M1,JO).

Activities included those that had been familiar to the resident as a part of their normal lives. It was noted that the residents' choice in the nature of participation was of importance:

> …we have a variety of people and activities brought into the home. [We include] pet therapy where a dog comes in to interact, Bingo games, nail painting, hair dressing, whatever you would do in your normal life. It's up to the individual how they want to integrate. They should have choice (DA,C1,AN).

Celebration of birthday parties, as well as providing a variety in food, were all mentioned to be aspects of providing entertainment and variety for the residents:

> …even food, they don't have the same food every day, so they have different options. Everyone gets to celebrate their birthday, even if they don't remember or don't care, they still have that birthday cake and they really enjoy it - and it's not only for the residents, but also for the staff. So, staff get their birthday celebrated with the residents as well (DA,C2,BI).

The founder of Group Homes stated that although they did not have a coffee shop in the home, the kitchen served as the communal meeting place for a cup of coffee or tea:

> We don't have a coffee shop within the premises, but we have a big central open plan kitchen as part of the living area, where anyone can have a cup of coffee or tea any time. Having a coffee shop in premises wouldn't support the group homes concept where it functions as a regular home, and people don't have coffee shops in their home! But the local shopping village with coffee shop is just up the road (GH,P1,TK).

The manager of Group Homes, mentioned the importance given to the kitchen as a place where organised activities took place sometimes incorporating residents from other homes:

> In the case of Group Homes, it's the kitchen that functions as the café and meeting place, much like in a regular home. Sometimes we do cooking demonstrations in our kitchen to which older people from other homes come and watch as well. We phone them up and let them know if we're having anything (GH,M1,JO).

As the General Manager of Dougherty pointed out, the provision of a wide range of services from self-care to palliative care in the same facility enables options for a diverse ageing community:

> I think it's [community integration] very different depending on your facility, and your services. Here for us, we have our facility integration, so a lot of our services like physio, and so on, are integrated and residential care residents go to self-care functions, and dementia care residents are not segregated, but integrated with other residents, so

> because of the way we are, we can provide that service. It's different than an average low care facility with a tack on high care residential aged care facility because it's still very separate and functions separate[ly], whereas we are different (DA,C3,DO).

A variety of activities were noted to be organised within the four case study facilities, providing choice to the residents in the type of activity and nature of participation. These included both group and individual activities.

Spiritual activities

It was stated by most that spirituality and practice of faith was very much up to the choice and preference of the resident. These activities were noted to take place mostly within the premises of the home for accessibility and practical reasons. The preference for spiritual services to be conducted within the home was because the higher needs residents were not regarded as being in a condition to participate out in the community:

> A lot of them were very active in their spiritual community, and they still have their Rabbis coming here, but they can't now go out to the community synagogue mainly because of logistics, when you get a thousand-people going to a synagogue, it's not very practical for them to go, so we offer synagogue services here at Monte (MF,M2,ML).

At Elanora, spiritual services could not be made available to everyone to the same extent, but provision was made for those needs which could be, to be met:

> Different people have different ideas about spirituality and their needs are different. So, in a place like this, you can create a spiritual space, but you can't meet people's expectations of providing for their spiritual needs exactly common to everyone (EL,M1,WD).

Montefiore however is a provider with a specific dominant spiritual and cultural focus. Therefore, the care model was seen to be based on these values and specific services were provided in line with the Jewish faith:

> Spiritual needs were of utmost importance; it is integral to the provision of aged care at Monte. Montefiore won a better practice award from the government, for provision of spiritual and cultural religious support activities (MF,P1,RO).

Spiritual activity was noted to be also integrated with the care philosophy of the provider. Those providers who were providing a care service with a specific cultural and religious focus, such as Montefiore, were most likely to provide specialised services to that cultural group. Providers who did not have affiliation to a particular dominant faith, such as Dougherty, provided that service according to resident needs by allocating a general space such as a room within the home for a priest from the community to come into the facility when required. It was however noted by all providers that spirituality was a personal preference which was the choice of the resident that needed to be respected above all else.

Inter-generational activities

Inter-generational interaction was considered a favourable form of community integration for senior residents. This included co-location of services such as an on-site preschool at Montefiore:

> We have the adjoining pre-school in the premises (MF,M1,JG).

Organised activities involving interaction with children was also achieved in other ways:

> We don't have a specific playground, but we have a large garden and facilities for outdoor games and toys for children who visit their grandparents (GH,C3,MA).
>
> We have a community garden which is tended by the local primary school kids, and also baskets of toys in lounges for visiting children (EL,C1,AN).

At Montefiore intergenerational activity also included on-site prayer services:

> …school children come in for activities. Every Friday an intergenerational Shabbat service with residents and school children is held here, even in the nursing home & dementia care section (MF,C1,AN).

At Group Homes, organised activities such as musical performances by children were included in intergenerational activities:

> School kids come to play musical instruments for residents and residents love it (GH,C1,CR).

However not everyone agreed with this form of integration. As the Founder of Group Homes noted, it was not part of their care philosophy "because this doesn't support the concept of a normal home, you don't have strangers and children just walking in your back yard or entering your home" (GH,P1,TK

A Director of Montefiore also noted the managerial and litigation aspects of providing such facilities:

> …we actually looked at this, but the logistics are very difficult, i.e. who manages it, who cleans it, who looks after it, from a safety point of view, who supervises it? We've got one at Hunters Hill. Do people just let children run riot- which we do, and when a child breaks their arm, who's responsible? So because of all these issues we didn't put one here (MF,M2,ML).

Activities in the local community

Activities in the local community were also seen to be an important aspect of a community integrated care model. Visiting public places such as shopping centres which offered a variety of

stimulation was of particular importance. A Dougherty care worker noted the preference for quieter spaces for interaction while still being connected to local shops and amenities in the local neighbourhood:

> As care workers, we walk up to Gloria Jeans [coffee shop], in the Mandarin Centre shopping centre in the neighbourhood where it's very quiet for shopping, because the Westfield shopping centre is too crowded and busy for residents, and also go for movies, which are all very close by (DA,C3,DO).

At Dougherty, the location close to a major urban centre was seen to aid activities involving residents in the local community:

> Pretty much every day, a group of our residents will go for a walk with our activities officers, they'll go out for coffee, they'll go out to the park. Because they are so close to the railway station and cinema, they can go out, or be taken out to cultural events, movies very easily (DA,P1,LB).

The founder of Group Homes mentioned partnerships with the local Council, that promoted residents taking part in suitable activities or entertainment programs for seniors:

> We do programs with the local Council, events hosted by the Council in the community for senior citizens which our residents attend (GH,P1,TK).

Integrative measures employed in residential aged care were not only restricted to special events or occasions in which the residents physically took part, in order to be effective. As a Director of Uniting Care Ageing noted, activities were meaningful to residents even as an observer:

> We try to get our residents out and about as much as possible. It may be sometimes quite exotic locations like the beach, and some may wish to just sit in the bus, but they still enjoy it (EL,P1,CL).

Walking in the neighbourhood was also noted as an important community integration activity for the physical health of residents:

> They go out for walk every day, healthy food, they go out a lot as it's really important for them to get their vitamin 'D' (GH,P1,TK).

All four case studies promoted community integration through educational programs for seniors. The Florence Melton School of Adult Jewish learning was mentioned as a collaborator in programs conducted at Montefiore for its residents:

> We have educational programs for seniors, such as programs on healthy ageing, where we bring in guest speakers who are experts in specific fields such as arthritis, or talks through the Jewish learning program Melton (MF,M2,ML).

Montefiore was also seen to promote intergenerational learning programs:

> Some of the Jewish facilities run adult education, in which younger people in the community join the residents (MF,M1,JG).

It was noted however that physical proximity to services alone did not mean that integration with the local community would automatically take place. As the General Manager of Elanora noted, these connections must be initiated and maintained, through incorporation into the management model:

> The location of the coffee shop and hairdresser at the entry is important in creating a social precinct. If the management model strives to get people in the local community [to] engage with the facility and see that they can be of mutual benefit to each other by creating social connections, it changes the whole dynamic (EL,M1,WD).

Therefore, community integration with the broader community was noted as requiring a two-pronged approach. The first was the aspect of residents going out to the local community; the second was the local community coming into the residential aged care home. Both these aspects needed to be carefully managed to achieve a successful community integrated aged care model in all four case studies.

7.5 Integration of dementia care

Central to the *operational environment* is the issue of moving towards community integration with more and more residents requiring higher needs care, particularly dementia care. This arose as an important issue in the stakeholder interviews. With specific regard to dementia care, the General Manager of Dougherty noted the significance of not separating dementia care residents in the process of community integration, either with the internal resident community or with the external local community:

> My approach to dementia is not to separate them, whenever possible. Our model of care involves bringing the dementia residents into contact and integrated with the activities of the other residents, because need to be part of what's happening. Yes, we have a secure section for dementia residents for their own safety, but they are constantly integrated with the other residents, i.e. one of the residents had her 103rd birthday, and everyone joined in who was capable of doing so and came out to the party. For me, you can't have a community of people with no memory having any kind of community or social entity if they are locked up and that's where they stay. You have to bring them out. They might forget that they were there, but that doesn't matter, because at least they're part of it (DA,P1,LB).

She also cautioned against the manufacture of activities for dementia care residents, as commonly adopted in conventional residential aged care. The importance of the involvement of dementia care residents in regular day to day activities along with other residents was highlighted instead. However, she noted the limitations of government policy in over-regulating the industry, which was not seen as conducive to implementing effective community integration initiatives that best suited for residents:

> All this garbage about washing lines, unit kitchens and things like that, is something I don't believe in. All our dementia care patients can be a part of normal activities with other residents. We encourage all dementia residents to come out of their rooms and take part in activities. It's not the financial restrictions that are stopping us from doing things, it's the over regulation of the industry. We are more regulated than a hospital, and yet this is someone's home! (DA,P1,LB).

It was reiterated that high care, particularly in the case of dementia, did not mean less activity or separation from other residents, rather, it was seen as an opportunity for education of carers and other residents on the needs of those suffering from dementia in order to better integrate them in a safe and professional care environment:

> Activities are still important in advanced care. One on one care becomes more important. It's important for carers and people who visit to learn about behaviours and how to deal with them, for instance with dementia care patients. Educating other residents on dementia residents is also important, as they are then better able to understand and get along and accept others in their resident community (DA,C1,AN).

Careful assessment by management was seen to play a major role in community integration particularly for residents with higher care needs, as the greater a resident's cognitive decline, the lower the opportunities are for integration to take place organically. This was not seen as an indication that higher care needs residents need less interaction and activity, rather the provision of an area where activity and integration were built into the residents lives according to their level of need and the nature of the activity:

> Management has to assess what residents' needs are and provide integration opportunities accordingly. Integration doesn't only mean physically, there are non-physical activities that residents can take part in which are equally important, especially in higher care. That is, over here every thirty minutes staff go and check on residents in high care and talk to them, massage, read and so on (DA,C3,DO).

Integration of dementia residents both within the community of residents as well as in general activities and outings was emphasised by many as part of a successful community integrated aged care model. This was noted even for those residents in advanced dementia care, to ensure better behaviour and health and wellbeing outcomes, contrary to the belief that these residents should be segregated in a separate secure environment:

> Dementia shouldn't be 'labelled'. They need to be treated for the people that they are before they had the diagnosis. So, we have the same programs, same outings as we do for the other residents as we do for our dementia care residents - art galleries, same visiting Rabbis, children's Shabbat programs - and just treat them the same. You see their faces light up when they have that interaction, and sometimes it improves their communication at the time it's happening, they might not remember it 10 minutes later, but at that point in time, they enjoy it, and express that joy (MF,M1,JG).

Dementia was also described as being as diverse as the ageing process, making the nature of integration highly individual:

> There are different types of dementia and other cognitive decline, and each person's ability to communicate and integrate into society is different (MF,C2,SA).

At the same time, it was noted that although older people with dementia and higher cognitive decline should be integrated into society, they also needed appropriate care often provided in a professional environment with trained care workers:

> The community sees the need to have more residential aged care facilities particularly with dementia, as there are more and more older people who fall into this category, and more and more families are being affected (GH,C1,CR).

It was overwhelmingly noted therefore that community integration was vitally important in the provision of higher care needs, reflected in better health and wellbeing outcomes. The challenges were seen to be the highly individualised nature of care, which was regarded as a better model of care when residents were not segregated according to care needs but integrated with the various levels of care within the resident community.

Education

The theme of education was not included in any of the closed questions in the questionnaire but did emerge as a dominant theme in the open-ended interviews with the stakeholders, particularly with regards to the community integration of dementia care residents. A key to reconciling community integration with higher needs care residents, according to the Group Homes Australia CEO, is the education of local communities. She had been instrumental in initiating community education programs involving the local shopping village with regards to the needs of those suffering from dementia, which has greatly facilitated the integration of their residents within the local community:

> Education for the community is important. One initiative that we're already doing is to create a dementia friendly shopping village, and training store owners on how to deal with customers/people with dementia, and that's a program we're taking on board. Because on the one hand you want people to be included in the shopping village, but there will be behaviours of concern that might come out in a shopping village context, so we have to create an environment that embraces them as opposed to being hostile. And we're looking at a project with coffee shops to encourage people who are not in Group Homes to come out once a month, so that they can be integrated as well. So, that is all about recognising what are the points of connections and different portals of connection, as different people in different points in their journey will want to connect in different ways (GH,P1,TK).

Educating the community was seen as important particularly in light of the increasing numbers of residents with higher care needs. It has become a community issue rather than a condition suffered by a few, having a significant social impact on society in general:

> I think dementia and palliative care is common now. So, it's a good thing to integrate residential aged care with the community because it's more and more a community issue affecting a lot of people. So, if everyone accepted advancing into higher needs as a part of life, through being integrated into the community, it will be much easier. That acceptance is important because it makes people aware (DA,C2,BI).

As the care manager of Group Homes Australia mentioned, the process of educating the local community served a dual purpose. It informed the general community about the ever-increasing numbers of people suffering from dementia, as well as facilitating those suffering from such diseases to function in society with some sense of normalcy and with reduced safety and security concerns:

> The major thing is that people in the community recognise that these people are not to be hidden away, that dementia is a part of society, and these people can function as part of society. If they were to be hidden away, the community wouldn't know that, and not recognise that it's a natural part of life, and that education is important for everyone in society as our population is ageing more and more. So, it works both ways with the members of the community being able to feel that they can be of help to these people and assist in the integration process, as well as the residents feeling that they are in an inclusive society, which has an impact on their health and wellbeing and quality of life (GH,M1,JO).

A care worker at Group Homes pointed out that it made it all the more relevant for local communities to be educated when incorporating a growing number of older individuals into their own local communities without segregation:

> Society should be informed more, as in educated on the nature of diseases such as dementia and provided basic information, so they have a better understanding of people with dementia, which aid[s] in the integration process. The older person preferably should continue to live in a facility in the same community as they've always lived, as then there is a familiarity and sense of continuity for the resident (GH,C2,FA).

This was a corresponding view from the provider of Elanora, which is a much larger facility:

> There is an overarching need for the community to be educated on aged care. Because it's about advanced care planning, with dementia growing rapidly, and there are a lot of myths about dementia, and this needs to be rectified. It's very important for people with dementia to be engaged in the community, and the community doesn't marginalise them. It's about seeing the person behind the disease (EL,C2,LI).

The education of professional care workers in the facility was also mentioned as an important component of the integration of higher needs care individuals into the community. This was noted as an important element in developing the specialised caring skills that are needed in managing psychological and behavioural issues arising from such illnesses:

> I think it's [integration] through different models of care. Rather than locking away people with dementia, you prolong their stay outside in normal society for longer with extra provision of respite care, so that the drivers to accommodate them in dementia specific accommodation are delayed. It may be education of carers. It might be through more

> dementia day care. It may be that when people are admitted for dementia care, they're not locked away, but given a more involving profile and environment. But that requires a level of management as they can have behavioural issues and they can get quite confronting or upset easily, and for people who are not familiar with dementia it is confronting. So that [the] level of community integration will need education and possibly a higher level of support. That may have funding implications and I'm not sure anyone fully understands the implications at the moment (EL,P1,CL).

This was a view endorsed by a care worker at the dementia specialty Group Homes:

> They need to be integrated however advanced they are in mental or cognitive decline, but they have to be accompanied by care workers who are very well trained so there is adequate supervision and care worker training and education for residents' safety (GH,C3,MA).

Other facilitators of the community integration of residents with higher care needs, particularly those suffering from Dementia include use of technology. The General Manager of Elanora foresaw the development of electronic aids which could assist in keeping people safe in the community while allowing them a certain degree of freedom of movement:

> People perceive a utilisation pattern which is based on current acceptable care. We're undertaking programs with the shopping centre to make it age friendly. Age friendly is supporting people with cognitive loss. I think over time, people may have things like a wristwatch where people can be monitored. Most older people even with dementia are quite ok to be part of the community as long as the community are aware of them (EL,M1,WD).

In the context of increasingly higher numbers of people with Alzheimer's and other dementia related illnesses, these findings were vital in ascertaining the relevance of community integration in residential aged care.

7.6 Conclusion

The impact of a community integrated approach on the operational environment of each facility was identified in many areas, with the benefits largely outweighing the challenges. The primary challenge was the possible increase in cost to the facility resulting from increased social connectivity and integration. However, this was seen by many as balanced by good management outcomes. Benefits included the increase in positive profile of the home, and most significantly, positive impact on the health and wellbeing of residents

In summary, the management model was regarded as a key feature of a supportive operational environment which impacted on the viability and extent of community integration initiatives. Of particular note were the policy and economic implications. Government policy determined the cohort profile of an increasingly frail demographic entering residential aged care. This in turn impacted the institutional policy in determining the effectiveness and nature of community integrated aged care provision. In fact, the most significant factor impacting on a community

integrated model in the current climate was seen as the higher cost of care including specialised staff, equipment and other associated costs to serve the higher needs population of residents. The shift in resident profile was seen to be driven by the policy of encouraging older people to age in their own homes even though they may not be able to receive the care levels required. For providers who offer a continuum of care, it was noted that there were not enough community care packages to adequately meet demand. In addition, stakeholders noted that due to the funding instrument requiring higher payments for higher care needs and inadequate funding for lower care needs, it was increasingly challenging to accommodate residents who needed residential aged care but were not qualified for care provision. This demonstrated that in order to deliver a care model based on salutogenic principles, does not comprise only the physical design and locational aspects, but also the social environment which must be facilitated through a supportive operational environment.

The primary economic force currently shaping aged care provision was regarded as the marked move towards a user pays model. This was described by the stakeholders as resulting from insufficient government funding to support the necessary care levels required for the emerging numbers of older people with cognitive decline. Overall, however, in an environment of older individuals with higher care needs, residential aged care was considered by the interviewed providers and management of the case study facilities, to be more economical than the provision of adequate high-care needs to older people in their own homes or through private care workers.

The providers noted that the management model needed to balance elements, such as the increased management of security, noise and disruption as well as disturbance in care routines, if these elements were not successfully built into the care model. On the other hand, interaction, activity and engagement were noted to be positive aspects of life, leading to resident wellbeing. The stakeholders were of the view that planned activities which took place internally were more important than interaction that took place in the local community. A good reputation for the facility was further described as a positive aspect resulting from a successful community integrated care model and was seen to influence resident/family choice of facility. From the stakeholder's point of view, in an increasingly consumer driven market, the factors influencing resident choice were tied to the care model and the quality of care. In the context of residential aged care, it is often a family member who is responsible for choosing the facility due to frailty of the resident and incapability of making their own decision. It was noted by the stakeholders that in such instances proximity to family was a deciding factor. Other locational aspects such as proximity to retail, public amenities and familiarity with the area were seen as less important to the choice of facility.

The stakeholders were of the opinion that where a management model provided for a positive resident experience, cost and affordability were not significant factors. In other words, the stakeholders were of the view that residents (or their families) would choose a facility that demonstrated a desirable management model incorporating community integration principles, despite the cost implications.

In terms of implementing community integration initiatives, the stakeholders prioritised elements that promoted greater integration within the facility, rather than those elements connecting to accessing the external community directly. Facilitating external community access to the facility was seen as challenging under current regulatory controls, and could impact negatively on safety, security, noise and disruption of care if not managed well.

The incorporation of dementia care was described by stakeholders as an inevitable feature of the current climate in residential aged care, with increasing numbers of residents requiring higher needs care and suffering from a dementia related illness. Therefore, dementia care was emphasised as having an increased impact on the nature of the operational environment of community integrated aged care. Incorporation rather than segregation of dementia residents with the community both internal and external to the facility was noted as a feature of the community integrated management and care model that delivered better health and wellbeing outcomes for its residents. In this respect, incorporating educational programs both for residents as well as the local community concerning the needs of dementia care residents into the management model, was noted as a significant facilitator of community integration. Internal resident education was seen to be important in fostering better relationships between residents. Staff education was also seen as important, as was education of the local community, all helping to facilitate better relationships with the community for successful community integration.

Chapter 7 confirmed an alignment between stakeholders views on the social environment of community integrated residential aged care and the salutogenic aim of providing a sense of coherence for residents by optimising their comprehensibility, manageability and meaningfulness in their later lives when requiring institutional care. This chapter has explored how these social ideals are reflected in practice in the operational environment of community integrated aged care and the challenges of increasing levels of high and dementia care among residents and the financing and regulatory environment. It has found a strong agreement amongst the stakeholders on the institutional policies and implementation methods required in the operational environment, and has demonstrated interrelationship between the social, operational and built environments. These relationships will be further explored in the

Discussion chapter in relation to the literature review and the salutogenic theoretical framework used in this study. The following Chapter 8 completes the tripartite stakeholder findings by analysing their views on the built environment of community integrated residential aged care.

Chapter 8: Stakeholder perspectives: Built environment

8.1 Introduction

This chapter discusses stakeholders' views on the role of the *built environment* in the community integration of residential aged care. It looks at the physical characteristics of the facility and its surrounds, as well as more qualitative aspects such as what constitutes a desirable atmosphere to support community integration. The impact of local government planning controls is also discussed broadly in terms of the limitations and opportunities that contribute to integrating aged care homes into the community.

As was noted in Chapter 6 (Figure 6.2), that the locational and design aspects of the care facilities, while significant, were nevertheless perceived as being of second order importance in supporting a community integrated social environment. Similarly, in Chapter 7, an implication could be drawn that it was the internal operational aspects of the facility rather than those relating to external connectivity that were seen to be more in supporting community integration. Nevertheless, as the following reveals, stakeholders did consider locational and design factors as having a significant influence in the successful implementation of community integration for their facilities.

In fact, a wide range of built environment factors was considered to be of importance in delivering positive outcomes in community integration by stakeholders interviewed for the research. They did, however, generally emphasised the internal elements of the facility, rather than the external and wider locational aspects. Table 8.1 summarises the four aspects of the built environment that were seen to be most important in facilitating community integration.

Table 8.1 Aspects of the built environment that were seen to facilitate community integration.

Stakeholder perspectives: The Built environment	
Drivers	**Impact**
Familiar atmosphere of home	• Creating an atmosphere of familiarity, rather than replicating the look of the residents own home • Signals of domesticity: inviting spaces, clean, comfortable

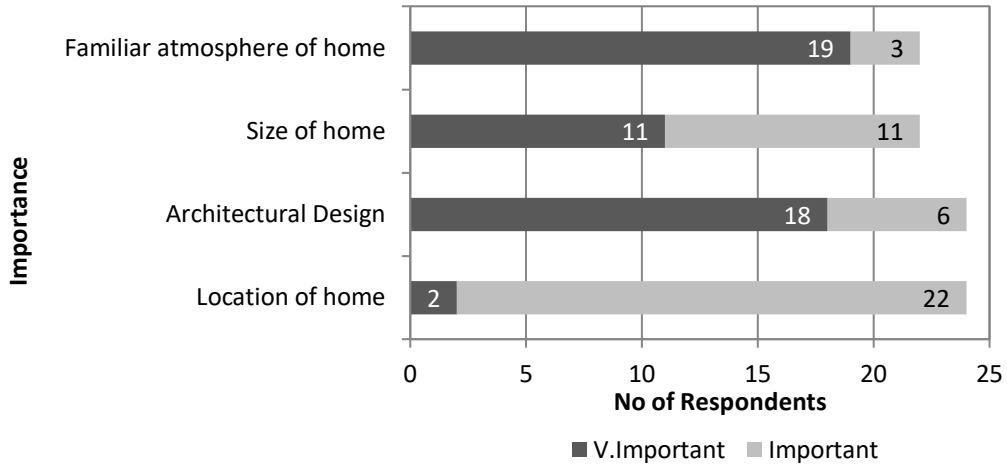
Size of home	• Non-institutional. i.e. smaller size is more conducive to non-institutional rather than larger size • Scale to suit the local neighborhood existing density and form of building
Architectural design	• Building form to blend in with the form of housing in that given location • Non-institutional appearance • Accessible design principles • Aesthetics and character • Natural light and ventilation • Spaces for planned meeting and mingling. i.e. activity spaces, gathering spaces • Spaces for unplanned meeting and mingling. i.e. stairs, corridors, lift, waiting or transit areas • Visual access to the outside world and activity. i.e. windows to the street from bedrooms, glazing connecting community spaces and outdoors • Local community acceptance • Co-location of services. i.e. coffee shop/ retail/ kindergarten or community facilities within the facility
Location	• Accessibility to public transport • Proximity to services • Public and private interface • Local government planning controls

8.2 Planning and design

Architecture and planning were noted by stakeholders to play a significant role in facilitating community integration. Key aspects among these were seen to be the location, variety of spaces, spatial differentiation, building form, aesthetics and character, co-location of amenities, accessibility, security, public-private interface, and the vision of the provider regarding the built environment and community integration.

Figure 8.1 shows stakeholders views of the importance of the four broad themes of planning and design of the facility that contributed to community integration. The below Figure 8.1 analyses the stakeholder answers to Question 10: In terms of community integration, how important is….(followed by the four main themes).

Figure 8.1 Main themes in planning and design



The 'familiar atmosphere of the home' was shown to be a key component in the architecture of the building. Subject to the amendment in terminology discussed in Chapter 5, nineteen out of twenty-four respondents stated this as very important. All interviewees noted architectural design as a significant contributor to community integration, with eighteen out of twenty-four regarding the architectural design of the home as very important, with the remaining six noting it as important. Opinion was divided as to the importance of the size and scale of the home, with eleven of twenty-four participants noting this as very important, and eleven noting it simply as important. This may be due to the large variation in size in the cases. In other words, the stakeholder could have a bias in justifying the size and scale of their own facilities. Location also noted as one of the four important elements of community integration with twenty-two of twenty-four participants viewing 'location' as important, but perhaps surprisingly given the discussion on connectivity with the local community as having a key role in community integration models (see Chapter 4), only two regarded this as very important.

Qualitative responses indicated that architectural design was seen to include elements such as, building form and size in relation to the urban context, specific design elements such as familiarity, spatial organisation, variety of spaces, and aesthetic character of the facility. Enabling access to outdoor spaces, and the quality of the public and private interface including the provision of security, was also noted as an important factor in community integration. These responses suggest that stakeholders viewed the facility itself (its internal design and environment) rather than its connectivity with the broader locational context as largely defining

community integration in their eyes. These, and other related issues, are discussed in more detail in the following sections.

8.2.1 Familiar atmosphere of home

There was general agreement amongst stakeholders that the use of the term 'home-like' was not appropriate for describing the atmosphere of the facility. Rather the terms 'familiar' and 'normalcy 'were preferred. Familiarity and normalcy were seen more in alignment with elements and signals in the atmosphere of the facility that expressed 'domesticity':

> It's more the familiar atmosphere of the home, rather than home-like, because everyone's home is different. So, it's about creating an atmosphere of familiarity, rather than replicating the look of anyone's home (DA,C3,DO).
>
> The 'familiarity' is very important. The term 'home like' is very condescending. The atmosphere is very important and familiarity is an important aspect of atmosphere (EL,D1,JF).
>
> Knowing the signals that refer to domesticity is important, not 'home-like' per se. It's the sense of what makes a home a home (DA,D1,DJ).
>
> Home is an atmosphere where you feel invited. But it is not necessary to recreate the clutter of your own home, they can be beautiful spaces that are inviting in a large place like this, and not a replica of the clutter of your own home (EL,M1,WD).

Favourable characteristics included emphasis on natural light and cross ventilation, views out to gardens and greenery, as well as a non-institutional architectural aesthetic. The specific elements of the building form are further discussed in detail in the following section, as well as being illustrated in the case study chapter.

8.2.2 Building form: Size and architecture

According to the views expressed by the stakeholders, the form of the facility had an impact on community integration since a building that was similar it its appearance to other surrounding fostered acceptance by the community. For example, one of the architects interviewed noted that architecture of the building was important in blending in with the built form of the neighbourhood:

> From the street, there is no differentiation that it's an aged care facility. It must blend in with the place, not type cast as high care, an institution or self-care and so on. Not to look like an institution is important. Urban planning can positively impact even on the internal environment. For instance, details like butt-joined glazing windows which from the inside give residents a feel of an expansion of space, and from the outside, it does not look like an institution. As an architect, you must believe that architecture is there to support people's lives, to live a life of vitality and enjoyment. It's not just about meeting all the regulations and accessibility codes, but also make sure that it doesn't become all-consuming and keep in mind that it is still somebody's home (DA,D1,DJ).

As the CEO of Montefiore explained, the architecture of the building was of primary importance as the building was to accommodate the large Jewish population primarily residing locally in the eastern suburbs of Sydney. She expressed that being a community-based facility, it was of utmost importance that the architecture did not appear to be institutional. Therefore, both the exterior and interior of the building was handled with great care, in close consultation with the architect:

> It [architecture and planning] impacts enormously in a number of areas. Biggest challenge was they knew they had to build a very large building in order to care for the whole Jewish community as there were no specific older peoples' home in the community at the time. So, it needed to absorb a large number of people. Therefore, we worked very closely with the architect to design the building in an aesthetically sensitive manner so as not to resemble a sterile institution-like environment. Interior design was used to make the interiors look like intimate spaces, and visually break down the monotony of large spaces to make them feel familiar and intimate. For instance, using neighbourhood models, such as in the design of signage and visual indicators, and small spaces (MF,P1,RO).

The founder of Group Homes Australia noted the need for a suburban renovation approach using existing housing stock to serve as an aged care facility incorporating universal design principles, rather than building a new facility. She saw this as a fundamental reality in view of the unavailability of land in residential areas for community integrated models specifically for aged care. She also suggested that the economic sustainability of a renovation model as opposed to the creation of a new complex, was also of benefit:

> It [architecture] plays a massive role. Architectural design is important because of sustainability and universal design, so as the person ages, you want the person to age in place and the environment has to be able to afford that, that's from architectural design component. And it's a complex process because each person ages differently so it has to enable everyone to live comfortably. From an urban planning perspective, we don't have a lot of property in Sydney, and we have a massive ageing demographic where if you're looking at 3000-5000 square metres of land, it takes five to six years to build an aged care facility, whilst the Group Homes model, takes an existing house or land of an existing house and you are able to build a Group Home of medium density. For the renovation model, we're talking about three months, instead of five to seven years for an aged care facility (GH,P1,TK).

The representation of familiarity and normalcy in the architecture of the home was noted by a care worker at Group Homes as being similar in appearance to the other dwellings in the local neighbourhood, rather than resembling an institution:

> The feeling of familiarity and normalcy is important. So, the Group Homes model is ideal, because it is a real functioning home, which looks like a home, inside as well as from the street. It's important that it's not made to look like an institution (GH,C2,FA).

The Architect of Elanora noted that the architecture of the facility was crucial to the degree of acceptance into the community. He also noted the increasing difficulty in meeting this criterion

as facilities were becoming larger due to the increasing demand of older individuals requiring residential aged care:

> Acceptance of the facility by the people outside these premises in the local community is most important. The building must be accepted by the community, it can't stand out to be a big hospital, as the community won't accept it, and that one is becoming really hard to solve (EL,D1,JF).

It was agreed across all four case studies that the built form was crucial to community integration in terms of community acceptance as well as providing a sense of familiarity to the residents. In all four case studies, this was achieved through the built form being compatible with surrounding development, be it in a low-density suburban neighbourhood, a high-density inner-city neighbourhood or a medium density residential neighbourhood. In the case of Elanora, however, acknowledging the existing built environment took the form of the front façade reflecting the scale of the adjacent shopping centre and village development, and the rear façade resembling that of the residential neighbourhood behind in scale and character.

In the view of stakeholders, the built form should not resemble an institution; so even large-scale institutions could be integrated into the surroundings through sensitive architecture and breaking up the external building form and internal spaces. The founder of Group Homes argued that the use of existing the housing stock employing the renovation model helped to achieve this outcome.

8.2.3 Location

Of the four aspects of community integration in Figure 8.1, location was seen to be a significant deciding factor in the built environment element supporting community integration, with an equal highest score, when both 'important' and 'most important' categories were combined. In addition, in responding to the open-ended part of the question, stakeholders actually had much to say about this factor. For example, as the General Manager of Dougherty who pointed, "we're old, but people want to come here because of our location, we're not out in the suburbs or something" (DA, P1, LB). This included proximity to transport as well as access to recreational spaces and retail amenities. Resident engagement in meaningful social activity such as going out to the park or enjoying the simple pleasures of life such as sitting on a bench and having an ice cream, were described as enablers of community integration. In this respect, visual access to neighbourhood activity was also seen to be a positive factor:

> …You need transport, you need appropriate care while they are out, you need to look closely at where they're going; for instance, we employed a person to organise where they were going and we would take them out to nice restaurants and different places, but we found out that what they liked most was just going to the park and having a sandwich because over here they get served lunch every day, so going to a restaurant and getting

> lunch served is not a big deal, while sitting in a park and having a sandwich is a big deal. (DA,M1,JG).

Reiterating the importance of location, the General Manager further stated:

> One of the things that they enjoy most is going up to the Chatswood shops, sitting on a bench and having an ice cream. They'll run down there to do it, because they can sit and watch people walk by, they can just sit and feel that they are a part of it all, and no one is watching them, and they are no different to any other person sitting there and having an ice cream. So they love it. And that's probably the most simple excursion that we do, and yet, the most popular (DA,M1,JG).

Location within a regular suburban residential neighbourhood, with good access to local shops, amenities and services as well as recreational areas, was thought of as generally supporting community integration. The characteristics of the street, in particular, being part of a quiet residential neighbourhood with family activities taking place, were thought to help make the residents feel part of the local community:

> Location is very important in terms of being close to shops and local amenities, which serves the dual purpose of getting their exercise as well as for them to feel a part of society and feel that they have choice and independence within their capabilities. The other important thing in location is a quiet street, where there is a park close by and a residential neighbourhood where you can go for walks and have people around, like school kids and people walking dogs, so that they can feel a part of the community (GH,M1,JO).

Similarly, safe and pleasant open spaces and parks in the neighbourhood were also noted as important aspects of the location facilitating community integration:

> Location is very important. To be integrated into community, it must be located within the local community, close to shops and neighbourhood residential areas. If a local community, for instance St. Ives, has a large proportion of older people, there should be a home in that community to accommodate the needs of the older population. It must be close to transport. It must be a safe and pleasant area for residents to be able to access shops easily, parks easily, and go for walks (GH,C1,CR).

The significance of location was also a key factor in planning community integrated aged care facilities, particularly with regards to facilitating meaningful activity both for the residents accessing the community and the broader community providing services to the facility or visiting it:

> The number one is location. It's [community integration] a two-way operation, one that residents can go outside either with their families or staff, possibly by themselves to pursue meaningful activity in the broader community. It might be going down to the shops, café or park. The second is designing the capacity in your residential aged care to safely bring in the broader community. This might be special interest groups, it might be small groups, or exhibitions, functions, groups of school children or volunteers. So, it's not a token entertainment aspect, but a more meaningful integration where people can feel

> that they have something to contribute as well as the broader community feeling that they have something to contribute as well (EL,P1,CL).

The Care Manager of Dougherty indicated that location had been the primary influence and facilitator of their community integrated care model. Even though, overall location was not considered a deciding factor that significantly influenced community integration, it was an element that was given high value by those who did think it was a primary consideration for community integration. Here, location was seen to work both ways for residents to access the dynamic city centre at its doorstep, as well as family, friends and other visitors to the facility having ease of access via public transport and good connectivity to major arterial roads and a walkable neighbourhood:

> The location and position of Dougherty is vital in this - because it is therefore able to keep the residents as part of the community, as they are sitting literally in the middle of one of Sydney's most vital city centres , they are only a block away from most services, so they can go to the optometrist, hearing aids - you know, without it causing any organisation stress for us because of its proximity, and they can be taken out for an ice cream without a great big fuss. But I know that a lot of aged care has been designed to sit out of the general cityscape, and when I've worked in those places, they can be beautiful, they can be luxurious, but the residents don't have visitors very often because it's too hard to get to and they get very isolated. Sitting in the middle of this as we're located, even residents with dementia are able to walk up the road and have a coffee - and they don't get lost. We are very careful, and we watch them, but also give them that freedom because they can often manage it very well, and it makes a huge difference to them, and allows them to be a part of the community. It's very important (DA,M1,JG).

Location was also the key to older residents having a sense of orientation, since all amenities were close by, and the risk of getting lost was minimal:

> Firstly, it's great that it's near the train station just five minutes away, relatives and friends can visit easily, even after work - they don't need to worry about making a separate trip, parking or anything like that. Second most important thing is the shopping mall [is] just five minutes away. The church is next to the building. The park and oval is just next to the building. So, this is the ideal place for social interaction, you can go for a walk, have a coffee or take the train if you can, and still be safe and close to where you live (DA,C2,BI).

Familiarity of the neighbourhood for residents was also noted as an important aspect of location of the facility:

> It's important that the location of the home, and neighbourhood is familiar, because they are used to it and not feel like they're in a strange place and they can get about easily (MF,C2,SA).

> The Jewish day school is in Maroubra, Emanuel School up the road, and Mariah College, and the synagogues are all around here, the university is around here, the hospital is around here, their hospital which they have familiarity with is St. Vincent's, or Prince of Wales. So, location-wise they love it (MF,M2,ML).

Proximity to family and the cultural community was also noted at Montefiore:

> This location is very important to the Jewish community. This facility was purpose built because of the location of the Eastern suburbs, living in the Eastern Suburbs. We also have a facility in Hunters Hill, and when this was built, a lot of the families moved their loved ones from Hunters Hill to Randwick because it was closer to where they lived and they didn't have to travel far to visit (MF,C3,CR).

A tranquil environment was another aspect noted as desirable in the location of the Group Homes facility:

> It's important that the location is quiet and peaceful, as noise agitates residents (GH,C2,FA).

On the other hand, there are benefits of the exposure a facility gets by virtue of its location at the heart of a busy city centre, which brought in a variety of visitors to the facility as expressed by a care worker at Dougherty:

> …visitors to the nearby conference centre drop into Dougherty. Recently a group of Japanese visitors from overseas came and took pictures because they thought it was a great facility and wanted to take the ideas back to Japan (DA,C3,DO).

Location therefore facilitated community integration in several ways, including proximity to services and transport, quality of the neighbourhood supportive of the lifestyle of residents including safe and pleasant open spaces and parks, the presence of amenities and convenient access to retail shops, familiarity of the location, and closeness to family.

It is clear from the stakeholders' responses that there is an important relationship between community integration policy, its care model and the location and physical design of a facility. This raises questions as to the role of local government planning controls in facilitating appropriate location and design for community integration, This is discussed in the following section.

8.2.4 Local government planning controls

From the point of view of the built environment, local planning controls were also seen to affect the nature of community integration. The architect of Elanora noted the beneficial impact of zoning which allowed aged care developments to be constructed in residential 2A (detached housing) zones, a significant contributor to *community* integration. The architect noted, however, that the community acceptance of large aged care buildings was a key issue in facilitating a successful integration, as most people preferred a domestic scale building in their residential neighbourhoods:

> …so, you're building these enormous facilities next to single houses. Whilst the planning rules try to ameliorate the obvious problems of that, they can never overcome the public

> attitudes which often translates into the local community protesting against a big institution next to their house. And so, the government needs to get on a campaign - the state government - because it's state government policy, to say to the community that they need these facilities in the community. To say that all you people are over sixty, it's only ten more years until some of you will need to start moving in to one of these. So, don't relegate them to the fringes. Keep them where they are within the community. So, the community attitudes are the main obstacle in preventing aged care being integrated into the community (EL,D1,JF).

Location was also tied to planning policy, which was noted by the CEO of Montefiore as needing to be more flexible with regards to planning controls for aged care facilities, in order to better facilitate community integration:

> Then in terms of integration it was about working with available space and being as innovative as you can be in terms of integrating amenities that would support integrating services. Not every provider can afford dentist, hydrotherapy pool, but a café is achievable for families of residents and friends to mingle, and courtyards and things like that. There needs to be far greater support for aged care developments such as zoning requirements, FSR (Floor Space Ratio) requirements, if you want to put more communal space, it requires more space. There needs to be more recognition from planning bodies and regulations providing operators more flexibility, if there is to be more integration (MF,P1,RO).

It is evident then that local government planning policy can have an important impact on the design of community integrated aged care facilities, both in terms of the architectural representation of the facility and the broader locational relationship within the urban context. Even if encouraging a community integrated care model, planning controls could also have financial impact. If the facility was located within an established community, there were clearly more opportunities for integration with the local community. Since the provision of community integrated services tare enabled by a facility's location, and design, the local government planning framework needs to be sensitive to these aspects.

8.2.5 Co-location of services

Co-location of amenities and services were also seen to play a key role in community integration. In the case of Dougherty, the coffee shop in the adjacent community centre was accessible via a covered walkway from the home. The introduction of a coffee shop in the new refurbishment was expected to increase the level of community integration:

> The coffee shop next door in the community centre, all our residents use it, but we don't run it, and we're trying to integrate those aspects with the new refurbishment (DA,P1,LB).

At the time of the interviews, Dougherty Apartments were undergoing architectural upgrades to enable even greater community integration. This included the location of commonly used services within the facility such as a coffee shop and hairdresser, as well as multi-utility rooms

capable of accommodating group activities and other educational and health related activities which could also be open to the older people in the general community:

> This is a good design for twenty-five years ago, but I've visited some pretty amazing facilities overseas, in the States, that had the full integration, that if I was to re-design this now, I would have the community facilities as part of the services and premises, I'd have the hairdresser, I'd have the library, coffee shop, multi-purpose room where you could show movies, and hold exercise classes where people out in the community could come, and we are lucky that we've got that in the next door community centre, and they are all incorporated in this facility in the refurbishment that Dougherty is currently undergoing - we're putting in a big multi-function room, and we'd be using that for exercise, falls prevention classes, and we'd be inviting the older people in the community to come and take part once that is opened (DA,P1,LB).

The co-location of ancillary facilities that complemented the community integration functions of the home were being taken into consideration for a proposal by Uniting Care for future development of an independent senior living community and retirement village adjacent to the Elanora facility:

> We're building a community centre next to the residential aged care at Elanora, and that would provide other opportunities for interaction. This would serve people who are not at a point or ready to come into res[idential] care, or commit to an independent living unit, to come on site and make connections and meet residents, as well as access healthy ageing initiatives like a gym, or yoga, or Pilates, or educational classes, and residents of res[idential] care could attend the same classes. We haven't started it as yet, but these opportunities will be there (EL,P1,CL).

The co-location of services and amenities incorporated into the design and planning of the facility was evident in three of the four case studies. Among these, the incorporation of a coffee shop in the facility was considered important, as were a hairdressing salon, library, and multi-utility rooms as well as spaces which could operate as function rooms. It is significant that two of the facilities were planning to extend co-location of services further in future.

8.2.6 Internal design and layout

Provision of a variety of spaces within the facility was also noted as a facilitator of community integration permitting different modes of interaction, such as "…common spaces to interact and having different spaces for different activities" (DA,C1,AN). The differentiation of spaces with varying attributes was also noted as important. This was seen to provide privacy and opportunities for mingling with others as the residents wished, facilitating choice and independence:

> …I can give you an example. When I did my placement, it was in [another Sydney aged care facility] – so what they had was downstairs was high-care with two residents each in a room with a curtain dividing the two residents, and it was a huge space where they had everybody. And the lounge room was huge where everyone was, so it was very depressing. But over here, I've been here for ten months, and it's like home, because you

> have different spaces, you have upstairs, downstairs, people can do different things in different spaces, and they don't need to interfere with each other, you don't see what other people are doing for instance when people are sick, they have their privacy - so it's like when you're renting an apartment you have your own space, but you see each other in stairways and lifts and places like that, and here you come together at mealtimes. So, this house is much more appropriate (DA,C2,BI).

The physical location of services within the facility was also noted as important, with utility services being located away from residential areas of the home, being sensitive to creating a pleasant home environment for the residents:

> The other thing I'd look at is how services are provided - how you provide services, and where you put your services - and we're doing some of that as in moving some of the services away from the residential part of it, such as currently our laundry is located up here (DA,P1,LB).

The gradation of spaces from the public to the private was given great emphasis in the architecture of Montefiore to provide both intimate and larger common spaces:

> The common spaces….when transitioning into actual areas where residents lived, they were designed for intimacy (MF,P1,RO).

With Group Homes being an exclusively dementia-oriented care facility, the spatial organisation and design focused on the way residents used space rather than on risk mitigation:

> …there's lots of stigmas and unnecessary perceptions. There are lots of misconceptions about what people with dementia can't do, and we're very risk averse in what people can and can't do in the built environment. So, it's important to focus on ability-based design and the health and safety issues, the infection control, and risk management driven design as opposed to focusing on people and how people use space (GH,P1,TK).

In the spatial articulation of a facility, many characteristics were regarded as supporting community integration objectives. The provision of a variety of spaces with different characteristics for the users was seen to encourage different modes of activity and provide a variety of stimuli. The spatial arrangement was also seen to be important in articulating various degrees of privacy. It allowed the resident a greater degree of choice and independence, easy access to services which facilitated mobility and integration with the local community, as well as spaces which allowed large group activities ranging to more intimate or solitary activities.

8.2.7 Aesthetics and character

At Montefiore, the first impression created by the facility was seen to be crucial in attracting potential residents and their families, as well as visiting family and friends. There was a notable emphasis on creating an active vibrant atmosphere:

> The coffee shop is integral. They [visitors] see the coffee shop and people make an instant judgement by what they see in the coffee shop as it's the hub of Monte. So, if there isn't good food at the café people think, that we're not giving good food to their mother. If the

> residents gathered at the coffee shop are not well dressed and presented, they think that we're not taking care dressing their mother properly. If there's a bib around a resident's neck, they think that the residents are not being treated with dignity. So, the coffee shop is very much a focus and it is our showcase here at Monte (MF,M2,ML).

The aesthetics demonstrated by the architecture and character of the building blending within the largely residential neighbourhood of three-storey apartments, medium density residential buildings and narrow streets was taken into consideration in the architectural design of Montefiore. When asked about the impact of the interior design, the care manager of Montefiore stated:

> Huge. Today all the research is around the environment. And the environment needs to look much like the persons home instead of an institution. Specific design features of Monte such as from the street it does not look like a big institutionalised aged care facility, from the outside it looks much like the surrounding apartment blocks around the area, and from the street level it is not more than two storeys high. And inside, there are very careful design features like carpeting instead of vinyl, memory boxes in corridors, and amazing art work on the walls, people often say that it looks like a five-star hotel, but more than that we describe it as being warm, having warm colours, welcoming, soft and warm, lot of woodwork to soften things up so it doesn't look like an institution (MF,M1,JG).

Another manager at Montefiore noted:

> Extensive! Originally, I was the admissions manager at its onset, so I can tell you from experience that architecture and design play a vital role. For example, the width of the corridors, the neighbourhood model, the fact that you don't have a hospital feel, so people don't feel institutionalised although they are in an institution, the memory boxes, the recessing of the doors, the handrails being available but not hospital like, the dining rooms (MF,M2,ML).

The importance of designing for ease of wayfinding for a community with specific disability levels such as dementia was also deemed to be necessary:

> Over here, it is purpose built [for cognitive decline and other disabilities]. All corridors lead to a common area, so for someone who is confused, it's an easy place to get around. We also have a neighbourhood theme, with colour and theme signage for ease of use and recognition. Each neighbourhood having a different colour and theme (MF,C1,AN).

Blending in with the architecture of the neighbourhood in scale and form of buildings was also noted as important in the suburban location of Group Homes:

> Architecturally, it should be similar to other homes around the neighbourhood, so that it is not stigmatised. It should be close to parks and transport, and beautifully landscaped to make outdoor spaces usable (GH,C1,CR).

The importance of natural light in a home, as well as access to direct sunlight in the design was noted by the architect of Elanora:

> Because of the constraints of the site and the way the site falls [at Elanora], we had to get a lot of light into the building with innovative solutions, and wanting to ensure that the residents had access to sunshine, climate, movement and so on. And we found that access to sunshine is therapeutic to people with dementia. And dementia or otherwise, every facility we have done, where the light and the sun is where the residents move to, and they do that for a reason. So rather than build buildings with solid walls with holes in them, we build buildings with sheets of glass and maximum light and direct sunlight and direct access to the environment…so, although we don't have any empirical evidence, in almost all facilities we have done, we have watched the residents all almost immediately gravitate towards where the sunlight is (EL,D1,JF).

The architectural design of Group Homes revolved around providing a visual and tactile experience of not being institutionalised for the resident, but like being in a regular suburban home:

> The Group Homes concept architecturally blends into the street, it's run like a home, so no visiting hours, smells like a home, looks like a home- it's a very simple concept, as if it looks like a home, functions like a home, smells like a home, then it IS a home! We don't try to do anything that is "home-like". There are three meals a day, go through normal house routines, if there's laundry that needs to be folded, it gets folded by the residents. These are all things that when their grandchildren come to visit, they are coming into their grandmother's home, not a facility or an institution where they have to go to the reception and all that. They just come and visit, make themselves a cup of hot chocolate or juice, we have special cutlery for grandchildren and they know where its kept and the cupboard with the toys are, and so on (GH,P1,TK).

The architect for Montefiore noted the fundamental importance of architecture in the design of the facility as a "living organism" that needed to be sensitive and provide for the needs of an increasingly frail older population. In this, he saw 'familiarity' as a key design requirement in designing for the residents of an aged care home:

> Whilst these buildings are a living organism, and they have to fit into the context in a conscious way. Only skilful architecture can make it happen. 'Home-like' is not possible any more…the crucial aspect is make the architecture 'familiar'. For example, Monte has three hundred rooms! No one lives in a hundred-room home. No one has an ensuite in every home. The whole notion of home-like was when aged care was still a suburban concept, but it's not possible now in the numbers that we're talking about (MF,D1,JF).

Architecture and planning were further highlighted by staff, as elements which were seen to impact on job satisfaction and therefore a reason to work in the facility:

> The architecture of the facility is what retains me here. I like working in a modern beautiful building (MF,M2,ML).

> The architectural design of this home contributes to the amenity. If architectural design has a focus on the amenity of a space, then the trends in what is fashionable may change, but that sense of amenity and functionality doesn't change. So, it's the relationship of rooms with living areas facing northern aspect, circulation of air, containment of noise. Work environment is important - the standard of architecture and its nature creates a sense of pride in place which results in pride in person which is an important aspect (EL,M1,WD).

In summary, stakeholder respondents were in general agreement that a non-institutional aesthetic of both the exterior and interior of the home was an important community integration facilitator. Several stressed their view that this was best achieved through being sympathetic to the surrounding architecture, blending in as much as possible. The use of colour that reflected a warm and inviting atmosphere both in the exterior as well as interior were other techniques cited by stakeholders as being of great importance in expressing a non-institutional feel. Penetration of natural light into the building as well as views out to the natural world and greenery were described by respondents as aiding in creating an ambiance that was conducive to community integration. Visual cues and way-finding mechanisms were another aspect noted to support residents' mobility and independence by providing a safe and comfortable environment where the resident could interact safely and without being confused.

8.2.8 Variety of spaces and spaces for interaction

Being a large facility, for Montefiore, the creation of its own community, was also facilitated by the variety of spaces available for interaction:

> It's important to have different types of spaces to do different things, both indoors and outdoors. That is, gardens, patio, activities and rooms and spaces on different floors so they are not in the same area. (MF,C2,SA)

> Having the café. Courtyards. Regular prayer services open to family as well, so spaces to provide for that. (MF,C3,CR).

Differentiation of spaces with different spatial qualities catering to specific needs was also noted as an important architectural and planning feature in Group Homes:

> It's important to have different spaces which provide the opportunity for different activities, indoors and outdoors. In a typical nursing home, there would be one big hall to play bingo, or one big dining hall, which is not desirable. It's important for residents to have a choice in the way and nature they wish to interact or not interact with other people, and a choice in the way they like to spend their time within the built environment enabling different activities, be by themselves or other people according to what they feel like, indoors and outdoors (GH,M1,JO).

The General Manager of Elanora noted the importance of breaking down spaces to form smaller units functioning as separate 'households' as an emerging design characteristic supported by the aged care providers to facilitate community integration:

> They're [aged care providers] increasingly going into a household model. Before, it was based much more on the leisure life, where there was the perception that you'd worked hard all your life, now you can retire and enjoy life. What they clearly misunderstood was that routine and being involved and in control of their environment is incredibly important in maintaining people's independence. So, they generally now have moved to a household model, generally not having to go over 20 residents, and that's a financial model issue. You could do a 12-household model, and you could do that according to the industry [pay] awards that you get, but it's quite difficult in Australia. The household

> model has a more domestic set up where people are assigned with household chores and involvement and interdependence with each other that causes that familial feel of a household. Even in a normal household each child and member of the household has different personalities, but that interdependence binds them together. In the physical design of this model, maybe it can look like a real house with service corridors behind the functional spaces (EL,M1,WD).

The specific internal planning and design of the facility was also noted as being important in reflecting changing models of care, and facilitating the implementation of those ideals:

> It then concerns the internal design, as we're moving away from the old hospital model to a more individual household living model. That might give people a sense of belonging rather than just being one of many, and giving a distinct sense of belonging (EL,P1,CL).

The General Manager of Elanora further commented on the interconnected nature of service provision, and the role of design and planning in being sensitive not only to the needs of the resident, but also staff and visiting family:

> As we get people with increasing cognitive loss and palliative care, it's important to have breakout spaces for families who come to visit and who may need to stay over for a couple of days. So, we have one of the dining areas which is a bit sterile, which I'm going to create a breakout space with a private living area with toys for children, a TV and so forth, and an attached bedroom. So, for visiting family to have a small space which is their little space…we function here as a household model, but it looks like a hotel model. Although it was built as a hotel model, it functions as a household model. (EL,M1,WD).

The Care Manager of Dougherty noted that even in a managed higher needs care environment, when opportunities to access outdoor spaces were limited, there was a noticeable level of adverse behaviour among residents. Therefore, access to outdoor space and activity was seen as a positive aspect supporting community integration directly impacting on the residents' health and wellbeing. Accessible outdoor spaces within the facility were regarded therefore as an important feature in the design and planning of the aged care home. This was also being taken into consideration in the current renovations of Dougherty:

> When the building work just started for the renovations, a lot of the outdoor spaces were closed off, and till we got a rhythm of taking the residents out, there was a noticeable aggravated behaviour which was settled once the regular activities, outings and things like that resumed (DA,M1,JG).

The provision of a variety of spaces was therefore seen to facilitate a range of activities reflecting a variety of needs and preferences of the residents. This included both indoor and outdoor spaces, the provision of which were described by stakeholder respondents as contributing to the health and wellbeing of residents.

8.2.9 Public-private interface

The manner in which the public private interface was treated between the home and the surrounding neighbourhood was considered by stakeholders to be a significant facilitator of community integration. In this context, outdoor areas accessible to the general community were noted as supporting community integration:

> The garden is well used, with the establishment of the vegetable patch bringing in the kids. The BBQ area is also popular (EL,C1,AN).

Although the coffee shop within Elanora was not frequented by outsiders, the fact that it was located at the entry of the facility with visual access to the busy shopping centre across the road provided a sense of vibrancy by being visually connected to the outside community:

> Having the coffee shop at the entry which is used a lot. Very much a community gathering place. We have a lovely garden BBQ area which the public can access, and people in the community can have gathering[s] and so on (EL,C2,LI).

The architect of Montefiore reiterated the importance of physical and visual connectivity in considering the architecture of the facility. He stated that connectivity creates a community atmosphere through location of services such as the positioning of a retail hub in a prominent and visible location. However, the co-location of services also required attention to the safety and security aspects of the pre-school which facilitated intergenerational programs:

> In the masterplan one of the key community integration facilitators was the community plaza with retail around it with back to back shops. The shops have access from both sides and security for dementia patients. The Day Centre program which is integrated into the premises, also has visual connection to the main facility. So, when people move in, they are already familiar with the building. The Pre-school and childminding facilities are also visually integrated, being located in the compound. So this can be seen as a cross-platform for intergenerational interaction (MF,D1,JF).

The interface between the facility and community was seen to be important. The new refurbishments of Dougherty Apartments had been aimed at improving this interface through the introduction of common areas linking the two domains with different special and functional characteristics such as walkable spaces, gathering areas and the café:

> The reason for the current refurbishment is to have a library, walking areas and outdoor gathering spaces, and have a café in the premises (DA,C3,DO).

Sensitive design, considering the needs of the users of the facility was seen as important as the internal community integration was afforded by the successful use of space by residents which depended on the quality of the spaces provided. As the General Manager of Elanora commented, partnerships with neighbouring institutions on space use which would be of mutual benefit

were also explored. Here, a physical link to a neighbouring church frequented by residents made this interaction much easier:

> What we're trying to do here is to partner with the Anglican Church in the next compound, and the use the green space between as a social space, with the entry point being the busy shopping plaza over the road (EL,M1,WD).
>
> There were a range of benefits from this simple adaptation: …. we had residents who went to the Anglican Church who had to go all the way around from here to get it, so we created a physical pathway across our properties which connected the two, so it's now in the single campus physically. We had problems with parking, and [the Anglican church] gave us free parking. So it's a better utilisation of space of mutual benefit. (EL,M1,WD).

Community integration brings with it greater connectivity to the neighbourhood, as opposed to building an isolated, gated community. This also applied to the way in which aspects of safety and security were addressed in planning and design:

> Urban planning is how the site and the buildings leading to designing what you are planning. What are the circulation paths, the connection points, how do you build safety into what you are designing, and passive surveillance? So, we may not wish to have a gated community, but at the same time we want to provide a safe community within which people can live (EL,P1,CL).

The provision of security was regarded as an important element of architecture and planning. This articulation of the built form needed to accommodate integration into the community and surrounds and yet provide the degree of safety and security required for an aged care facility. The spatial articulation of the public and private interface was also considered an important factor in facilitating community integration. This was achieved through the location of spaces encouraging community interaction as well as connections to external spaces, both visual and physical.

8.3 Conclusion

As noted in the introduction to this chapter, while the findings of the previous two chapters indicated that stakeholders gave less prominence to design and locational aspects, they nevertheless generated a surprising amount of comment and discussion.

Most strongly emphasised was the need for schemes to support a **familiar atmosphere** within the facility. Rather than replicating the look of the residents own home. It was noted that the term 'home-like' might have negative connotations due to the assumption that it represented a type of home of an older person which typically was full of clutter, dated furniture, or simply looked 'old'. The term 'familiar' however was seen to be more acceptable, as it described the atmosphere of a home which demonstrated the positive signals of domesticity such as an inviting space, clean and comfortable, which were not tied to the particular aesthetic taste of the

resident. This could also demonstrate a management bias towards accommodating the preferences of a particular group of people by providing an architectural palette that could absorb individual preferences while maintaining a unified aesthetic.

The **architectural design** of the facility incorporated elements of all four features identified in the built environment: familiar atmosphere, location, size of facility, as well as location. There were specific aspects however that pertained to purely design characteristics. This included the architecture of the building to blend in with the existing built form of the neighbourhood rather than stand out, which also was seen to address community acceptance, an important facilitator of community integration. The emphasis of architectural design was on a non-institutional appearance. With regards to desirable architectural qualities within the home, natural light and ventilation, as well as visual access to the outside world, while maintaining the privacy of the residents was emphasised.

The internal location of amenities such as coffee shops were found to have facilitated much social activity. The provision of a variety of spaces to suit a variety of activities were noted to be an effective tool in supporting community integration as well as providing for privacy and interaction within those spaces. Variety gave the residents a choice of interaction or non-interaction, but still provide access to communal and recreational spaces. Outdoor spaces were also seen as important with the provision of a variety of useable spaces such as gardens, paved areas, and courtyards.

The provision of a variety of spaces facilitating various types of activity, such as communal gatherings, offering opportunities for a variety of ways to interact or to provide privacy and seclusion was also noted as a key to successful community integration, both with the internal and external communities. Co-location of spaces providing mutual benefit, such as the day care centre at Montefiore, and the covered link from Dougherty to the coffee shop in the adjoining council building, were considered effective ways of initiating community interaction. Usable outdoor spaces such as landscaped gardens, courtyards, and parks were regarded as desirable areas for interaction. Access to direct sunlight creating pleasant, bright, airy and sunny outdoor spaces created an atmosphere favoured by residents, while also being regarded as important for promoting health and wellbeing.

While tied to the architecture of the facility, the development **scheme size** was regarded as important, primarily in determining its appropriateness to the density and form of building in the neighbourhood. It was suggested in discussions that if a scheme could not physically integrate into the community, community acceptance will not be created and therefore integration of residents with the local community would be less successful.

Although **location** was considered important by all interviewees, only 2 out of 24 considered this element to be *very* important. An additional 20 still regarded it as important. The combination of both, representing the equal highest response with architectural design. Indeed, the interviews revealed that accessibility to public transport, proximity to services, and the nature of the public and private interface, were considered the more important elements of location facilitating community integration. Designing for ease of access with covered walkways, well-paved, safe, wheelchair-accessible pathways and other secondary spaces such as parks and accessible outdoor and shaded areas to link access to community destinations were some of the features also said to be desirable elements facilitating community integration. This latter finding may reflect the overriding concern by stakeholders with the internal functioning for their facility, also noted in previous chapters, which may have led them to downplay the locational aspects that support community integration.

As for stakeholders views on the operational and social environments that characterise community integrated residential aged care, the findings of their views on what characterises the built environment aspects, are likewise consistent with salutogenic theory, and its application via Psychologically Supportive Design, which has also focussed largely on articulating the physical environment aspects in hospitals and aged care. The location and design of these facilities are clearly aimed at enhancing comprehensibility, manageability and meaningfulness for their residents and thereby contributing to the salutogenic aim of sense of coherence. This will be discussed in more detail in the Discussion Chapter.

Findings Part 2 - Residents or their family member's perspectives

Part 2 of the Findings turns to the experience of community integration in the four selected residential aged care facilities through the eyes of the residents or their family member interviewed for this study. The three components of the CI-RAC model, namely the social, operational and built environment components, often overlapped in their responses, given that the residents experience was approached from a holistic point of view. Where possible, the chapter nevertheless attempts to marshal the responses into the three component parts where the narratives allow.

These findings are highly significant for this research as they describe the extent to which the lived experience of residents and families confirm or contradict the views of the stakeholders regarding the relevance of community integration in delivering an improved quality of life to an increasingly frail demographic which is entering into residential aged care. As such, the views of the residents and their families might be considered as a form of corrective to assess whether the three components of the CI-RAC model have actually been delivered, or at least perceived to have been delivered, by those who live in these homes.

The chapter starts with an overview of the residents' profiles using data collected from the in-depth interviews which contextualises the broad spectrum of ability levels and impairment brought on by the non-linear ageing process. It then proceeds to document the findings of residents and where necessary, their families, in relation to the three components of the social environment, the operational environment and the built environment. The chapter concludes with a summary of the views of the resident/family members on aspects of community integration, as facilitated by the CI-RAC model.

Chapter 9: Community integration: The residents' perspectives

9.1 Introduction

This chapter presents the findings from semi-structured interviews with a sample of 20 residents drawn from across the four case study facilities. There were interviews with five residents or their family members (in the case of Group Homes Australia) from each of the four case studies. As detailed in the methodology chapter of this thesis, the selection of residents interviewed was made by the management of the facilities according to a purposive sampling frame provided by the researcher. This was necessary due to the limited ability levels of some of the residents interviewed and privacy guidelines adhered to by the facilities where permission had to be granted by the residents' guardians when required.

The chapter commences with details of the impairment level, cognition, age group and gender of the resident sample that was identified with the help of management. In recognition of the vast diversity of the ageing process and the varying activity capacity of each individual, the resident sample demonstrates a variety of impairment levels and age groups within the higher needs care sector.

The findings of the resident interviews, similar to the stakeholder interviews, are categorised into the three components of the CI-RAC model; social environment, operational environment, and built environment. The elements identified in each component are viewed through the resident's eyes in relation to Research Questions 2 and 3:

RQ 2: How do care receivers perceive the value of community integration?

RQ 3: How well are the needs of higher care residents accommodated in the practice of community integration principles?

The chapter concludes with an extended discussion of these findings, noting the aspects of CI-RAC addressing the three components of operational, social, and built environments, but noting that residents do not necessarily perceive the delivery of the care they receive in such compartmentalised ways, which in turn leads into a more nuanced revision of the CI-RAC model in Chapter 9.

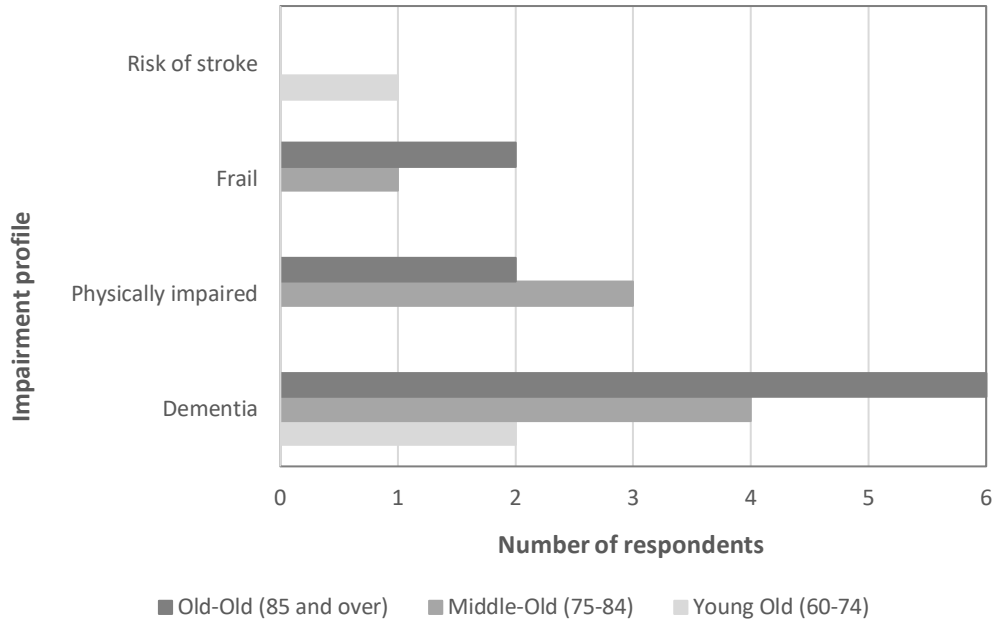
9.2 The resident sample

This section presents a profile of the 20 residents included in the research. It serves to highlight the diversity of the ageing process and nature of higher-care needs. As the voice of the residents, this chapter primarily aims to identify the diverse groups of communities seen as important for

community integration from the viewpoint of the residents and their families, followed by the factors facilitating community integration.

Sixteen females and four males were interviewed for the resident interview component of this study. Therefore, although the typical sample included five residents from each of the four case studies, six residents were interviewed at Montefiore due to the inclusion of a married couple in Montefiore who were at different levels of high care needs. Dementia care residents with varying degrees of severity were shown to constitute a larger proportion of the interview sample. As indicated in Figure 8.1, those who suffered from dementia did not necessarily correlate with advancing age, with two of the youngest residents interviewed in their early sixties being higher needs care dementia residents in Dougherty and Montefiore. Those with physical impairments were the next highest group of residents, followed by those who were frail due to old age. The oldest resident interviewed for this study was 101 years old in Dougherty Apartments.

Figure 9.1 Resident age and impairment profile

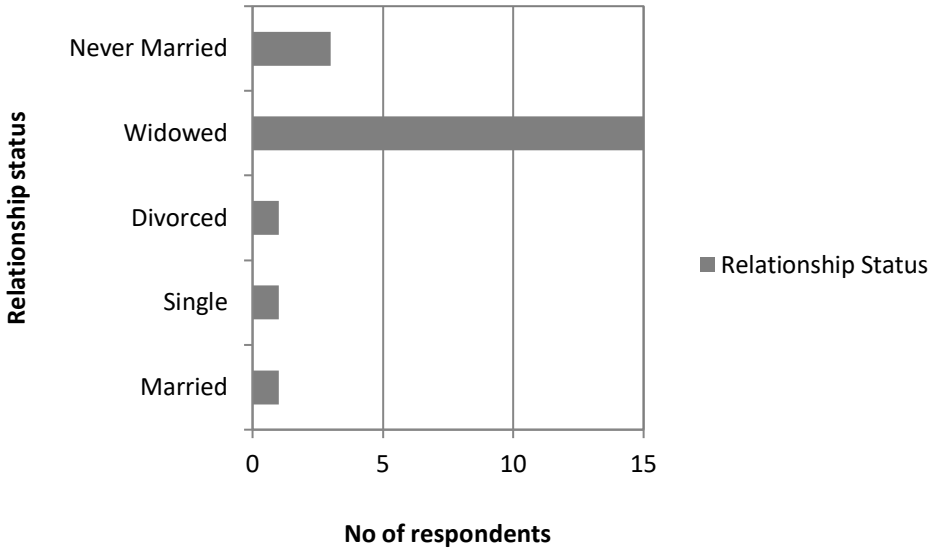


Three of the four case studies included residents with advanced dementia, with case study three, Group Homes, being exclusively a dementia care home. Residents suffering from dementia required the highest levels of care, with all such residents receiving all or most of their personal care from care workers. This was followed by those who were suffering from a physical impairment due to paralysis following a stroke or other age-related physical conditions. The residents that required minimal personal care performed by care workers, were

those who were frail due to the natural ageing process, and therefore belonged to the older age groups of the interviewees.

Amongst the resident participants, fifteen were widowed, two were never married, one was divorced, one resident single or separated, and one male interviewee was married and lived in the home together with his wife who had dementia (Figure 8.2).

Figure 9.2 Resident relationship status



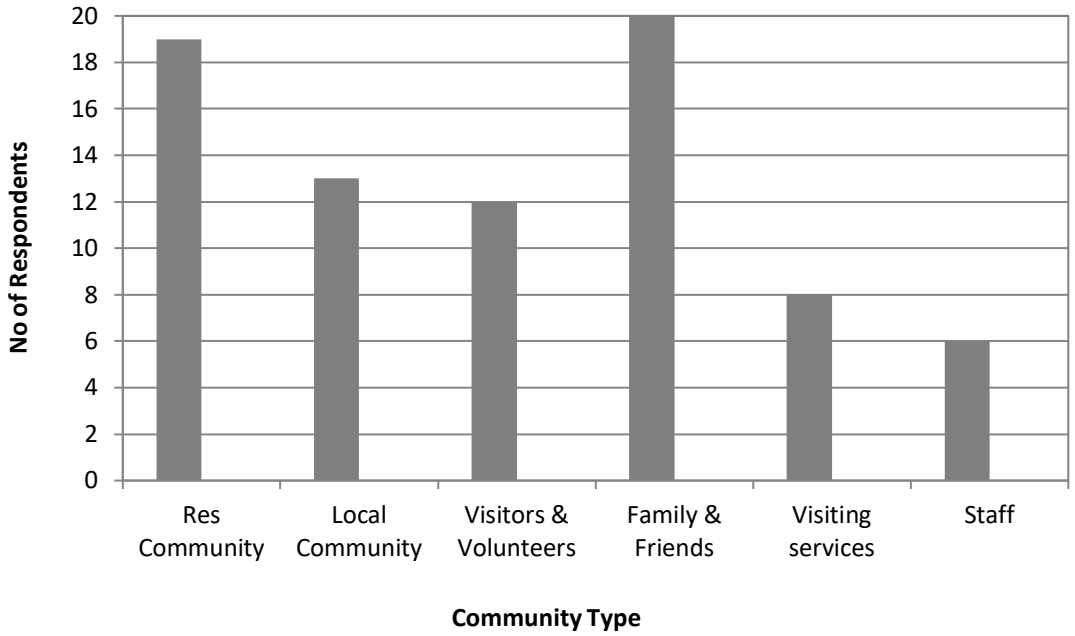
Of the twenty residents selected for this research, eleven were financing their residency through private funds, eight through the age pension and one through superannuation and private funds. More than 50% of residents had lived in the local area prior to moving into the facility, half of whom had lived there for over 50 years. Only three residents had not lived in the area previously, and all three had moved to the home to be close to their family. The details of residents' personal information are further listed in Chapter 5, detailing the four case studies.

9.3 Resident perspectives: Social environment

9.3.1 Who is the 'Community'

In order to investigate the nature of community integration generated by the social environment of the facility and its degree of importance, it was critical to ascertain what represented community integration from the point of view of residents. For the purpose of this research, a typology of six groups of 'communities' was included in the questionnaire from which the residents were asked to choose which they considered to be their community (Figure 8.3).

Figure 9.3: Resident definition of 'community'



N.B. This was a multiple answer question

Figure 9.3 shows the resident responses to the categories of communities that were considered to form their community. The residents could choose one or more of the categories presented. All twenty residents chose family and friends as being included in their community. Nineteen out of twenty residents stated that the residents living with them in the facility were also their community. The local community, volunteers and visitors to the facility were noted by about two thirds of the residents as being important. Staff and support workers were the least likely to be considered as part of the resident's community. It follows from this that those operational and environmental aspects of the facility that supported interactions with family and friends and connections with other residents within the facility are also likely to be considered most important from the residents' point of view. This suggests a close interplay of the three

components of the CI-RAC model in practice, which will be discussed further in the Discussion chapter.

9.3.2 Family and friends

The high importance of family and friends was reflected in the interview responses, including two residents who did not have family but considered their long-standing friends to be their *de facto* family. This was applicable to even those who had infrequent visits by family or long-standing friends.

As a centenarian resident from Dougherty stated:

> Family are the most important. I have 2 daughters of my own and grandchildren who visit, and I also have 3 daughters of friends who are now passed on who come and visit me - 3 women. One comes from Queensland - she said to me: "Well, we've known you all our lives since we were little and mum was alive, so you are our family and we like to keep in touch" (DA,Res,1F,100).

The notion of 'family' extended to long-standing friends, especially for those who were migrants to Australia where close bonds were formed with friends whom they considered as family. As one resident volunteered:

> I have a friend who comes every week. She comes to visit me whenever she can, and her daughter [mentions name] who now lives in the Blue Mountains with her family comes to visit often as well. And I Skype them all the time, they're my best friends. Then I have another friend I met when we arrived in Australia, and we used to play tennis together, and she comes and sees me. And I have other friends who come and visit. I also have a friend I Skype in Newcastle. I don't have any family, because I only had one daughter and she died from a brain tumour (four years ago). Then I lost my husband two years ago. Then I had an operation which paralysed me from waist down, and that all happened within the past 6 years. I got grandchildren, but one of my granddaughters' lives in Sydney, and she's got three children, and the eldest one is five, and there's no way she can do things for me, even to visit, she couldn't bring three children in here. So, my friends are my family (EL,Res,2F,86).

As pointed out by this resident, distance played a part in preventing more regular contact with her own grandchildren, but it did not seem to matter to her as she had a 'family' of close friends with whom she interacted. The use of 'Skype' to keep in touch was also important to her as a means of communication where loved ones were geographically distant. Family was also noted as important to this wheelchair-bound resident, in Elanora, even though he only had rare visits by his only daughter:

> I have a daughter who comes to visit rarely. She is the most important person to me (EL,Res,4M,85).

It was confirmed by management upon inquiry by the researcher, that this resident had not had a close relationship with his family due to a history of family conflict. He spent most of his time

in his room, and did not socialise, except with one other male resident in the facility who was also wheelchair-bound with higher needs care. The two had a coffee every morning in the café located within the facility.

9.3.3 Resident community

The similarly high importance of the resident community was commented on by many residents. For example, one resident suggested that he now considered the resident community as his family:

> I say good morning to everybody when I see them first thing in the morning when they come for breakfast or come for a meal because they're my family at the moment (DA,Res,1F,100).

This aspect of community was also emphasised by a resident from Elanora:

> They (the residents) are my community now, because I don't have family (ES,Res,2F,86).

Another Elanora resident also expressed similar sentiments:

> I like the atmosphere here, and the community of residents living here. They're like family (ES,Res,3M,81).

Of the two residents who did not consider her fellow residents to be her community and had limited interaction with the other residents. One was from Montefiore. As explained by her son, this was due to her younger age of 63 years and her advanced dementia, whereas the other residents were much older than she, often over the age of 80. It should be noted though, that a similarly an aged female resident with advanced dementia at Dougherty, found the resident community to be a very important group subject to her choice of when and how she wanted to interact:

> In general [the resident community] is very important, but depends on how I feel (DA,Res,2F,61).

This statement also highlights the need of the resident for privacy and choice, whilst appreciating the companionship of her resident community.

There were only few who regarded the internal community as unimportant in the interviews for different reasons. For one resident who did not see interaction with fellow residents as important in Dougherty, it was her experience of autonomy:

> It's important that you have people who don't make trouble to live with, but interacting with other residents is not that important because I've always lived by myself, and always depended on myself (DA,Res,3F,94).

This was evidence that her personal preferences related to the pattern she has lived throughout her life. According to the son of the younger aged dementia resident at Montefiori, it was related to her age difference with other residents:

> I think she would like more interaction, but she is a younger resident in aged care as she came here when she was 61, and most residents are in their 80s, so she's way below the average age, and with that comes the fact that the other residents are geriatric, and she's not, so that has been a fundamental problem for integration. We've looked at other facilities, and we haven't been able to find a better option in terms of quality of care, proximity to family, so we can be here a lot. (MF,Res,5F,63)

Thus, Montefiore demonstrates a more porous nature in its ability to absorb a social environment *within* the facility, while Dougherty demonstrates a more permeable social environment with a two-way flow between the resident and local community.

Thus in community integrated aged care, social relationships are formed *between* the resident community as well as within the local community. Therefore, it was evident that the resident community played a key role in a residents' sense of contentment and satisfaction contributing to the nature and level of engaging in community integration.

9.3.4 The local community

More than half of the residents interviewed at Elanora considered the local surrounding community an important part of their notion of community. An Elanora resident paralysed from the waist down following a stroke found the local community to be extremely important:

> I love going out to the shops and it's very important to me to look around and be connected. That is the reason I moved here from my previous home, which was also very, very good, and I had lots of friends there, but here it's easy for me to get on my chair and go to the shops just across the road, and pay my own phone bill (EL,Res,2F,86).

This statement also highlights the importance of the wider physical environment to accommodate the aged care needs of some residents. Only two Elanora residents did not regard the local community as important because they could not go out to access the neighbourhood with ease on their own due to increased frailty, as well as personal preference. Another resident of Dougherty, who was bed-ridden visited the coffee shop at the adjoining community centre with the aid of a care worker who pushed her there in a wheelchair. Although this resident regarded the local community as generally not important, the regular visit to the coffee shop was an activity she enjoyed. Notably, however, none of the residents at Montefiore found that there was any need to access the local community as they had everything they needed right at the facility. A reason for this could be the greater focus on the care model of focussing on incoming community groups to the facility, with the provision of a café and restaurants within

the facility. In addition, a greater focus on security surrounding the facility as a largely Jewish community facility may also contribute in that community integration is managed with greater ease within the confines of the facility, where only approved personnel or community groups could enter.

9.3.5 Visitors and volunteers to the home

Visitors and non-residents to the home were important as part of their community for a little over half of respondents. The centenarian resident from Dougherty stated how much she enjoyed her 100th birthday with guests "coming from everywhere". When she was asked about the importance of visitors and non-residents to the facility; she replied:

> Yes, I had an immense crowd for my 100th birthday, I enjoyed it very much and it was very important to me. They came from everywhere. There was one man who came from India for my birthday and flew out the next day. It was a man who I knew from years ago, and he corresponds with my family, so my family told him it was my birthday and he came (DA,Res,1F,100).

An Elanora resident noted the regular volunteer activities such as 'the piano man' as an important aspect of her community:

> Entertainment is very important part of our community, and we have a volunteer piano man who comes in every week, which is very important to me (EL_Res_2F_86).

However, this was not the case for others. A family member of a Group Homes resident stated that her mother was distressed at being made to engage in musical entertainment against her will::

> "my mother comes from a highly musical background, and one of the reasons she was unhappy in [the] previous facility was because they were forced to listen to Andre Rieu, which my mother found quite painful. Here she has a choice of how she wants to entertain herself" (GH_Res_3F_78).

Therefore, choice to not be involved was also noted to be an important aspect of engaging with the incoming volunteer community.

For a Montefiore resident in her early 60s suffering from dementia, her paid companion was the most important aspect of her community, as she did not have interaction with any others in the resident community. As stated by her son, "her paid companion who visits her on a regular basis is most important" (MF,Res,5F,63). He further stated that the paid companion was essential to the resident as she did not identify with the other residents because of her relatively young age of sixty-three, compared to the other residents.

Thus, the importance of incoming volunteers as part of the community in community integrated aged care, is contested. However, for some it is important, and as pointed out in Chapters 6 and 7 is an essential element of community integrated policy, practice and social activity.

9.3.6 Staff

In contrast to the views of stakeholders, staff were least likely to be included in residents' definition of their community, with a little less than one third placing importance on this group. However, in the interviews, staff were noted as being of some importance due to their role in enabling a community integrated lifestyle. As a Dougherty resident stated:

> Staff have to plan the day for you. They make sure I get my exercise once a week and go to my balancing class…staff are very important - they feed you and wash clothes for you. This place wouldn't function without the staff. Getting washing and laundry done is very important (DA,Res,4M,73).

There was only one instance of a resident considering the staff to be a part of her community and not merely as an enabler of the functional and practical aspects of maintaining social activity. As the daughter of a Montefiore resident with advanced dementia states:

> The staff are a big part of the resident's life and sense of community, as she [the resident] was a solicitor all her working life, and she always had a really good relationship with her staff, she always knew them all by name - the typists and clerks - it was part of who she was - so here [at Montefiore] she goes to staff meetings, and if she sees staff in the corridor she would probably speak to them before speaking to residents. Even when she was working, apart from one friend, it was the staff she was closest to (MF,Res,4F,97).

Unusually, from her daughter's perspective, this resident clearly saw staff not only as an essential part of the daily function of the home, but also an intrinsic aspect of her sense of community which resonated with a familiar aspect of her daily life prior to being diagnosed with dementia.

9.3.7 Summary

This discussion demonstrates that all five groups of community comprising of visiting family and friends, the resident community, the local community, visitors and volunteers to the facility as well as staff were intrinsically interwoven into the concept of community as regarded by the residents social environment. The nature and extent in which each resident viewed their social environment was based on personal preferences and needs. The nature of the care philosophy of the facility also influenced the nature of the social environment.

As observed earlier, Montefiore is a community whose built form is as a secure gated community with a range of services and amenities and social interaction provided within the facility. This encourages a focus on integration and interaction with residents and visitors

within the premises. In contrast, Dougherty is intrinsically interwoven with the local community. This is reflected in its physical location at the heart of the bustling town centre. Resident interaction occurs within and outside the premises with a high level of physical and visual connectivity with its surrounding neighbourhood. The residents access the local community as much as the local community can access the facility. Community integration and building of social relationships take place in both contexts.

9.4 Residents' perspectives: operational environment

The operational nature of the care model employed by the aged care facility was perceived by residents or their family member to play a critical role in supporting community integration, primarily by the way it can support health and personal care, entertainment and recreation, spiritual care, sense of safety and security, companionship, choice and independence, privacy and the role of staff.

A family interviewee summarised the importance of a care model that supports social interaction for a resident with dementia:

> The best care model makes the residents feel at home. Other facilities have a hospital design, whereas this is more like a hotel. Ageing is not seen as a disease to be medicated over here. When we came here mum was taking one of the psychotropic drugs for frontal lobe dementia, and Monte was happy to have her without any medication as she was and they were happy to work out a management strategy for her. She can be extremely bright, but she has frontal lobe dementia so she can be extremely inappropriate, and hard to manage. Now she's not angry anymore, she's very happy now at Monte. The level of social interaction that she gets here, she could not get at home, which has helped in her behaviour. She's not bored here because she can talk to staff, she meets different people. (MF,Res,4F,97)

A Dougherty resident noted that staff were encouraged to socialise with residents while respecting their privacy.:

> If people don't have visitors the staff make sure they go in and talk to them and when you have the door open they know that you don't mind people coming in for a chat (DA, Res, 1F, 100).

A family member of a Group Homes resident reported that the care model respected her mother's choice and independence despite her advanced dementia. She appreciated the way behavioural issues were managed through participation in activities that her mother valued, rather than being administered drugs:

> The ability to walk by herself was very important and [she] resented having someone walk with her. So, Group Homes took that into consideration, and she walks by herself up to the shops and back, and a carer would unobtrusively watch from the facility in case she goes wandering off, and for her own safety. She is off all sedatives and anti-

> psychotic drugs that she was on in the previous facility, and she's the happiest she's ever been, in spite of increasing cognitive decline (GH, Res, 4F, 82).

As the above indicates, community integration embedded into the care model was seen as beneficial on many different levels. These statements indicate that in a community integrated approach, staff attitudes and their dealings with residents require respect for privacy and choice which has a positive impact on health and wellbeing.

9.4.1 Health and personal care

Personal and health care were regarded as crucial to enable residents to remain active and engaged. The nature of aged care provision in Australia is such that eligibility for access to residential aged care is rapidly moving towards higher and higher needs care. As a reflection of this, all residents interviewed were in residential care due to a medical or health related condition. They required constant care which prevented them from living in their own homes but were able to lead a life integrated with the groups of community that were important to them.

Health facilities in the local community were particularly important to some residents for both medical and therapeutic services:

> My doctor lives up the road. It's very important that they are close by, so the girls [care workers of the facility] can take me to my regular doctor easily (DA,Res,4M,73).

> My mother is taken for an aromatherapy massage once a month at the local shopping village. She also sees a podiatrist who comes to the home once in two weeks (GH,Res,1F,86).

Outdoor spaces within the premises of the home were also used for therapeutic activities:

> We have a balancing class in the home, which is sometimes outdoors. That's very important to me, and we come together with others to keep fit (DA,Res,4M,73).

Hairdressing and grooming services were also noted by the residents as important to personal care. Most residents preferred the in-house facilities of hairdressing services;

> …the hairdresser is in here at our home, we don't need to go out (MF,Res,2F,86).

> …once a week I get my hair done in the home salon (DA,Res,5F,78).

> …the hair dressing salon is in the home, which is very handy (ES,Res,1F,83).

.Pride in appearance was of importance to some. For one resident, having internal services enabled her to be better presented to go out.

> If I go out of the home I'd want to make sure I'm dressed well, so I get my hair and nails done. I wouldn't go out if I wasn't, it's the way I've always been (DA,Res,2F,61).

This discussion indicates that it is not only the essential health care necessary for a higher care needs residential care facility, but also therapeutic services were considered to be of importance. Personal care was also noted to impact the residents wellbeing, with hair dressing services particularly highlighted.

9.4.2 Care Model and Staffing

A care model providing high level care while enabling residents to stay active and connected to the community incorporated a high ratio of care workers to residents. This was understandably seen as an important aspect of the success of a community integrated care model:

> The care model [of Montefiore], and the management model, it is care focused and not staff focused. They have more care. It is a state-of-the-art facility. Where she was previously they had a lot less staff so they had to control the resident to suit staff levels. Here mum can do whatever she wants because there's enough staff to keep an eye on her. We're very lucky that mum could get in here (MF,Res,4F,97).

> The ratio of carers and resulting high quality care [was seen as a desirable aspect of Group Homes] (GH,Res,3F,78).

The ratio of staff to residents were therefore seen as an important factor in facilitating a community integrated care model, whilst the cost was not seen as a determining factor for many families who chose quality of care as the benchmark for the selection of the facility. This likely reflected the demography of residents in two of the case studies, Montefiore and Group Homes, located in more affluent suburbs of Sydney. The families of these residents were therefore able to select the facility for its care model, rather than its affordability:

> The previous home was a high ranking facility, equal in cost, but was extremely unsatisfactory in terms of care model (GH,Res,4F,83).

Significantly, one of the most important aspects of the care model was the provision for specialist needs such as dementia care:

> The family had to find a place that could accommodate the resident's dementia needs without being drugged till she was comatose. The previous home she was at could not cope with her dementia behavioural issues. Here she is happy and she's not on drugs. They have a good care model to accommodate dementia (MF,Res,5F,63).

Activities and sense of 'normalcy' for the resident were also seen as important aspects of the care model, with freedom of choice and independence encouraging engagement in activities:

> The care program was important as they encouraged activity, and that it was a real home (GH,Res,5F,83).

> I like the freedom of going and coming as you wish. It's not restricted, and that's important (ES,Res,1F,83).

Some residents also identified the physical characteristics of the home in relation to the care model:

> This is a modern facility providing state of the art care and good management and care structures (MF,Res,4F,97).

Words such as 'modern', and 'state of the art', were significant in describing positive aspects of the home and care model. Most residents, including those with dementia related illnesses resonated with familiarity and comfort through efficient care provision, rather than a re-creation of the physical characteristics of their former home.

9.4.3 Social, entertainment and recreational facilities

The resident interviews indicated that social, entertainment and recreational activities made an important contributed to resident satisfaction and wellbeing. Meeting in the café located within the home or nearby was frequent, in all four case studies:

> …we meet in the café in the home every day (ES,Res,1F,83).

> I meet my friend who lives here in the café inside the home every single day. The fellow who runs the coffee shop makes the best coffee this side of the coast (ES,Res,4M,85).

Entertainment brought into the home from the community was also regarded as an important aspect of their community integration:

> I like entertainment events coming into the home, it's important. I like to have organised activities and events at the home (DA,Res,4M,73).

In addition, walking for recreation was also enjoyed:

> Monte has extensive grounds and a lovely meandering walk, where she walks (MF,Res,4F,97).

A dementia resident at Montefiore, due to her younger age, did not necessarily enjoy participating in recreational activities as a form of integrating with the resident or local community. However, it was revealed by her son that she enjoyed having a piano in the home, for her own entertainment:

> …she likes the fact that there is a piano [which she often played] (MF,Res,5F,63).

Some residents preferred solitary activities, while still appreciating the organised events and entertainment brought into the home:

> I'm just happy if I have a book in my hand, but I like having the activities (DA,Res,3F,94).

The daughter of a Montefiore resident with advanced dementia noted the social stimulation of activities as a crucial factor in maintaining health and wellbeing, which could only be provided in a professional care facility:

> … my sister and I just could not provide the social interaction that she needed. Even if she had a full time carer at home, she would have been lonely, because she doesn't have that engagement she gets here - argue with, friends with, help get dressed, range of food…so the move was primarily about keeping her entertained and having that social interaction, at home she'd just be waiting to die. My uncle aged in the community in his own home, and he was just waiting to die and very lonely, the home care he received was getting the frozen food delivered. No interaction. Very lonely. It does not work when you're old - living at home (MF,Res,4F,97).

For a resident at Dougherty, the view out to the street complementing the residents' sense of connection, and engagement with the surroundings was an important factor:

> We have the community centre just next door, it has a café, so we don't need to go too far for a coffee or a piece of cake and meet people. You know, you always see someone in there that you know. I look out my bedroom window and I can see who's coming in to the home and get a view into Chattys [the community centre café]. I can see to the street from my bedroom window when my sister & husband come here (DA,Res,4M,73).

Ease of access was thus important to the resident and the families of residents, and connectivity was facilitated through both physical and visual access.

Recreation activitieswere used both on site and in the local community. It is important to note that recreational activities did not always incorporate socialising, it could be something that the residents enjoyed alone in their own time, such as the ability to go to a desired destination which was accessible to them within their physical or cognitive capabilities. Walking up the road, observing activity in the general community such as at a shopping centre, or relaxing at a park, as well as activities within the home such as playing a musical instrument, reading, or mingling with other residents were mentioned by residents. In all activities, the key characteristic was choice and independence to the resident in accessing or choosing the recreational services with which they engaged.

9.4.4 Spiritual care

Community integration through maintaining and providing the residents with an opportunity to continue to practice their faith was also important to many residents. It was noted that there were three ways in which spiritual needs were met for residents, depending on the spiritual orientation of the home.

1. Directly by the home: where a facility was affiliated with a particular faith;

2. Non-denominational approach: where the facility was seen to meet the different religious requirements of residents by bringing in different services to the home as required;
3. Taking residents out to access religious institutions: this was not seen to be an approach that was widely used due to the nature of higher care needs.

Three out of the four case studies, Montefiore, Elanora, and Dougherty regarded the spiritual needs of the residents as part of their care model and a space was allocated within the home for this. Dougherty is strictly a non-specific religious facility, but arrangements were made for residents with the local Catholic priest to come into the home for Sunday Mass. Three out of five residents interviewed attended the Mass and considered it very important that the service was brought to the home without which they would not have been able to participate.

> The church minister comes into the home, which is very important because I couldn't go out every week (DA,Res,1F,100).

This thought was reiterated by Elanora resident (ES,Res,2F,86), who mentioned that due to her paralysis, attending a public Mass and the logistics of travelling to a church service was limited with even the weather being a major obstacle to getting about. Therefore, the spiritual service and facilities provided by the home within the premises was important to her.

Montefiore Jewish Home provided a care plan based on a Jewish lifestyle for its majority Jewish residents, which included the celebration of important days in the Jewish religious calendar as well as having an in-house Rabbi to perform the Jewish prayer service:

> I wanted to be in a Jewish specific home. That's why I came here. There is a Rabbi in the home (MF,Res,2F,86).

While spiritual needs were noted to be of significance to some, others did not find it an issue of importance:

> …spirituality is something that you need, but it's not very important to me (DA,Res,2F,61).

A wheelchair-bound resident of Elanora noted:

> … it would not be possible to go to a church, it would be too much trouble for me to get in and out of taxis, then go to a crowded place, and what when it rains, I would have to have someone with me. It would be troublesome. I much prefer to have the service here (ES,Res,2F,86).

In all case studies spiritual needs were met within the home, rather than in the local community in consideration of the higher care needs of residents.

9.4.5 Safety and security

Both the psychological and physical aspects of safety were noted to be important aspects of the care models for community integrated facilities. There were seen to be two clear aspects:

1. Personal safety issues, where concerns of residents arose from frailty related incidences such as falls; and
2. Security issues: where concern was expressed around vulnerability to crime.

The fear of crime shared commonly among residents was evident, even though all four case studies were located in affluent areas with low crime rates. The feeling of being in a secure facility was important to many residents. Security was a critical issue for residents with dementia when living in their own homes and a major reason contributing to entering residential aged care.

Many residents noted the feeling of safety they had in their current care homes, while others pointed out the very real dangers faced by older people brought on by isolation and ill health. As pointed out by a resident of Dougherty:

> One time you didn't have those thoughts about safety, but nowadays all sorts of things happen, and I feel safe here. I sometimes watch the news and I can't go to sleep afterwards, because it's dreadful what things happen, then I have to take two Panadols to go to sleep (DA,Res,1F,100).

One resident of Montefiore stated:

> Well, I prefer to be completely better, in perfect health, able to get around and do everything, but I can't, can I? Because I couldn't do it. So I like it here because it's safe (MF,Res,1F,88).

This was reiterated by another Montefiore resident:

> I feel safe, content, and I didn't feel safe or happy when I was at home. Here I have lots of people around me and activities and [am] well taken care of (MF,Res,2F,86).

The daughter of a resident of Montefiore referred to the physical dangers faced by her mother in her own home prior to moving into the facility.

> There were two things that made it impossible for mum to stay at her own home, one is that her dementia needed twenty-four-seven care and watching. She was living in the Cross [Sydney suburb of Kings Cross], and there were people following her into her house and stealing money from her (MF,Res,4F,97).

The potential for self-harm was mentioned by the son of another Montefiore resident, due to his mother's dementia:

> She can't cope in her own home, as she's a danger to herself and needs advanced dementia care. And she hasn't asked to go to her home in over one year (MF,Res,5F,63).

Some residents indicated that it was important for them to go out, but felt safe or able to, only when they were accompanied by a care worker due to their increased frailty:

> I can go out only when they take us out, because I'm not able to go out on my own, it wouldn't be safe, and I enjoy it very much when we do (DA,Res,1F,100).

Safety was considered a major benefit in an aged care facility with a community integrated care model. A resident could enjoy a more normalised life and engage in activities not having to be concerned about personal safety related to medical conditions, accidents/falls and self-harm, as well as personal security from perceived risks in the outside world.

9.4.6 Companionship

The absence of loneliness and isolation was a positive aspect of living with other residents in a community integrated care home, particularly for those with advanced care needs who previously lacked social engagement in day to day life when living independently. The importance of celebrating each other's birthday parties as well as daily activities like company at mealtimes, were regarded as very positive aspects of community integrated care:

> It would be pretty lonely without people, so it's very important (DA,Res,3F,94).

> I didn't have much choice, my family made decisions as I had a mental problem. I didn't want to go anywhere, but I had to and everyone was so friendly when I got here. I was renting a place and it was very lonely, and until I came here I didn't realise how much it meant to me to be here, and be with others who are in the similar situation (DA,Res,1F,100).

Unplanned encounters and socialising with residents were noted as a favourable aspect of living with a community of residents:

> Mostly you just run into residents/bump into them at various places inside the home, or drop into their rooms for a chat. You don't plan meetings (DA,Res,5F,78).

> It is very, very, important to be living with a community of residents; we meet in various indoor areas every day (ES,Res,5F,84).

Socialising within designated spaces such as a café within the home was a popular activity which gave the resident the feeling of going out to a special place to meet with friends:

> I meet my friend who lives here in the café inside the home every single day. The fellow who runs the coffee shop makes the best coffee this side of the coast (ES,Res,4M,85).

The importance of integration of high and dementia care was noted at Montefiore where one resident was living with his wife who had dementia. Although he himself did not suffer from dementia, he was a higher care needs resident who needed substantial levels of personal care.

He had the ability to socialise with his brother in law who was also a resident at Montefiore, because of the integration of care:

> My brother in law is in the hostel [one floor up] and I meet with him every day. I don't have anything in common with the people on this floor, because this is the dementia care section (MF,Res,3M,93).

Engaging in various activities with other residents was considered important. Activities and meetings did not have to be planned as they all lived together and had a sense of community and companionship within the facility. Planned activities with other residents ranged from sporting activities to recreational outings in public parks:

> when they take us all out to public parks and places it's really nice, and I enjoy it (DA,Res,1F,100).

> We used to play badminton outdoors with other residents before refurbishment construction work began. I like to go out and about in the garden, and bump into people and socialise at times - unplanned meetings (DA,Res,4M,73).

Residents often frequented local restaurants or engaged in other planned outings:

> I go to a local restaurant across the road in the shopping village with the chap [other resident in the facility] twice a week (ES,Res,5F,84).

> We go out twice a week for outings, I love it very much, it's very important (ES,Res,5F,84).

Or they may simply stay indoors and enjoy the company of other residents:

> I watch TV every night with my friends here (MF,Res,1F,88).

The resident community was also important where residents didn't have family or friends. Other residents would help to create a supportive community for them within the home:

> There are people in here who are from other countries and have no family or friends to visit. One lady is from England, and we are her family, she's got all of us (DA,Res,1F,100).

Two of the residents in adjoining rooms at Elanora had also formed a romantic relationship since moving into the home. Although both residents answered the relationship status question as *not* being in a relationship, it was confirmed by management.

In the case of Group Homes, all respondents agreed that it was very important that there was no regimented routine, rather residents' day to day lives were accommodated just as they would be in their own homes:

> It's very important that there is no regimented routine. It's very much based on residents' choice and preference…It's very important that this is a regular home, which looks and feels and smells like a home (GH,Res,3F,78).

Regarding the rather younger dementia resident at Montefiore, her son employed a paid companion to take her to restaurants or other places of interest:

> The friend and companion is very important in this category, as most interaction and outings take place with the companion. …. As a one off she enjoyed a group trip to the Art Gallery - but that was more the content of the trip rather than the companionship with other residents. She goes out with family and her companion, but not with other residents. (MF,Res,5F,63).

The sense of companionship in living with a group, as opposed to isolation if in their own home, was appreciated by most in a community integrated care model.

9.4.7 Choice and independence

While community integration was considered essential to a high-quality operation in all four facilities, the degree and nature of choice and independence in interaction was also very important. As expressed by the family member of a resident of Group Homes, the non-regimented routine and her mother's wishes regarding interaction or non-interaction being taken into account, was important in creating a safe and harmonious environment:

> …so residents have the choice to do what they want just as you would in your own home, but in a safe environment [due to dementia care needs] (GH,Res,3F,78).

The paralysed resident from Elanora found choice and independence extremely important in the way she preferred to be connected to the community:

> I go out a lot on my own, as my independence is very important to me. I go to restaurants often with friends, not residents. And we meet in the indoor areas in the home as with my having to be in the chair, I can't have an extra chair in the room for visitors, there's not enough room. There's not much garden here to meet with friends in the garden (ES,Res,2F,86).

This comment also indicated the continuity of life in a social environment similar to the life she has always lived, as being positive.

Choice and independence were also noted as an important factor in resident activities. As mentioned by the daughter of a dementia care resident at Group Homes, choice in the way her mother participated in activities was important to the resident and her wellbeing. She indicated that her mother's adverse behavioural issues were exacerbated through forced engagement in activities the resident found unpleasant in a previous aged care facility. At Group Homes she has a choice of how she wants to entertain herself (GH,Res,3F,78).

It was noted that activities were accessed both within the facility as well as outside, facilitating community integration in both locations. The family member of a high care needs dementia resident of Group Homes, credited choice and independence as having a direct influence in

increasing quality of life, health and wellbeing of her mother so that she did not require medication, despite advancing into higher needs care:

> It was very important to my mother that she could and was allowed to walk by herself. The ability to walk by herself was very important and (the resident) resented having someone walk with her. So, Group Homes took that into consideration, and she walks by herself up to the shops and back, and a carer would unobtrusively watch from the facility in case she goes wandering off, and for her own safety. She is off all sedatives and anti-psychotic drugs that she was on in the previous facility, and she's the happiest she's ever been, in spite of increasing cognitive decline (GH,Res,4F,83).

A resident of Dougherty Apartments, expressed that it was important that management did not force the residents to take part in activities or interact:

> …because everyone gets along. The staff is great, very friendly. They have activities that suit me. I don't go out to anything that doesn't suit me. Nobody forces you to do anything (DA,Res,4M,73).

> Freedom and choice is very important. We have the freedom to choose what we want to do. Everyone is left to their own devices here, we can do whatever we feel like. (MF,Res,2F,86)

Another resident of Elanora stated his satisfaction at having freedom of choice:

> I've got the freedom to do what I like. (ES,Res,2F,86).

The emphasis on choice and independence of the residents, even with higher care needs was contrary to the common perception that older frail individuals are not as capable of exercising this. It was noted that even higher care needs dementia residents had improved behaviour and overall wellbeing when provided with the opportunities to participate in activities by exercising their choice and independence.

9.4.8 Privacy

Preferences regarding levels of privacy, were also important to the residents when engaging with others within the home, in interaction with the local community, visitors and family. Personal space is an important aspect of privacy, which in residents' views played a crucial role in community integration. According to Altman, personal space is a mechanism humans use to regulate privacy. He defines privacy as "selective control of access to the self or one's group" (Altman 1976, p. 8). This concept was clearly demonstrated by the resident interviews.

In the case of interaction with the resident community:

> …there are some people [amongst the resident community] who I have a good rapport with, but there's someone here who I don't like (DA,Res,2F,61).

> In general, [interaction with resident community] very important, but depends on how I feel (DA,Res,2F,61).

The physical design of the facility was also considered important in providing privacy:

> I like it much better than where I was before, where there were three people in the one room. Here I have my own room and bath, and that would do me (ES,Res,4M,85).

The freedom and ability for a resident to be in control of their desired level of social interaction or for solitude, was therefore considered to be an important aspect in the design of a community integrated aged care facilities.

9.4.9 The role of staff

As noted in the social environment section, from a residents' perspective, staff were regarded as an important aspect of enabling community integration and the effective delivery of the care model. Given higher care needs, specialist trained staff, knowledgeable about facilitating community activity, played a critical role in residents' quality of life. As the daughter of one resident of Group Homes expressed the view that:

> It feels comfortable here. We know all the staff, and we know she is well cared for. Knowing that there were only a small number of people, we know she's well cared for. We saw some horrors when we were searching for a home for mum, and you wouldn't put a dog in there, especially with Alzheimer's. We were looking at places which were known to be specialised for Alzheimer's, but they were not good, people were sitting in dining rooms all day long, there was no interaction or anything to do - these were high-end people. My mother's always been an outdoors person, and they had no outdoor contact, and when you've got high needs you need more staff and they don't have staff (GH,Res,5F,83).

This view was echoed by another Group Homes resident, who noted the importance of staying engaged in the activities of day to day life:

> Care of staff and the Group Homes home atmosphere is very important to keep residents active within the community and engaged and interested in day to day life. The beauty of surroundings and the home, freedom and choice, and independence offered to residents in daily life and decision making within their capabilities, is really important in this (GH,Res,1F,86).

The role of staff and the quality of their relationships with the residents was noted by of a Montefiore advanced dementia resident's daughter:

> She [the resident] was a solicitor all her working life…so here she goes to staff meetings, and if she sees staff in the corridor, she will probably speak to them before speaking to residents. Even when she was working, apart from one friend, it was the staff she was closest to (MF,Res,4F,97).

Consequently, staff were seen to be integral in facilitating effective community integration by not only caring and providing the basic daily necessities but also as an important contribution to the life and atmosphere of the facility. This included providing the residents with

companionship, moral support, sense of familiarity also referred to normalcy, as well as contributing to a resident's satisfaction and mental and physical wellbeing.

9.5 Resident perspectives: Built environment

A resident's relationship to location was seen to signify varying degrees of meaning. For many, it meant connectivity to family or familiarity with the area through living in that community for a length of time. Location of the facility in terms of accessing services, retail, and transport were also important. The characteristics of the area which contributed to a particular life-experience was also related to a resident's identity and affinity with a place. The design and layout of the facility itself was also identified as being highly significant in creating a sense of social cohesion and inclusion both internally and with the external community.

9.5.1 Familiarity

Most residents expressed the importance of affinity with the area in which the facility was located. In the words of a resident from Group Homes, she had "settled like a petal" at the home, which her daughter also attributed to being close to family, and familiar with the area (GH,Res,2F,78). Having grown up and lived her whole life in Sydney, a resident of Dougherty stated her affinity to the harbour and ease of access to familiar places as being important aspects of the location of the home:

> I'll go anywhere, but I like it here because of where it is. I like to go to the club sometimes when they take us. I like to go by the water too, which is close by - the harbour is so beautiful (DA,Res,1F,100).

To others, from all cases, it was their history and attachment to the local area in which the facility was located:

> Location is very important because I've always lived here, only a little way up from here (DA,Res,3F,94).
>
> This is ideally located. We've both lived in this local neighbourhood all our lives (MF,Res,3M,93).
>
> I've lived in the area for twenty-four years, so I have lots of friends in the community (ES,Res,1F,84).
>
> Location is very important as she [the resident] grew up in Randwick (MF,Res,4F,97).

The residents of Group Homes accessed the neighbourhood on a regular basis by going for walks. This helped create a sense of familiarity between residents and neighbours:

> Sometimes the residents are invited to neighbours' homes for tea [on occasion], as they see them going for walks in the neighbourhood, so they are familiar with the residents (GH,Res,2F,78).

As noted by a Montefiore resident, continuation and familiarity were important in the places she could frequent to continue to engage in familiar activities, in the community:

> Four days a week I go out shopping with my daughter to Bondi Junction - to David Jones, where I've always shopped. (MFRes,2F,86).

The feeling of safety which accompanies a familiar place was also noted by a family member of a Group Homes resident:

> The area is familiar to her - there is a feeling of safety in that (GH,Res,2Fm,78).

A Montefiore resident stated:

> I didn't choose this place, my daughter did, because I came here after a stroke and I couldn't speak and I couldn't go back to my home. But I'm familiar with the area as I've always lived in Paddington and Woollahra. (MF,Res,1F,88).

A sense of belonging to the residential aged care home was expressed by a Montefiore resident who had not lived locally. Her affinity came from years of association contributing financially to Montefiore and was her reason for moving from Canberra, specifically into Montefiore:

> I have always supported this institution with donations, and so I have always felt that I belonged here (MF,Res,2F,86).

A Dougherty resident noted her familiarity with a geographical area of Sydney that she identified with:

> This home was recommended by the hospital as the best place to be, when admitted to hospital after fall, broken arm. We were told this was the best facility on the North Shore, and I've always lived on the North Shore (DA,Res,5F,78).

Location was thus seen as the most important factor for a resident's sense of familiarity and continuation of lifestyle. This included people as well as places and surroundings, experienced in varying ways.

9.5.2 Proximity to family and friends

Proximity to family was a primary factor in residents' appreciation of the location. Since the choice of residential aged care facility was often made by the family of a resident following extenuating circumstances. Therefore, proximity to family was also of more importance for the resident so their family could access the facility and relatives with ease:

> Selection of facility had nothing to do with me. My sister had power of attorney, and she selected it because I was at a respite place where I was for about a week. This is close to where she lives. I lived in Marrickville for 40 years, so not lived in the area before, but it's close to my sister (DA,Res,4M,73).

Likewise, as expressed by the daughter of resident (GH,Res,3F,78), who had to make the decision of choosing the care facility for her mother suffering from dementia and requiring high-needs care, "the location was critical as it's near to her [the resident's] only family member, myself (GH,Res,3F,78).

The daughter of a Group Homes resident also regarded location as important to family being able to visit with ease:

> There was a good place up in Arena, but we couldn't have visited or travelled so often [due to distance]. (GH, Res, 5F, 83)

For some residents who did not interact with family, it was simply a case of not having family, as expressed by this resident of Elanora, who was originally from England:

> My family is far away, I'm originally from England (ES,Res,1F,83).

Reflecting the importance of virtual communities as a reality of modern life, another resident of Elanora who originally migrated to Australia as a young adult relied on Skype for communicating with her daughter who lived in Sydney, a few hours away from Elanora. Her daughter was her only family, and as a result of having a young family of her own, travel to Elanora on a regular basis was not an option. Therefore, virtual links were noted to be important:

> I don't have any family, because I only had one daughter and she died from a brain tumour (4 years ago). Then I lost my husband 2 years ago. Then I had an operation which paralysed me from waist down, and that all happened within the past 6 years. (ES,Res,5F,83)

This resident also commented that even though she had a granddaughter, she did not live in close proximity to a young family of her own. She mentioned therefore that Skype was a more viable method of regular communication rather than her grand-daughter travel to visit with three children under the age of five from New Castle to Sydney, which was a 2-hour drive.

Therefore, it was evident that proximity to family was critical in facilitating ongoing connectivity with a resident's family and with friends following their entry into residential aged care.

As well as proximity to family, proximity to services and transport was also highlighted in facilitating ease of access to get to the home as well as contributing to the quality of life of the resident by making it easy to stay connected to the outside world and the activities they enjoyed taking part in.

9.5.3 Proximity to services and retail

Of the four case studies, proximity to retail and services was particularly noted by the residents of Elanora and Dougherty. Due to her paralysis, an Elanora resident stated that the ease of being physically connected to the shopping centre across the road gave her a sense of independence:

> I was in [another home] for three years, and I loved it…but, I moved here, because my friend who comes to visit me often, the one who did the dusting for me the other day, she felt she had to look after me and she's not too well herself, so I thought if I moved closer. I'll be closer to her, and most importantly close to the shops just across the road, and yesterday, I went and paid my phone bill, which I couldn't have done at [the previous home]. So, although I had a lot of friends at [the previous home], I'm very glad I made the choice to move here, because I like it here close to the shops (ES,Res,2F,86).

This was also expressed by other Elanora residents:

> It's very handy with the shops just over the road … I go to a local restaurant across the road in the shopping village with the chap [resident in the facility] twice a week (ES,Res,5F,84).

Proximity to retail and services also, and providing access to transport was important:

> I am a social butterfly - I'm very social by nature and I don't like to be closed in. So, I like it here. It's spacious and beautiful, plenty of places to meet up and socialise, and just across the road from shopping centre (ES,Res,1F,83).

> When this was being built, I lived across the road, and I thought it looked very nice. So, because I was getting older and on my own, I put my name down on the waiting list, because it's important for me to live close to the shops. I was the second resident here, and had the whole place to myself. I have been in this area for twenty-eight years (ES,Res,5F,84).

For some residents, proximity to services was not important, as stated by a Dougherty resident, "...no I don't worry about shops, I've got all the clothes I want" (DA,Res,3F,94). However, proximity to services was significant to the majority of the interviewed residents at Dougherty, allowing them independence, activity and engagement. These were found to be important to the residents' health and wellbeing even when moving into higher needs care.

One Dougherty resident stated:

> It's important that shops are close by and I can go by myself. Like to have a banana every morning and before going to bed, so I go to the shops to buy my bananas (DA,Res,4M,73).

The shopping centre was also his preferred place to meet with his only family member, his sister, as well as a location of unplanned interaction with other residents of the home which made it a familiar environment for him:

> I go to the shopping centre if my sister phones up and says to meet up for a coffee at the shopping centre. With other residents, even though I don't plan to go out, we might bump into each other in the shopping centre (DA,Res,4M,73).

Shopping centres and shops were also enjoyed for passing time by looking around even though residents may not necessarily buy anything. They were viewed as a safe and vibrant destination reinforcing a sense of connection:

> I go to the shops every second day in my electric scooter and have a look around (ES,Res,5F,84).
>
> I love it! I love observing other people when I go out shopping (MF,Res,1F,88).
>
> I like watching people. I used to work in a legal section and I was in charge of the section, so observing people is a habit (DA,Res,3F,94).

Recreational activities in the community included frequenting popular venues such as the local RSL:

> I have a game of darts or snooker at the local RSL (ES,Res,3M,81).

Maintaining social ties in the community through regular activity, as well helping out fellow residents who might not be as mobile reflective community engagement levels:

> I have a chat with the newsagent every Sunday when I go to get the paper. I get one paper for myself, and one for my friend who lives here too (DA,Res,4M,73).
>
> I sometimes have lunch with a friend who I meet at the shopping centre (ES,Res,2F,86).

Recreational services incorporating the local neighbourhood were noted:

> We do group physical therapy outdoors at Monte two times a week. And we walk around the streets in the neighbourhood for exercise (MF,Res,2F,86).

External medical services were also accessed occasionally by residents, who had their own longstanding connections to family doctors, as well as other health related services in the local community:

> I visit the village shops very often to go to Podiatrist in the local community (GH,Res,1F,86).
>
> I go twice a month to the doctor's clinic up the road (DA,Res,5F,78).
>
> I had to learn to speak after my stroke, and went often to a speech therapist in the neighbourhood, but I don't go now (MF,Res,1F,88).

Coffee shops were shown to be the most favoured location for most residents:

> I go to the cafe at the community centre next door. It's very easy because it's connected to this building (DA,Res,1F,100).

> I go out with my nieces to have coffee at the shopping centre, when they come to visit (DA,Res,3F,94).
>
> I go to the coffee shop in the community centre with the nurse in my wheelchair almost every day (DA,Res,5F,78).

Also important was the public being able to access the home. The residents particularly appreciated the entertainment activities brought in:

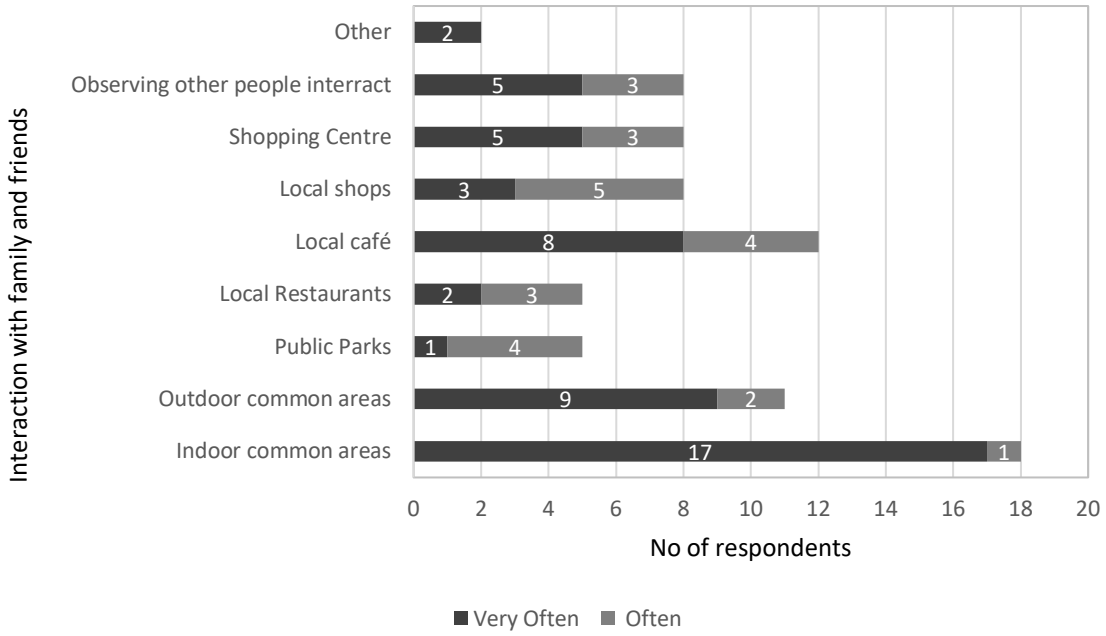
> People from the community come into Monte, to do various activities with us or for entertainment, which is important and I enjoy that (MF,Res,2F,86).
>
> Activities organised with people coming into this home for entertainment and interaction. It's important because it's the only entertainment some people get, only if someone comes in here, because no one comes to see them or take them out (DA,Res,1F,100).

Residents of the two facilities of the four case studies, which were situated in the closest proximity to retail and services were seen to particularly appreciate this aspect. These two facilities, Dougherty and Elanora were not only situated in close proximity, but had ease of access incorporating wheelchair access as well as visual access from the facility. frequent was particularly noted by the residents of Elanora and Dougherty. Proximity to services were seen to be more relevant, rather than shops, which could reflect the needs of higher care needs residents. However, shopping centres and shops were used as recreational spaces not necessarily for the need of purchasing goods but as a vibrant destination reinforcing a sense of connection. Coffee shops though were noted to be the most commonly used and enjoyed places to interact with others or by oneself.

9.5.4 Places of interaction with family and friends

Since family and friends were a primary community for residents, the nature and location of that interaction was important. The interviews revealed that most interaction with family and friends was within the care facility; the nature of the spaces for socialising within the facility were therefore of primary significance. As shown in figure 8.5, residents interacted with family and friends most often within the indoor common areas of the care home, while outdoor common areas were shown to be less frequently used. When they did interact out in the community, residents often did so with family.

Figure 9.4 Places and frequency of engagement with family and friends



The residents also noted that observing other people interact in the community was an activity they often indulged in. Trips out to the local shops and restaurants featured less frequently than interacting in shopping centres, while the local café was also mentioned as a popular place to intermingle with family and friends. However, particularly for the frailer residents, family visits centred around the family spending time at the care home. Notwithstanding the above, trips to familiar places and places of habitual interest were also viewed as important for residents as noted in the resident comments below.

A 101-year-old resident of Dougherty Apartments noted that she liked to frequent the nearby shopping centre with her family:

> Well I can only go out now if they take me. And I like to go out when my three children visit me to the shopping centre. I have two girls and a son, and grandchildren who visit (DA,Res,1F,100).

She also noted her recent picnic with her daughter:

> My daughter baked some cakes and they took me to the park and had a picnic, which was very nice (DA,Res,1F,100).

Some residents needed professional supervision to access the community. As the family of a Montefiore resident pointed out:

> She can't go out to public places unless supervised with other residents because of behaviour problems due to dementia (MF,Res,4F,97).

It is evident that most interaction with family and friends took place within the care home, although places in the local community were mentioned. As stated by the quoted resident and family member, this could be because of the higher care needs and specialised care required to assist the resident in accessing the local community. It was seen to be more comfortable and manageable le to interact with family and friends within the facility.

9.5.5 Interaction with visiting friends

Interaction with friends was not noted to be high due to many having outlived them, or because of the similar frail state of some of their friends. In the case of residents suffering from dementia, many were shunned by their friends, due to their illness, as indicated by the son of this 63-year-old at Montefiore:

> As a result of her dementia friends stay away from her. Her friends never visit here. But she now considers the paid companion as her friend who comes and takes her out and spends time with her. (MF,Res,5F,63)

This sentiment was reiterated by other residents even though they thought interacting with friends was important:

> Her friends never come to see her. They kept away when she got dementia (Daughter, GH,Res,2F,78).
>
> She now has just one friend who visits (GH,Res,3F,78).
>
> …well, friends are too old, so we can't meet up. Sometimes we phone (DA,Res,3F,94).

Location was also seen as a factor in limiting interaction with friends:

> I come from the country, so I don't have any friends here (DA,Res,4M,73).
>
> Friends are too far away to visit (DA,Res,5F,78.).

As the links to old friends and family faded, the sense of community and new friendships formed at the home was important for some:

> My friends are now the people here, and it's important to me that I'm with them (DA,Res,5F,78).
>
> …all my friends are now at Monte (MF,Res,2F,86).

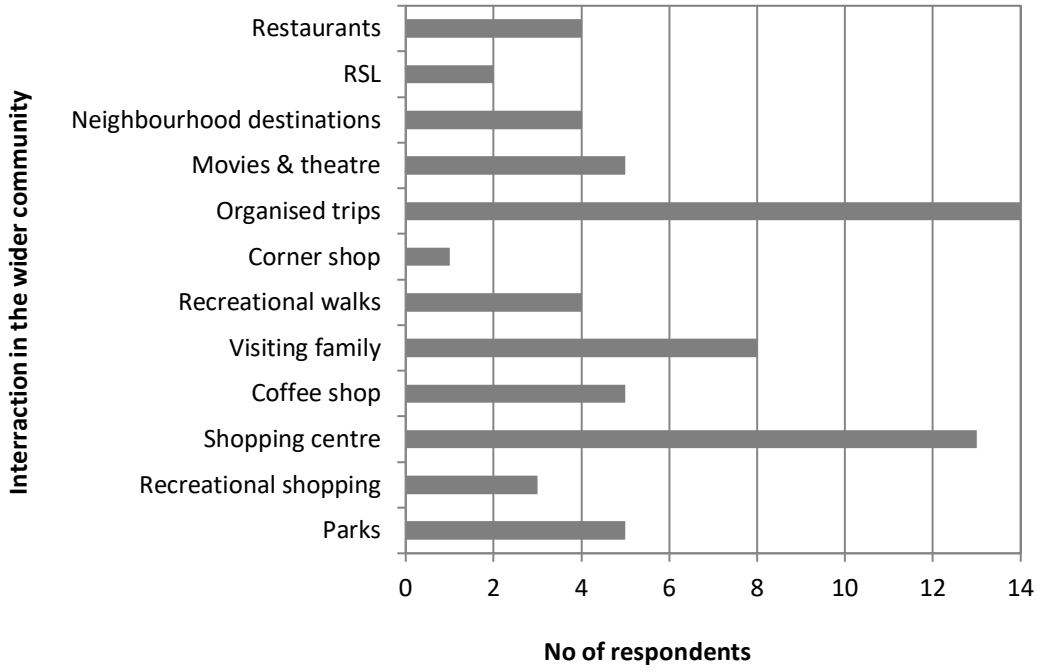
A common reason for lack of visitors stated by residents and family in all case studies was simply that they had outlived their friends, or that they were similarly frail and immobile. As a resident of Montefiore noted "I don't have many friends left, they're all dead" (MF,Res,3M,93).

9.5.6 Places of interaction in wider community

The residents' favoured local places of interaction which were mostly through organised activity, probably reflecting the higher care needs of residents, need for accompanying care workers, and other support structures.

As shown in Figure 8.6, most residents viewed organised trips to destinations of interest as their most common way of interacting with the wider community, followed by visiting the local shopping centre.

Figure 9.5 Places and frequency of engagement in the wider community



* Multiple answer question

Montefiore residents regularly walked around the block, mentioned as important in their daily lives, reacquainting them with a familiar, safe neighbourhood. The neighbourhood was primarily a residential area, with many blocks of multi-storey units, ranging from three to six storeys. It had relatively low traffic flows around Montefiore and well paved, tree lined, pedestrian pathways. In addition to extensive landscaped private grounds within Montefiore, it is also in close proximity to Centennial Park, a prominent public park in inner Sydney:

> We walk around the block twice a week for exercise, and we all walk to a restaurant at night, sometimes (MF,Res,2F,86).
>
> Yes, we might go to Centennial Park, when the kids come to take us out. They would drive us there and we'd spend time in the park (MF,Res,1F,88).

Dougherty Apartments similarly enjoyed a prime location, with parks and safe, pleasant pedestrian walkways in the neighbourhood - enjoyed and used by the residents regularly:

> Yes, my daughter makes cakes and puts them in a box and we go out to a park (DA,Res,1F,100).

Going to restaurants was less common amongst residents, but it was occasionally noted to be a destination when family visited or for a special occasion. Behavioural issues were cited by family, in choosing not to visit a public restaurant with a resident. On the occasion that residents did so, it was likely to be as a group activity organised by the home where residents were accompanied by their care workers:

> I only go out to a restaurant if it's a special birthday then they [the family] take me to a restaurant (DA,Res,3F,94).

Even higher needs care residents saw the connection with and accessibility to the community as important. An Elanora resident stated that although she could not walk, her mobility on her electric scooter enabled her to move around even outside the home:

> I go on the electric scooter every day to the shopping centre (ES,Res,5F,84).

Similarly, a resident at Elanora who was paralysed from the waist down (ES,Res,5F,84) and therefore unable to perform any personal care activities, gained mobility on her electric wheelchair. Her electric wheelchair enabled her to access the shopping centre unaided and meet with her friend there. It was of the utmost importance to her health and wellbeing.

Most residents of Montefiore, however, stated that there was no need to access services in the community as all services were available at Montefiore, a self-contained community. Others though cited physical limitations for inability to access the local neighbourhood:

> I'm not physically able to go to shops because I'm bedridden (DA,Res,5F,78).
>
> My daughter used to take me out, but now, with me in this chair, it's not possible (ES,Res,4M,85).

Age and ability level were noted by two residents as an impediment to using outdoor spaces in the local community, which impacted on the frequency of their outings brought on by decreased ability levels:

> I go outside with the nurse occasionally. I can't go on my own (DA,Res,5F,78).
>
> I'm too old to meet people outside; I'm in my 90s (DA,Res,3F,94).

Overall, accessing the local community for engagement and activities was important for the residents. This was mostly facilitated through organised activities enabling higher care residents to visit a variety of locations in the local community via various modes of integration.

Therefore, higher care needs were seen to impact on the frequency of community engagement as well as the places in which that engagement took place. However, it is important to note that in whatever degree or nature of interaction, accessing places in the local community was a desirable activity even for higher care needs residents.

9.6 Conclusion

This chapter has discussed findings of the interviews with residents and/or their families on their perspective on the importance of each of the three components of the CI-RAC model: the social, operational and built environments in the case study community integrated aged care facilities. The results indicate how interdependent the aspects of these three environments are in community integrated aged care and makes their relative importance difficult to ascertain. Many of the aspects of the social environment that residents identified and praised, such as the internal layout and access into the facility for non-residents, would not be possible without the facility's operational environment or the design elements of the built environment. Similarly, aspects of the built environment supported the framework of the operational environment as well as providing the basis for social interaction to take place.

So, what elements of the three components of community integration that were identified in the CI-RAC model were seen to be significant from the perspective of residents? In considering a supportive social environment, the residents identified their most important community as being their family and friends. Family and friends were seen to be important for residents to maintain connections and interactions with their wider community, even in cases where residents had infrequent visits from family or did not have close ties with them. In addressing the importance of the built environment, the element of location becomes important here. Distance from family was given as a reason by some residents to explain why they were unable to have more frequent contact with their family members, although technology such as 'Skype' was noted as a tool for a few to communicate with family and friends who were not in close proximity to the home.

Where this interaction took place, within or outside of the facility, as well as the nature of interaction depended on the organisational care model of the facility. This varied significantly. For example, Dougherty was more relaxed model in terms of access to and from the facility, also enabled by the familiarity of the facility in the local neighbourhood ensuring a natural policing of residents by the local community. In contrast, Montefiore had a high emphasis on security with carefully managed visitation times and policies in place. The Group Homes care model allowed access into the facility any time of day by registered family members who all had free

access to the combination lock at the front door, much like they would have access to their parents own home.

The local community outside the premises was another layer of community that residents considered important in terms of integration with their perceived community, particularly access to and interaction with shops, services and amenities. Location and ease of access to the local community was of particular significance in three of the four case studies at Elanora, Dougherty and Group Homes Australia. These three facilities relied on the service of shopping malls, coffee shops and public parks located in the local community for residents to access in order to develop and maintain interaction with the local inhabitants. Elanora and Dougherty also allowed the local community to access the facility for planned or volunteer activities, while Group Homes considered the care model to be that of a person's home, where a non-family member of community would not be able to freely access the facility. At Montefiore, interaction with the local community was undertaken mainly through a strictly managed system of volunteers from the local Jewish community as well as key professionals required for particular resident's needs. The interaction also took place within the complex, which had its own facilities such as pool, shops and coffee shops as well as an expansive garden catering for outdoor activity.

Visitors and volunteers to the home were also noted as a significant part of the residents' community, which helped to create a vibrant atmosphere, giving them a sense of being connected to society. Volunteers also provided mental and physical stimulation which may otherwise not have been experienced by residents if they were ageing in their own homes,

Staff were noted as an enabler of community integration for the residents, rather than a major component of what they considered to be their community. It was noted by residents that day to day functions for most residents who required higher needs care levels would not be possible without staff to facilitate a resident's ability to function in a normalised environment with dignity and quality of life. The quality of staff care therefore was an important secondary factor in supporting engagement with the wider community.

The findings also indicated that care needs did not seem to be associated with age. A resident's ability level likewise did not necessarily relate to their activity level or engagement with the community, as it was seen that even the highest care needs residents including those with varying degrees of dementia engaged in active participation in community and social activities.

Personal preferences being taken into account was also important in maintaining a sense of dignity and autonomy, even if this was an aspect that appeared to be planned into the care

model with the assistance of trained staff. This demonstrated the interconnected nature of the supportive social environment facilitated through a supportive operational environment in the delivery of care. The safety and sense of security the residents felt living in a professional care environment also facilitated a more active lifestyle and increased the quality of life of many residents. This indicates that even though staff were not seen as a community group to residents, they were an important enabler in residents maintaining a good quality of life and engaging in social interactions.

In considering the built environment, for a majority of higher needs residents, interaction mostly took place within the facility. This implies that the design of internal common spaces of the facility are important in fostering community integration. Shopping centres and cafes were noted as popular destinations for planned trips to public. This indicated the importance of proximity to town or village centres as well as ease off access to popular destinations in enabling community integration with the local community as well as socialising with family and friends.

Of the four facilities, Montefiore had a high degree of community integration which took place within the facility. By virtue of the facilities available, such as a café, restaurants, medical facilities, shopping facilities as well as being a facility situated within a large compound with landscaped gardens, it also had capacity to absorb community interaction with the outside world as well as the local community within the walls of the facility. Dougherty in contrast, is a facility which has good connectivity to the local community located in the heart of a town centre. Its residents mentioned accessing the local community with ease in daily life, such as the resident who walked to the shopping centre to buy his Sunday newspaper. Therefore, community interaction can take many forms, both with the residents accessing the local community, with integration taking place within the local community, as well as that which takes within the facility between residents, and with different layers of local community, family, service providers and visitors to the facility.

Access to the facility from the local community was also enabled by the care model. Group Homes functioned just as a regular home, with relationships developed between residents and their families, such as families of residents getting to know each other, and on occasions family members even assisting staff by picking them up at the train station or giving them a ride back to the station. It was observed by the researcher that the kitchen at Group Homes was a popular place for gathering and interaction, with residents taking part in normalised activity such as assisting with cooking or ironing in the living room in front of the television.

At Elanora, residents mentioned the ease of access to the nearby shopping centre as a popular mode of social interaction, but also the many planned activities within the facility. The in-house coffee shop and hairdresser was particularly noted to be popular. It was noted that living among other residents in similar circumstances fostered a sense of community. At Elanora, despite a community of 100 residents, the care model encouraged friendships to be formed with smaller groups around social activities, such as the knitting group. As discussed, in in the international exemplar included in this study, De Hogeweyk, smaller communities are created, within the larger community of the facility through the operational model grouping together like-minded residents and activities. This enables Comprehensible and Meaningful activities for residents according to their needs and interests, by creating a Manageable environment for those activities to take place.

These features demonstrate the capability of the facilities in enabling internal social interaction as well as affording interaction in the local community and reveals that it takes place in varying degrees and forms. Personal relationships and nature of interaction likewise were enabled by all three aspects of the social, operational and built environment, in different ways in the four facilities, some having a higher degree of permeability between the facility and the local community and some, in contrast, showing a higher capacity to absorb social and community interaction exclusively within the home. The nature of relationships developed between resident and local communities likewise also depended upon the nature of the care model of the facility, some encouraging a higher degree of connectivity with family such as at Group Homes, some with more contact and relationships developed with the local community such as Dougherty, and one with highly organised internal communities and social groups such as Montefiore.

This discussion highlights how, in practice, the receivers of residential aged care do not see the distinctions between the three components of the CI-RAC model proposed in Chapter 3 as clearly defined or delivered. They responded to how they experienced the care provided and the milieu the facilities created as they perceived it in a holistic fashion. The cross-cutting way in which the three components of the CI-RAC model are effectively integrated in practice will be picked up again in Chapter 10 in reflecting on the validity of the CI-RAC model in the light of the research findings.

As was observed from the analysis of stakeholder interviews, residents views of the experience of living in community integrated age care also reflect the principles of salutogenic theory, generally indicating a positive sense of coherence through perceiving their surrounding environment (organisational, social and physical) as structured and coherent

(comprehensibility), having the personal resources to cope with the challenges of life (manageability) and motivation to remain engaged with both the internal and external communities (meaningfulness). With regard to the built environment component, it is also consistent with Psychologically Supportive Design, also derived from salutogenic principles and applied hospital and aged care design (Dilani 2004; Lee et al, 2007), but extends the notion not only in the built environment, but as co-existing with a supportive social environment facilitated through a supportive operational environment. The relationship of these findings to salutogenic theory and Psychologically supportive design in the light of the proposed CI-RAC model developed for this thesis will be presented in more detail in the Discussion chapter.

Chapter 10: Discussion

This chapter discusses the synthesis of Parts 1 (Stakeholders) and 2 (Residents and their Families) of the findings of this research in relationship to the CI-RAC model proposed in Chapter 4, which was formulated through the theory and literature reviewed earlier in Chapters 2, 3 and 4. First, this chapter presents the research findings in relation to the nature of community as defined by the care providers and care receivers interviewed for the research.

Second, the chapter then summarises what the respondents understood to be the driving forces behind the development of a community integrated approach in residential aged care in Section 10.2. It describes the relevance of this research to the context in which residential aged care delivery is changing to a more consumer directed approach, as well as the changing demographic of a higher needs, yet more independent, older population with increased financial power. In turn, the benefits to providers, residents and their families in contextualising the relevance and viability of the CI-RAC model, is discussed.

Finally, this chapter then applies the findings to propose a further refinement of the CI-RAC model that incorporates three integrative cross-cutting dimensions – *permeability, porosity and propinquity*. These attempt to express how the three components work together in practice at a range of social and spatial scales to support the implementation of the principles of community integration.

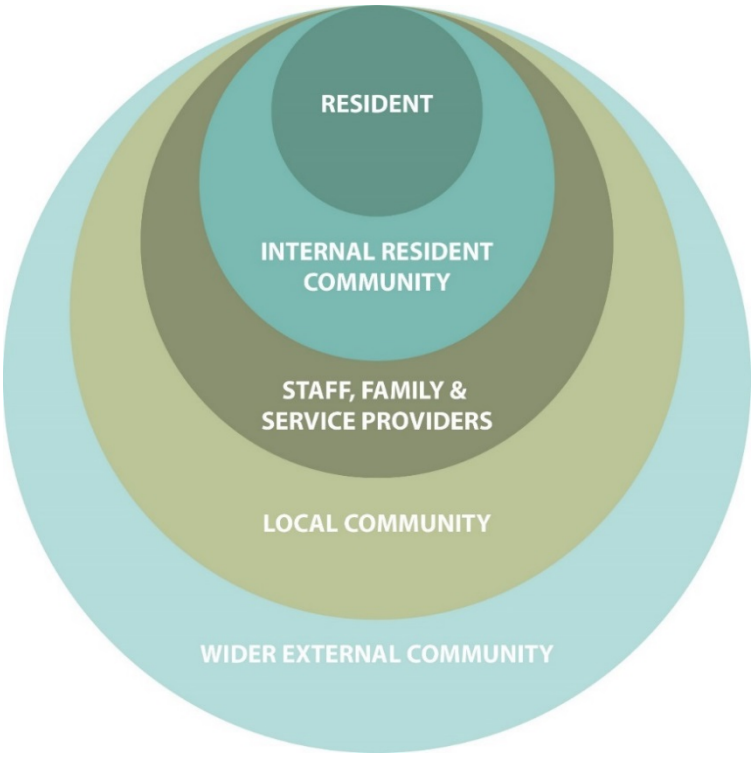
10.1 The nature of community in community integrated residential aged care.

A fundamental issue for this research was contextualising what constitutes 'community', in community integrated aged care (Section 3.5.1). Firstly, the literature review discussed concepts of community, which then were further refined as applicable to the socio-demographics of the ageing population, particularly those who require higher-needs care. As outlined in Section 4.1, the concept of community for the purpose of this study incorporates the combined dimensions of ecological aspects, social interactions, networks and support structures, as well as social responsibilities. In the case of what constitutes community for the ageing population, the schema presented by Lui et al, (2009) proposed key features of an age-friendly community identified by selected aged care case study models, noting aspects that enhanced the suitability of physical and social environments for declining physical and mental ability levels (Chapter 4, Table 4.4). In then incorporating the suitability of the physical and social environment to incorporate the dynamic of community integration, McColl et al state "integration involves relationships with others, independence in one's living situation and activities to fill one's time." (McColl et al. 2009, p. 17). Indeed, this research demonstrated that

for successful community integration to take place, it was not only the enabling physical and social environments that were important as proposed by Lui et al, but also an operational environment that enabled relationships with others, independence in one's living situation, as well as activities to fill one's time, as proposed by McColl et al. (McColl et al. 2009, p. 17). The CI-RAC model proposed in this research brings together both these concepts proposed by Lui et al and McColl et al, based on a theoretical foundation of the salutogenic theory. The three interrelated supportive environments of the CI-RAC model; social, operational, and built environments, then form the basis for successful community integration which was validated through the case studies of this research.

The results of the interviews revealed that community was a complex socio-spatial concept based on many different layers of social engagement, which could be independent or interdependent. The resident interviews (Chapter 9) revealed that social engagement varied in importance between individuals, subject to personal preferences, lifestyles and ability levels, corroborating with the literature review (Tornstam 2005; Altman et al. 1981; Nahemow 2000). At the onset of this research, it was assumed that community integration primarily referred to the integration of residents with the wider society (Section 3.2). While this was found to be so in all four case studies, a significant finding was the importance of the internal resident community and interaction between it and the wider community when that interaction took place within the care home. The lack of emphasis of the importance of the internal resident community to the sense of community is a shortcoming in the schema presented by Lui et al defining community integration exclusively in relation to the community external to the care facility. Figure 10.1 indicates the four socio-spatial layers of community that were identified from the resident and stakeholder interviews of this study.

Figure 10.1 Layers of community in community integration



10.1.1 The Internal Resident Community

The findings revealed that at a micro level, community starts with the individual resident's choices in the way they interact with others according to their need for privacy or social engagement. As noted by a resident in Dougherty Apartments, while the resident enjoyed the social interaction with other residents in the common areas of the facility, he also enjoyed sitting in his own room, looking out the window to the street and interacting at a distance perhaps by waving at a care worker who was walking down the street. Likewise, the way in which a particular space or environment is used by each individual also varies. As discussed in Chapter 8, the central kitchen at Group Homes was used as a meeting space between family members and the resident, while another resident may use it as a preferred reading space, another was observed using it to prepare food. From a salutogenic perspective, the accommodation for both privacy and solitude is consistent with Androvsky's (Antonovsky 1979) notion of *''manageability'*, having the resources available to choose to engage or disengage from community participation, as appropriate to one's needs and preferences. The design of the physical environment has an important role in supporting this. This is illustrated in the case of a resident at Dougherty Apartments, having the choice to wave every morning out the window to the care worker as she came into work. Having a room with a window overlooking the street provided the physical environment to enable this. Dougherty Apartments also had many different activity rooms, some catering to large groups, some for smaller groups

and even solitary activities to enable such choice, for example the dementia care resident who was observed by the researcher to be engaged in a word game drawn on the white board. Contrary to the challenging behaviour patterns that dementia care residents were noted to exhibit, this resident and many of the observed six residents at Group Homes Australia, exhibited a calm disposition engaged in activities of their choice. The physical environment of Group Homes was noted to be conducive to a variety of normalised activity, similar to those in a regular home environment. The design of the kitchen as an open plan in the large central area of the premises allowed for many residents to use that space in a meaningful way, such as meeting with family members, reading a book, having a cup of tea by themselves or with others, cooking, or eating, as unique to them(as noted in Chapter 9). In this respect, the salutogenic concepts of *manageability* and *comprehensibility* also become important, in accommodating the needs and preferences of how different individuals may use the same space in varying ways as *meaningful* to them (Milberg and Strang 2004).

As noted in the fourth case study of this research, Elanora, demonstrated, a supportive built environment both within the facility and surrounds as well as the main connection to the local community, the shopping centre, which was particularly conducive to making it a manageable comprehensible one. Many wheelchair-bound residents were observed to lead an independent lifestyle afforded by the wheelchair accessible pathways between the facility and the local community, connecting directly to the shopping centre opposite the facility. It was noted that the quadriplegic resident interviewed travelled on her own, in her wheelchair to pay her telephone bill, meet up with a friend or go to the shops, as the physical environment was *manageable* due to the design features catering to her ability levels. This also reflects Lawton's Environmental Press Theory (1973, 1983, 1990) discussed in Chapter 2, of the design of the ecological dimension of enabling coming integration by providing the right level of environmental press within the zone of maximum comfort, important for individuals of increased frailty and care needs. Likewise, by virtue of the clear visual access between the facility and the immediate neighbourhood including the shopping centre, the surroundings were *comprehensible* to the residents. They had clear orientation of where they were in relation to the aged care facility by virtue of its clear visibility and connective pathways, if they ventured out into the community. *Comprehensibility* and *meaningfulness* was further demonstrated in the internal layout at case study no 2, Montefiore, where the architect utilised 'memory boxes' to personalise the public private interface within the facility. The memory boxes were alcoves at the entry to the resident's private room which contained photographs, memorabilia and other objects of personal significance which gave the residents a sense of *comprehensibility*, by providing a connection to their past. The enabling of the continuation of their past makes their

environment more comprehensible. In this instance, *meaningfulness* is expressed through the ability to express individual ownership and identity, i.e. 'my place', and *manageability* is expressed through the ease of 'wayfinding'. Therefore, it seems that although salutongenesis breaks down sense of coherence (SOC) into these three aspects, in a particular situation they all need to be present for it to be considered salutogenic.

With the individual at the centre, the interaction in a resident's immediate surroundings takes place with the internal resident community. It was found that even though a resident may choose not to socially interact with other residents, their fellow residents were still an important component of their community influencing their day to day quality of life. As discussed in Chapter 9, a resident at Dougherty noted that the resident community had become her family. She noted that the residents look after each other as 'we are all in the same condition'. Another Elanora resident expressed that having a cup of coffee at the coffee shop located within the facility in the morning with his friend who was also a high care needs resident was an important social interaction (Chapter 9). Therefore, as expressed by a resident at Dougherty (Chapter 9) it was important for the residents to have a 'harmonious resident community'. Further, it was noted by the residents and stakeholder interviews, that this 'harmony' was largely facilitated through a supportive operational environment, due to the management of higher care needs of residents. For example, according to a manager at Dougherty, residents were educated regarding the needs and behavioural issues of Dementia residents, in order to facilitate better understanding among residents which led to creating a harmonious resident environment.

Many interview respondents expressed their satisfaction in living in a residential aged care environment with others who were facing similar challenges to them. There seemed to be an empathetic bond created through living in such a community of residents. A resident at Elanora expressed the intense loneliness she experienced while living in her own home, whereas in the Elanora community she had an active social life with likeminded people with whom she could choose to interact or not (Chapter 9). In terms of salutogenic principles the resident community enabled her to lead a *meaningful* life, through engaging with a likeminded community. Montefiore, is built on Jewish principles and cultural values. A resident interviewee expressed that she moved from her hometown of Canberra to Sydney particularly to live at Montefiore as all her friends were there which made it a meaningful community to her, as her friends were Jewish and the facility catered to particular Jewish customs and group social and cultural aspects. Another resident at Montefiore noted that he was living with his wife who was suffering from dementia, while he himself was a high care resident, who had little in common with the residents living on their floor level which catered for dementia residents,. This resident though

had a choice in the community he interacted with, choosing to socialise with his brother-in-law who resided on the floor above to whom he was very close. Living in a multi care level facility which incorporated opportunities for resident community integration within various care levels in the facility, enabled this resident to choose his community as meaningful to him and to maintaining relationships at a social level. A high care resident interviewee who was bedridden, mentioned that living at Dougherty enabled her to participate in activities she enjoyed even if it was going out to the coffee shop to meet with other residents aided by a care worker, or simply to observe social activities and feel a part of the community. Here the aspect of *manageability* is experienced by the resident. The personal care and specialised facilities provided in the care home enabled her to integrate socially. The resident staff ratio of all facilities also greatly enabled the higher care needs residents to engage in activities which otherwise would not be possible.

It should be noted that the variety of community integration initiatives that took place were also enabled by a supportive physical environment. In the case of Group Homes Australia, the central kitchen, served as dynamic meeting space. While many facilities could have a kitchen, as seen at Dougherty or Montefiore, this space was not accessible to the resident community, as the care model emphasised spaces such as the dining room or café for similar social interaction. However, the care model of Group Homes Australia emphasised that of the functioning of a regular home environment. Therefore, an accessible kitchen, where residents not only prepared food or partook in meals, but also accommodated regular socialising or solitary relaxation, was enabled through the large open plan kitchen located centrally within the home. In the case of Montefiore and Elanora, the coffee shop and hairdresser internal to the facility was noted as a positive feature enabling community integration between residents. A variety of internal spaces, such as a library, smaller activity rooms together with larger spaces allowed for a variety of activities enabling a psychosocially supportive environment. At Group Homes Australia, three residents were observed watching television together, while another resident was engaged in ironing clothes in the living room in front of the television. These were all high care dementia residents who used the same space in different ways. As noted in Appendix 1, all case studies had outdoor gardens where residents interacted, and even engaged in gardening activities. As theorised by salutogenic Theory, these examples demonstrate how the aspects of *comprehensibility, manageability, and meaningfulness* are operationalised within the case studies. In doing so, it supports the notion of psychosocially supportive design which enables a resident to easily engage in an activity in a safe environment (Dilani 2008; Wiesmann et al. 2009).

10.1.2 The Staff, Family and Service Provider Community

The next level of community identified in this research, are the staff, family and service providers. These groups had regular interaction within the facility as they either provided a service to the residents or facility or had personal reasons to access the facility. As such, the degree of interaction depended upon the ability or intention of the care model to incorporate and encourage such activities within the facility. Indeed, this layer of community was incorporated in different ways in the four case studies. For example, Montefiore utilised a highly organised volunteer scheme comprising largely of the local Jewish community accessing the facility as well as services accessing the facility which created a dynamic interactive environment within the facility. From a salutogenic perspective, *meaningfulness* is facilitated to the Jewish residents in Montefiori by a high degree of managed community volunteer participation from the local Jewish community providing connection to their cultural community. It also supports *comprehensibility* by representing what is 'familiar' and continuous with their past life experiences. Dougherty by virtue of its location next to a busy commercial centre and established residential neighbourhood has more permeable access and interaction with the local community. This allows a natural flow of the local community to easily access the facility.

Group Homes was freely accessible by family members at any time of day but did not allow for unplanned local community interaction as the model of care was based on a regular home environment model, much as a stranger would not walk into a home uninvited. Whilst contrary to the model of care used at Dougherty, the more intimate model of care utilised at Group Homes Australia also engenders salutogenic principles. They argued for a 'home like' environment whereby *comprehensibility* was supported by maintaining a home like atmosphere much like a regular home, as it provided a continuity of the past. The residents thereby experienced familiarity in the home, and visitors were family members and service providers who were familiar to them. This normalised environment also contributed to *meaningfulnes*s, as the activities and social interaction were not contrived by management, but those that occurred in a natural way much like the residents would interact with family members and invited guests in their own home. The physical and social environments were made manageable by incorporating universal design principles throughout the home. The high staff to resident ratio which was built into the management model, also enhances the residents' experience of manageability by providing the necessary levels of support in enabling a resident to engage in activity.

10.1.3 The Local Community

With respect to the third level of community, in all four facilities, engagement with members of the local community outside the facility was described as an important facilitator of the community integration. As a manager of Montefiore described (Chapter 6.4), the participation in social activities both by the residents as well as the local community created greater acceptance of the facility within the local community. The CEO of Group Homes Australia stated the importance of educating the local community on the needs of high care residents which enabled greater understanding between the local community and residents. This also gave community members a sense of civic responsibility, as well as benefitting residents maintaining social connections with their local community. Furthermore, by virtue of the education programs conducted by Group Homes Australia with the village shopping centre and local shops, a greater acceptance and understanding was enabled for the local community about residents needs and behavioural characteristics. This enabled social integration by enhancing the residents' *manageability* to interact with the local community. Likewise, *comprehensibility* can also be seen to increase due to the familiarity of the resident with the local community.

At Dougherty, the familiarity of the neighbourhood creates a psychosocially supportive environment for the residents and local community to engage. The natural surveillance and familiarity of the neighbourhood in which the facility is located, create a manageable environment for residents to mingle with the local community. As described by a facility manager, one of the more popular activities for the residents was to walk to the ice cream van in the local neighbourhood and eat an ice cream sitting by the village green.

10.1.4 The Wider External Community

The outer most layer of community identified in this research is the interaction with the wider external community beyond the local community. This layer of community had no immediate vested interest or regular need to access the facility to interact regularly with residents. Rather, it consisted of interactions that took place during events such as a special outing for the resident to a destination or event accompanied by family or an organised group activity by the facility. In a higher care needs environment, such activities required careful planning and resources due to the need for specialised care by care workers as well as enabling equipment. As such, these activities mostly were organised by the aged care facility, although occasional outings with family members were also mentioned. This layer of community interaction however was noted to be *meaningful* to residents as it represented a nostalgic activity in their younger years. It also represented a break from the familiar and the routine which was noted to be important in a resident's sense of maintaining connection with the wider world.

The sense of community fostered by all layers within the aged care facility and the relationships between residents were noted as key to the success of community integration. This was reflected in their willingness and ability to stay engaged and active within their capabilities. The individual differences and perceptions of residents influenced their choice of which community layer to engage with. The web of social relationships that were maintained between different layers of community, including both intimate relationships with family and close friends and more formal relationships with other individuals and groups, enabled the resident community to be socially integrated within the facility, as well as the local community. The layers of the theoretical underpinnings of this research reflect individual and group behaviour and demonstration of their incorporation into the physical world as discussed in Chapter 2 of this research, provide a framework to better understand the findings of this research.

However, a significant finding was that there was a clear difference between the perceptions of stakeholders and residents on what constituted 'community'. As noted in Chapter 6.2, all stakeholders regarded the resident community as the primary community they related to, with the staff as a close second. A second tier of community encompassed both visiting professional staff as well as family and friends of the residents. Other visitors and the local community were ranked at a third level. This stands in some contrast to the perceptions of community among residents who all placed their own family and friends as the primary community to whom they related, followed closely by the other residents of the faculty (Chapter 8.3). A second level comprised the local community and other visitors and volunteers. Visiting professional staff and facility staff were rated at a much lower third tier. Table 10.1 summarises the definitions presented by the two interviewed groups, of what comprised the 'community'.

Table 10.1 Stakeholder and resident definitions of 'community'

Community group	**Stakeholder ranking of community group (Fig 5.1)**	**Resident ranking of community group (Fig 8.3)**
Resident community	1st	2nd
Staff	2nd	6th
Family and friends	3rd	1st
Visiting services	3rd	5th
Local community	4th	3rd
Visitors and volunteers	5th	4th

Note: *Both surveys contained multiple answer questions relating to the definition of 'community'. However, stakeholders were asked to rank responses and residents were not. As such, the*

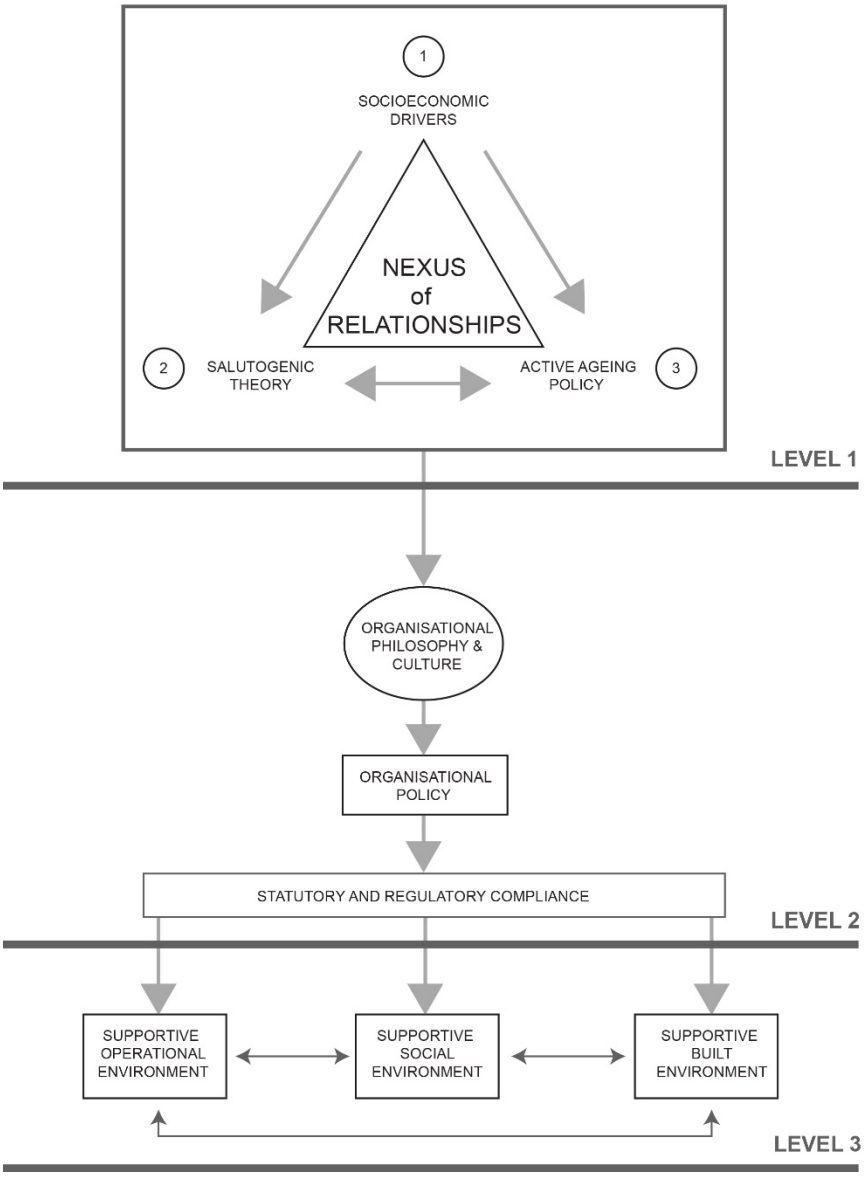
stakeholder ranking is based on first ranked responses only, and resident ranking on most frequent responses. Therefore, the data is recorded in each column differently, but while not comparable, they are indicative of different priorities.

The stakeholders who work in facilities that explicitly incorporate principles of community integration appear to conceptualise 'community' in a more internalised and limited way than did the residents and their families. The latter placed greater emphasis on the external family, friends and local community. Importantly, while stakeholders considered staff (both facility and professional) as key components of the community, these were least recognised by residents. This may be explained by the more operational and instrumental focus of stakeholders as opposed to the more experiential perspective of residents. It is not surprising that the residents themselves take centre stage for the stakeholders as the care provision must be tailored to the resident. For the stakeholders, it is delivering the aspects of *manageability* and *comprehensibility* though their operational model that enabled community integration. While for the residents, if that operational model was delivered successfully, the internal community particularly of residents was one that was seamlessly managed and was not so evident to residents. For the residents, community layer which was seen to be most important was the visiting family and friends who were regarded as *meaningful* to their lives. Visiting services though were seen to be of equal importance to both stakeholders and residents. By this we can deduce that visiting services were important to the stakeholders in the delivery of care that is *meaningful, manageable and comprehensible* to the resident, while they were equally important to residents in experiencing the care provided.

It is important to note that there is a significant overlap between the different layers of community. An example is the resident at Dougherty who engaged in his regular social interaction by watching the street below and exchanging pleasantries with his care worker coming into work. Here, the resident was taking part in a social activity engaging with the local community from the privacy of his own room via visual interaction. Therefore, these layers of community do not exist independent to each other, but concurrently, while demonstrating salutogenic principles within and across the different layers of community. The significance of the different layers also varies between individuals based on their personality, circumstances and ability levels. Thus, in the context of community integrated aged care, what constitutes community is both complex and highly personal.

10.2 Applying the CI-RAC model

Figure 10.2 A conceptual model of community integrated residential aged care (from Chapter 4, Figure 4.1)



10.2.1 Level 1 – Forces driving community integrated residential aged care

So, what are the key generic processes within the wider societal and policy environment that lie behind the current move towards better community integration in the provision of aged care facilities in Australia? The research provided material that provides a perspective on these drivers of change which are worth discussing here. As depicted in Figure 10.2, there were essentially two of these 'Level 1' factors – the rise of the Baby Boomer generation creating a growing demographic who are likely to demand this kind of care, and the perceived benefits from a wider range of stakeholders involved in the sector of key policy understandings relating to age care derived from theoretical advances. Although the socio-demographic change stood

out as its own entity, salutogenic theory and Active Ageing policy, as presented through the conceptual model of CI-RAC, were demonstrated in terms of the benefits of community integrated aged care to residents and their families as well as stakeholders.

i) Socio-demographic change

Interviews with stakeholders of the four case studies, as well as industry leaders, academics and providers (Chapters 5 to 7), highlighted the significant impending impact the aging baby boomer generation will have on the development of aged care provision (Chapter 5.3). Providers of aged care interviewed for this research considered this new population cohort to be a significant social driver of community integrated aged care due to baby boomers' independent outlook and the desire to stay connected to society. However, as discussed in the literature review in Chapter 5.3, this cohort are also at an increasingly higher risk of dependence on formal care in older age due to the increase in diabetes and dementia related illnesses resulting from increased longevity (Cruickshanks et al. 2017; Ginneken et al. 2017; Alzheimer's Association 2018; Dementia Australia 2019). Demands and expectations of the vast numbers of the baby boomer generation who desire to stay connected to society, but who may be unable to age in their own homes in their later, due to the need for and high cost of personal nursing care, are therefore an important driver of community integrated aged care reflecting of this important socio-demographic change.

As noted in Chapter 1, even though as a *percentage* of the population higher care needs have shown a decrease due to better care in the community provisions, there has been a marked increase in the *absolute numbers* residents requiring higher care as a result of cognitive decline in an increasingly aged older population(Dementia Australia 2019; Low et al. 2012). As discussed in Chapter 3, this observation is corroborated by WHO statistics indicating an increased percentage of those aged 85 years or older with some degree of cognitive decline and or an increase in Type 2 diabetes or Alzheimer's disease (McKinney 2011). Equally, in the Australian context, as discussed in Chapters 1 and 3, the numbers of older individuals suffering from dementia continues to indicate a marked increase (Dementia Australia 2019; Low et al. 2012; Paola 2017; Vanden Heuvel et al. 2012; Australian Government Productivity Commission 2008, 2018). Therefore, aged care processes will need to cater to this demographic of older individuals who are less competent, yet still retain the ability to be engaged with society. For individuals who require such higher needs care, an environment that provides formal specialised care, greatly enhances their ability to live a meaningful life with dignity (Paola 2017). This clearly points to a powerful social force driving community integration backed by

research endorsing the benefits of activity and social interaction on the health and wellbeing of older individuals.

Dementia was also found to be of increasing significance in terms of the care required, to all providers in the case studies due to the increasing numbers of people affected. However, as demonstrated in case study 3, Group Homes Australia, the changing views around managing the behavioural issues of dementia care sufferers as individuals capable of leading a normalised life within a managed environment, indicates this socio demographic change as a clear driver for informing care models and practice towards a community integrated approach (Paola 2017; Graff et al. 2007; Gitlin et al. 2008; Fratiglioni et al. 2000; Fratiglioni et al. 2004).

ii) Salutogenic theory and Active Ageing policy: Perceived benefits of community integrated residential aged care for providers, residents and families.

Residents and their interviewed family members expressed the importance of activity (within their capability) helping to maintain their independence (Section 8.4). They also noted that this contributed to a better quality of life. The families in turn, enjoyed peace of mind that their parents or loved ones were well looked after and were maintaining connections with society instead of being isolated and forgotten. This is consistent with the salutogenic theoretical framework selected for this study, as discussed in Chapter 2 of this thesis, which adopts a wellness model of care rather than catering solely to a person's sickness, with a focus on individuals experiencing a sense of coherence arising from the three contributing components of *comprehensibility, manageability, and meaningfulness (Lindström and Eriksson 2005; Eriksson and Lindström 2006)*. The current focus on Active Ageing within the policy framework, both nationally and internationally, as discussed in Chapter 3, also demonstrate the recognition of active and inclusive participation of the older population within communities, as one that enhances positive outcomes for health and wellbeing (World Health Organization 2002b). Salutogenic theory emphasises the engagement in meaningful activity of older individuals as having proven positive effects for biological function as well as meeting emotional and social needs. The social ties and networks of residents encouraged through a community integrated care model, were reported to have had a significant impact on the health and wellbeing of residents. In turn, residents were regarded as having a more positive disposition in behavioural issues particularly brought on by higher cognitive decline and diseases such as dementia. This consequently also impacted on care providers, both through reduced stress on care workers and management as well as generating a positive reputation for the home. It is worth mentioning here that the reputation of the care facility and provider is of utmost importance as

it could appeal to the aged care consumer. Hence bringing beneficial economic dividends to the aged care provider, in what is a competitive market of aged care provision.

As the stakeholders noted (Chapter 6.3), it was often the residents' families who were the decision makers in choosing a care facility for a family member who required formal care. In the view of the stakeholders, as well as family members interviewed for this study, a strong preference for their loved ones to engage in social activity and not be isolated was expressed. The family members particularly considered community integrated specialised care a desirable and acceptable solution where they were unable to provide the required level of care to their loved ones in their own homes. Therefore, the proceeding discussion demonstrates the provision of care in keeping with principles of salutogenic theory whereby a person's sense of coherence is enhanced by *comprehensibility, manageability, and meaningfulness*. It is suggested that this is better achieved for older people with higher-care needs in a specialised care environment (Brownie and Horstmanshof 2011b). As indicated by a manager at Elanora, *manageability* was reduced for older individuals requiring higher care needs as family members acting as informal carers lacked specialised training, equipment or resources in a family home. In addition, taking on the role of an informal carer resulted in stress on their own families coupled often with carer fatigue, confirming the view of (Zhang 2007). In turn, older individuals requiring higher care were not able to achieve *manageability* without required levels of support and care. As expressed by a respondent at Montefiore, with the diagnosis of advanced dementia of his wife, and he himself experiencing increased frailty with advancing age, he could not manage to perform even the basic functions of living in his own home. He expressed that living in at Montefiore gave him the resources to manage his daily living and lead an active life. The salutogenic concept of *meaningfulness* is also highlighted here as this resident expressed the ability to engage in meaningful activities such as socialising with his also ageing relative as a result of living in a multi care level facility such as Montefiore. This flexibility of choice in choosing the community of preference in social interaction in turn reflects the principles of active ageing policy, whereby a person's ability to remain active corelates to better health and wellbeing outcomes (WHO 2016; World Health Organization 2019b; Gonzales et al. 2015), Many interviewees also indicated that residents had improved health outcomes, through social integration as opposed to isolation, a view supported in the literature (Sagy et al. 1990; WHO 2016). This view was expressed by both groups of interview respondents; the stakeholders as well as residents and or their family. This finding could not be medically or psychologically verified in this research but was anecdotally reported by both stakeholder as well as residents and their families. The aspect of social integration was particularly apparent in the interviews with family members of dementia care residents (Section 8.4.2), where two family members

noted that their respective family members who had moved to the case study facility from a previous facility reported the resident to be isolated in a medicated state to manage his or her behavioural issues. She noted at Group Homes Australia her mother engaged in social activities without any medication, even managing to go for a walk up the road – a regular meaningful activity for her throughout her life – without assistance, although unobtrusive supervision was provided by a care worker who monitored her movements (Chapter 9). In keeping with WHO Active Ageing policy directives (WHO 2016), the provision of an adequate level of care to lead a meaningful, active life for those with higher care needs is central to increased health and wellbeing outcomes despite physical and mental decline brought on by advancing age. As the stakeholders noted (Chapter 6.3), it was often the residents' families who were the decision makers in choosing a care facility for a family member who required formal care. In the view of the stakeholders, as well as family members interviewed for this study, a strong preference for their loved ones to engage in social activity and not be isolated was expressed. The family members particularly considered community integrated specialised care a desirable and acceptable solution where they were unable to provide the required level of care to their loved ones in their own homes. Therefore, the proceeding discussion demonstrates the provision of care in keeping with principles of salutogenic theory whereby a person's sense of coherence is enhanced by *comprehensibility, manageability, and meaningfulness*. It is suggested that this is better achieved for older people with higher-care needs in a specialised care environment (Brownie and Horstmanshof 2011b). As indicated by a manager at Elanora, *manageability* was reduced for older individuals requiring higher care needs as family members acting as informal carers lacked specialised training, equipment or resources in a family home. In addition, taking on the role of an informal carer resulted in stress on their own families coupled often with carer fatigue, confirming the view of (Zhang 2007). In turn, older individuals requiring higher care were not able to achieve *manageability* without required levels of support and care. As expressed by a respondent at Montefiore, with the diagnosis of advanced dementia of his wife, and he himself experiencing increased frailty with advancing age, he could not manage to perform even the basic functions of living in his own home. He expressed that living in at Montefiore gave him the resources to manage his daily living, and lead an active life. The salutogenic concept of *meaningfulness* is also highlighted here as this resident expressed the ability to engage in meaningful activities such as socialising with his also ageing relative as a result of living in a multi care level facility such as Montefiore. This flexibility of choice in choosing the community of preference in social interaction in turn reflects the principles of active ageing policy, whereby a person's ability to remain active corelates to better health and wellbeing outcomes (WHO 2016; World Health Organization 2019b; Gonzales et al. 2015), Many interviewees also indicated that residents had improved health outcomes, through social

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The daughter of a resident suffering from severe dementia at Group Homes Australia stated that the cost of having the required level of constant care at home, was not within her economic capabilities, yet it was critical to this family member that her mother was not isolated and medicated but retained a degree of social connectivity. As a stakeholder interviewee at Group Homes expressed, this connectivity could be achieved if elders with similar problems and who needed continuous care lived in the same facility. In this way specialised services and their costs could be shared. Therefore, the inability to provide specialised care by family members taking on the role of a carer is a further driver of community integration of residential aged care (see Chapter 6.5).

It is evident from the current direction of policy in Australia that the state is increasingly transferring the financial responsibility for aged care onto the individual, due in part to the costs associated with a rapidly growing older population requiring higher needs care (Kendig 2017, 2010). The literature review noted that due to the disproportionately large increase in older populations around the globe as compared with the working population of a country, governments are becoming increasingly challenged to provide appropriate funding for the increasing older population (Herrmann 2012; May 2012a; Leibfried 2002). However, it was noted through the findings of this research, that community integration of older individuals requiring higher needs care is viewed favourably by families and residents themselves (Chapter 8). The baby boomer generation has the numerical and financial power to influence a consumer driven market, which will demand better solutions to residential aged care. The findings of this

research clearly pointed to this demand as a key factor supporting a community integrated approach to aged care within the higher needs group.

Given this understanding of the drivers of change toward community integrated models of care, the impact of community integration on aged care delivery models is discussed next.

10.2.2 Level 2 – The impact of community integration on aged care delivery models and practice; organisational philosophy, culture and policy, subject to statutory regulations.

This section discusses the second level of the CI-RAC model, the organisational philosophy, culture and policy supportive of community integration as viewed through the findings of this research. The statutory regulations which govern the delivery of care is also taken into consideration as the filter through which the organisational philosophy, culture and policy are translated in the delivery of care.

Corresponding with salutogenic theory and psychosocially supportive design, the central element adopted in the community integration initiatives of the selected case studies was the focus on a resident's *ability* rather than their *disability* level. For service providers, the initial driver of the nature of care was found to depend on the socio-demographic profile of the older individual seeking residential aged care. As revealed through the literature review in Chapters 3 and 4, the current and incoming residential aged care receivers were marked by higher cognitive decline brought on by advanced aged, as well higher percentages of those suffering from diseases such as dementia (Dementia Australia 2019), The findings of the four case studies indeed corroborated the evidence of the literature review, with all stakeholders noting increasing impact of residents entering residential aged care with significantly higher needs requiring constant formal care which was not economically feasible to be delivered individually to a person in their own homes. Formal care was also sought by family members who did not have the capacity to act as informal carers or meet the required care levels. For example, an interview respondent at Dougherty who had never married and had no family of her own, stated that she had never had the option of informal family care, and now needed constant care following a stroke. This was reflective of the literature review which noted the socio demography of the growing increase in single person households within the Australian context (Australian Government Productivity Commission 2018). Therefore, higher care needs requiring specialised care was noted to be increasingly influencing the nature of care provided.

It was the view of the majority of stakeholders that integration with the community greatly enabled an active meaningful life to residents. Contrary to keeping residents less active due to cognitive decline and other conditions of frailty, community integration was seen to be

particularly relevant for those with higher care needs in creating a meaningful life. This corroborates with the principles of salutogenic theory of *meaningfulness, comprehensibility and manageability*. Community integration was seen to foster meaningful relationships, which were made comprehensible and manageable to the residents who were not capable of engaging in social interactions without the interventions of specialised care and support. An example is an interviewed resident at Dougherty who was bed-ridden. However, she was lifted with specialised equipment and wheeled in a wheelchair to the coffeeshop adjacent the facility. This was a meaningful social engagement activity for the resident, which was made comprehensible and manageable through the supportive operational environment which provided trained care workers and specialised equipment. A supportive built environment was provided via the elevator in the facility and ease of access via a covered walkway to the coffee shop. In turn the coffee shop was a hub of activity which was used by residents and local community alike, creating a dynamic social environment. Engagement in activity according to a resident's ability level was considered an important aspect of community integration by both residents and stakeholders.

As revealed through the international exemplars discussed in Chapter 4, the form of the care model itself was first influenced by a care philosophy of the provider organisation which stated an interest in providing for positive health and wellbeing outcomes for the care receivers. As was seen in Humanitas Apartments for life (The Netherlands), Extra Care Housing (UK), Dementia Care Partnership (UK), and De Hodeweyk (The Netherlands), while the socio demographic change created the demand for more community integrated care approaches, it was the philosophy of the care provider which was crucial in influencing the development of the care model. Likewise, the four case studies in this research all demonstrated a visionary philosophy borne out of a need for the delivery of the particular model of community integrated care adopted. As described in Appendix 1 case studies, Dougherty was the brainchild of the then Mayor of Willoughby who recognised the need for aged care provision within the local community of Chatswood so older people could age in their own community maintaining their community linkages. Dougherty Apartments was therefore constructed as a joint venture between Willoughby City Council and the NSW Department of Housing. While Willoughby Council owned and donated the land for the aged care facility, the Department of Housing constructed the building on condition that there will always be allocation for public housing accommodation (Dougherty Apartments 2018). Montefiore likewise was borne out of the Jewish Community interests in serving the needs of their own local community. The location of Montefiore in the Eastern Suburbs of Sydney NSW, containing the largest Jewish community in Sydney, is testament to the community's interest in integrating their older population needing

care within the community. Group Homes Australia, likewise, was created to answer a need for high care dementia suffers and older individuals with neurological decline who needed high care to age in a normalised home-like environment integrated into the local community. While the residents may not necessarily be from the local community, however the care model envisaged by its CEO and founder is built on a care philosophy of better health and being outcomes to the high care needs ageing population through a normalised environment which includes integration with family, as well as the local community.

The policy review in Chapter 3 discussed the policy framework as applicable to the Australian aged care context. As noted in Section 3.3.2, Australia demonstrates a highly regulated federal government aged care delivery framework applicable to all aged care providers who receive federal government funding (Aged Care Quality and Safety Commission 2019). The delivery of care incorporating all levels of care, from low care to higher care needs is subject to the statutory regulations applicable in eight standards (Aged Care Quality and Safety Commission 2019). Therefore, as indicated in the CI-RAC model, the operationalising of the care model is filtered through the statutory national and state regulatory framework in the delivery of care to aged care residents in three inter-related domains, as discussed in the following section.

10.2.3 Level 3 – The three enablers of community integration

At the third level of the model the delivery of community integrated care was evident in three structural environmental domains; a supportive operational environment, a supportive social environment, and a supportive built environment. These domains are discussed based on empirical evidence in Chapters 6 to 9 as well as reflecting on the literature review (Sugiyama and Thompson 2007; Day 2008). Table 10.2 below provides mapping characteristics of community integrated aged care under the three supportive environments against the principles of salutogenic theory. Therefore it provides an illustrative summary of the ways in which the four case studies addressed community integration. The following section expands on this further, drawing on examples from the case studies to illustrate how the CI-RAC model aligns to the empirical evidence with regard to the three environmental domains – organisational, social and built form.

Table 10.2 Community integrated aged care and salutogenic theory

		COMMUNITY INTEGRATED RESIDENTIAL AGED CARE		
		Supportive Operational Environment	**Supportive Social Environment**	**Supportive Built Environment**
SENSE OF COHERENCE	**Comprehensibility**	• Age proof accommodation until death • Continuous care services until death • In-house (visiting) primary and allied health services • Specialised trained staff • Multi-care level environments • Education of residents, families and staff	• Ordered and predictable program of social events • Ordered and predictable program of external outings • Like-minded social groups • Variety of activities • Education of residents, families and staff	• Clear wayfinding • Invisible access control • Personalisation of private spaces • Personal control over access to private spaces • Accessible outdoor spaces • Variety of activity spaces • Safety and security (both psychological for the resident, as well as special needs security such as for dementia care residents)
	Manageability	• Flexible visiting hours for family and friends • Strong volunteer involvement • Invisible security systems • Education of local community to accept visiting residents • Trained staff for assistance in performing tasks • Assistance in accessing required levels of Government funding packages	• Choice for engagement in social activities • Intergenerational activities • Freedom of choice • Individual control over privacy • Staff assistance • In-house social activity • Planned social activity	• Multiple spatial options • Close proximity to retail and community facilities • Integrated community • Co-location with intergenerational facilities (Eg schools/kindergartens) • Universal design principles for accessibility • Safety and security • Well-designed visual and physical connections to the local community
	Meaningfulness	• Person-centred care model • No uniforms for staff • Wellness focus in staff training and attitudes • Normalised activities • Familiarisation of the facility for older people who live in the community should they require moving in to the facility in due course.	• Familiar local community • Flexible family/visitor access • Diverse spiritual activity options • De-segregation of dementia residents • Intergenerational activity • Normalised activities • Access to the local community	• Non-institutional building aesthetics • Similar building form and to surrounding built environment • Smalless of scale • Incorporation of public/community facilities in the facility • Physical/visual connection with nature through quality landscape design • Home-like environment • Non-clinical colours/décor • Visual connection with public realm

i) A supportive operational environment

The research revealed examples of how care providers' *operational* environments were structured to support a range of community integration outcomes for residents. A key feature, highlighting *comprehensibility* and *meaningfulness* in all four case studies, as noted in Table 10.1 was the nature of its care model to provide for age proof accommodation alongside advancing care needs. Therefore, residents could continue to live in their familiar aged care community which was noted to build and maintain community connections, developed throughout their stay in the facility. The General Manager of Elanora commented on the acquisition of land by Uniting Care directly opposite the Elanora facility with the view of extending further care levels from retirement living to acute care. Indeed, even within the existing Elanora facility, residents varying in ability levels to the highest care needs residents who were bed-ridden were accommodated. As noted in Appendix 1, Table 1, 2, 3 and 4, the wide variety in ability levels and care needs is clearly shown of residents interviewed in all four case studies. In this respect, trained care workers in specialised higher needs care is seen as critical in facilitating community integration of residents adding to the *manageability* of residents in leading a comprehensible and *meaningful* life as unique to them. Here, the notion of person centred care recognising that each resident has unique needs is critical in addressing all three components of *manageability*, *comprehensibility* and *meaningfulness*. The activities utilised, largely though planned activities in order to enable community integration varied according to the preferences of each individual with a focus on 'normalcy'. For example, the Group Homes model, which caters exclusively to high needs dementia residents, had a strong focus on residents' engagement in regular day to day activities in which each resident found purpose and meaning. They were not simply imposing group activities on residents, but activities that were aimed to engage the residents that were similar to what they had enjoyed in their residential environment prior to entering the home. This care philosophy demonstrates the salutogenic principles of *meaningfulness* via the familiar normalised activity which are also comprehensible to residents in their day to day life. Likewise, demonstrating *meaningfulness*, the General Manager of Elanora described gardening activities which the residents engaged in, both as observers as well as active participants, as a meaningful occupation for residents. This also served to promote intergenerational activity as the vegetable patch in the home was also tended by the local primary school children as part of a partnership between the school and the home. It was evident that a management model aligned with community integration principles is required to facilitate meaningful community integration initiatives. The *manageability* of these activities for higher care needs residents were facilitated by virtue of these activities being incorporated into the care plan, with the required care support levels provided by staff, as well

as the organised nature of the activities themselves which may not necessarily organically take place. The impact of adopting a community integrated approach to operational functions was seen to be generally positive in all four care models from the perspective of providers, other stakeholders, residents and their families. Specific comments by relatives addressed the more positive disposition of their family members receiving care, and a more active and engaged life due to non-medication such as at Group Homes (Chapter 9.4). Residents themselves also expressed their appreciation of the planned activities, and care worker support which enabled them to lead a meaningful active life (Chapter 9.3.6). Whilst a community integrated operational approach was regarded as increasing the positive profile of the home, it also aided in building positive relationships between the local community and aged care facility resulting in better understanding and acceptance of the facility and its residents. The increased transparency facilitated more diligent care by workers and management, a significant benefit to residents who were described as emotionally more stable in such an environment (Section 9.4.8).

However, there were some potentially negative impacts noted by management and providers on the operational aspects of community integrated aged care delivery models. One was an increase in operational costs if the management model did not efficiently incorporate community integration initiatives and implement them with diligence (Section 6.4). Another, in regard to higher needs care, was that if integration methods were not well managed in terms of cost and personnel within the care model, it could lead to the need for increased security measures or an increase in the number of staff, and hence cost. Adopting a community integrated management model did therefore impact on costs, as well as requiring more highly skilled and trained staff with understanding of the importance of the emotional needs and behavioural issues of higher needs care, including dementia (Section 6.5).

Another potentially negative impact was the disruption of care routines from the more flexible visiting hours or increased activity implied by community integration (Section 6.2). It was emphasised that incorporating these elements was meant to enhance, not disrupt, the care model. For example, the founder of Group Homes noted the importance of educating residents' families on the needs of dementia care, whilst also accommodating their preferences, privacy, independence and choice.

ii) A supportive social environment

Overall, the resident and stakeholder views recorded in the findings of this research indicated that an active social environment arising from a community integrated approach contributed to positive health and well-being outcomes. As summarised in Table 10.1, the success of a

supportive social environment demonstrated addressing all three components of *comprehensibility, manageability*, and *meaningfulness*. It was the view of the stakeholders that the care models of the case studies were supportive of providing a variety of activities to cater for a wide range of ability levels. This was key in ensuring each residents' needs were accommodated for in supporting their comprehensibility, manageability and meaningfulness as unique to each individual. The residents' views, expressed through the questionnaires, agreed that the activities provided in the facilities did recognise the non-linear and vastly varied ageing process of each individual. Here, the notions of privacy, individual preferences, choice of activities, and freedom of choice to residents in engaging or not engaging in activities were as critical as the availability of the activities themselves, in enhancing a person's sense of coherence. Indeed, the resident interviews revealed that having a variety of activities and engagement also enabled a choice in activities according to their individual preferences and social ties (Section 8.4). This approach was noted to encourage the residents' activity levels considerably, by 'keeping their spirits up' and forming new social bonds. In some instances, such as the case with dementia care residents in Group Homes, a family member noted that an active social environment had improved the residents' cognitive function (Section 8.3).

The lack of a shared sense of community created by the ageing population when they are excluded from society due to increased frailty, was particularly evident in the findings of this research. Many family members, particularly those with parents suffering from dementia related illness, referred to the abandonment of the residents by their regular social networks. The residents themselves often noted their lack of friends in the community due to their death, old age or inability to socialise or visit due to frailty. Encouraging interaction within the resident community of the residential aged care facility was itself seen as a method of successful community integration, through new patterns of interaction which were created with peers who shared common backgrounds and interests. This demonstrated that the formal care environment of an aged care facility vastly contributed to resident's *manageability* of social interaction and participation, as it had not occurred organically in their own home due to increased frailty.

Three of the four providers in this research, Montefiore, Elanora and Dougherty, expressed the distinct advantage they captured by providing a spectrum of care, which catered to a resident demography with different ability levels and care needs. This enabled the facility to provide a range of activities to suit different groups of residents providing choice for residents which in turn encouraged community integration (Section 6.3). This not only helped to create a diverse and dynamic resident community, but also made it feasible to provide a wide variety of activities through sharing services and resources, not possible in a smaller scale care model.

However, on the other hand, it was noted that Group Homes, while small and exclusively catering to dementia care residents, also provided several levels of care, as dementia itself is a vastly varying disease in terms of cognitive decline. Therefore, the Group Homes small scale, facilitated individualised and personalised care with engagement activities tailored to each resident. The small scale approach therefore was seen to address the three components of manageability, comprehensibility and meaningfulness in a more targeted and individualised manner required for the unique and diverse needs of dementia care, in order to enhance a successful community integrated approach of the social environment. The larger scale facilities such as Montefiore and Elanora addressed this aspect through creating smaller communities within the larger residential aged care community of the facility. These like-minded groups of residents or residents with similar care needs was seen to enhance the residents comprehensibility and meaningfulness through social integration. An example are the various hobby groups such as the knitting group at Elanora, which a resident interviewed noted was meaningful to her, as it was a familiar activity she enjoyed through interacting with a small group of likeminded people.

Education as a means of community integration was emphasised in the findings of this research (Section6.5). Education programs for residents are supported by studies that link physical decline with mental ability levels (Middleton et al. 2011). In addition, public education is benefitted with the incorporation of the increasing numbers of the older population into society and their continued engagement with society despite increasing cognitive decline (Middleton et al. 2011; Sumic et al. 2007). Both Elanora and Group Homes, engaged in active educational programs with the adjoining villages/shopping centres including training shopkeepers to identify and assist older residents with high care needs such as dementia, and the associated behavioural issues, thereby taking measures to improve the relationship between the residents and the local community by creating a more supportive environment of mutual understanding and easy communication. This was noted by the stakeholders as encouraging more socially positive behaviour in residents as well as building trust and understanding with the local community. This aspect of the interrelationship between the residents and their environment reflects the ecological model of ageing as discussed in Chapter 2, suggesting that behaviour is dependent on the qualities and dynamic interaction of both the people and the environment in which it is located (Wong and Candolin 2015).

The residents interviewed in the larger institutions in this study expressed their satisfaction in being a part of a large and diverse community, where bonds were formed at different levels of social interaction. There were residents in these homes who stated that they could choose their friends and what activities they wanted to be involved in when there was a larger community of

residents, while having the option of privacy when needed. These findings support the studies by Bennett et al (2006), who concluded that a larger social network size was better for increased cognitive function in Alzheimer's disease, where the social network size modified the association between pathology and cognitive function. Though this could not be demonstrated empirically through the findings of this research, the families of dementia care residents in two case studies, Montefiore and Group Homes, reported a marked improvement in health and wellbeing of their parents who were taken off all medication after having moved to their respective homes (Chapter 9). The family member observed that the resident become engaged in frequent meaningful activity as opposed to the medicated states experienced in their previous aged care homes.

The sense of community which was fostered among the residents was noted by most residents as a beneficial effect of living amongst a community of residents in 'similar circumstances' (Chapter 9). Sharing empathy and understanding was described by residents as being a source of comfort and companionship. While there were married couples, who were living together in some care homes each having different care needs, there were also couples who had formed relationships after entering the care facility. A friendship between a female and male resident of Elanora was described by the management of the facility as having had a positive impact on their health and wellbeing. The residents who were both interviewed indicated in turn that shared hobbies gave them a sense of purpose and joy in life. This example is also consistent with studies by sociologists, such as Cohen (Cohen 2004) who identified the links between the health and social networks of older people emphasising the importance of close friends and relatives, marital status, and affiliation to religious and volunteer associations, in terms of the strength of their connectivity and integration into their communities.

The Montefiore case study demonstrated the value to residents of cultural ties in supporting a strong community outcome (Chapter 8). One resident noted the importance of living in a community that understood her particular cultural identity and shared experiences, stating that most of her friends from the community were also now residents at Montefiore. This was woven into the care model of Montefiore, which employed specialised staff to attend to the needs of Jewish residents who had undergone shared traumatic experiences as holocaust survivors. It was noted by management that this brought distinct benefits to both family and residents through sharing experiences that had often not been discussed with families. In turn, residents played a role in educating local school children about their shared heritage, cultural values and history by sharing about such experiences.

Congruent with the salutogenic concept of *meaningfulness,* was the value of new bonds created within the resident community encouraging meaningful relationships. As noted in Chapter 9, a centenarian resident of Dougherty expressed that there was a common thread of understanding and acceptance creating a meaningful community as they were all in the same condition, therefore they look after each other. A resident from Elanora noted her satisfaction with being amongst a resident community, since prior to the stroke which precipitated her entry into residential aged care, she had been leading an increasingly isolated life as a widow with "only a bird to talk to" (Chapter 9). Therefore, the findings of this research demonstrated that moving into residential aged care which promoted elements of a community integrated care model, gave residents an opportunity to form new relationships and bonds with a like-minded cohort with shared social experiences. This was regarded as a much better alternative to ageing in one's own home which could be increasingly isolating due to the loss of mobility. Furthermore, the potential for forming new bonds within the facility supports the definition of community as demonstrated in this thesis (see Level 2 on Figure 9.1). As summarised in Table 10.1, a supportive social environment clearly demonstrated the validity of salutogenic theory as its foundational theoretical basis by highlighting the need for social activity to address all three aspects of comprehensibility, manageability and meaningfulness, within the social environment, for successful community integration.

iii) A supportive built environment

The role of the physical environment in aiding and promoting community integration was a significant finding of this research. As summarised in Table 10.1, the built environment characteristics of the case studies embodied a range of features that were congruent with salutogenic principles of *comprehensibility*, *manageability*, and *meaningfulness*, particularly with features such as universal design playing a central role in enabling residents to live a meaningful life. Notable emphasis was given to the appearance of the home not resembling an 'institution'. This was further strengthened by stakeholders and residents voicing that the scale and form of the building should reflect the characteristics of the surrounding built environment. Dilani's studies on salutogenic design principles in hospital settings (Dilani 2008), discussed in Chapter 2, similarly suggested many of the same characteristics in the context of these care homes reflecting designing for wellness instead of illness as well as designs which do not reflect traditional institutional characteristics.

The design and location of many traditional aged care institutions were seen by the stakeholders, as discussed in Chapter 7, to inhibit the integration of the institution into the surrounding environment. The stakeholders, as noted in Chapter 8, concluded that the design

characteristics of a traditional aged care institution represented isolation and segregation, reflecting a model of institutional hospital design. In line with these observations, the case studies of this research promoted integration through focusing on accessible user-friendly connections to the neighbourhood, including well paved pathways, accessible open green spaces, and the provision of a variety of spaces facilitating different activities, were all emphasised in the findings. These aspects of the built environment were confirmed by the stakeholders and residents (Section 7.2) as promoting activity and enabling social engagement amongst the older population.

The location of the facility was also identified as a very important factor enabling the care models to achieve their objectives for high care needs residents. The chosen four case studies demonstrate that residents were given opportunity to engage in interaction with community and organised activities, which was greatly aided by the location and design of the facility (Chapter 8). This is also consistent with the seminal ecological theory of Lawton's (1983) Environmental Press Theory on the significance of the design of the built environment in facilitating the ease of performing tasks with declining ability levels. Therefore, the architecture of the facility as well as the nature and design of the local neighbourhood, were found to be significant in reconciling higher-care needs and the ease of community integration.

Commenting on the built environment, some care workers noted in Chapter 7 that they would not like it if the facility was an 'institutional' environment devoid of social activity or connection with the local community. This reflects Psychosocially Supportive Design which promotes the design of a physical environment that caters for wellness rather than sickness. It also demonstrates that the three environments of a supportive operational environment, a supportive social environment, and a supportive built environment must co-exist, in order to provide for a combined living environment that incorporates the principles of salutogenic theory; *meaningfulness, manageability*, and *comprehensibility*. This research demonstrates therefore that community integration provides better outcomes for high-care residents and their families, as residents were seen to have a good quality of life through connectivity to the community and social engagement irrespective of their care level. Moreover, families had peace of mind that their loved ones were well looked after.

Clear wayfinding in the design both internal to the facility and for accessing the local community was highlighted in all four case studies. For example the personalisation of space with 'memory boxes' at the entry to every room at Montefiore, enhanced a residents comprehensibility in relating to the space as their own, as well as meaningfulness through the memorabilia in each individual memory box meaningful to the resident. These individualised spaces therefore were

important way-finding tools for residents to recognise the location of their own room enhancing a residents manageability. At Elanora, the direct visual access to the adjoining shopping centre and paved accessible pathways provided clear way finding cues to the local community, supporting a resident's sense of coherence through comprehensibility, manageability and meaningfulness.

For residents, accessible outdoor spaces were important. In this regard, safety and security in being able to access outdoor spaces were also important. The care model of Group Homes with emphasis on the function of the facility exactly that of a regular home, had a well utilised back garden within the premises. Although, the low-density residential neighbourhood was also conducing for the care workers to easily and safely organise walks around the neighbourhood for residents. Dougherty on the other hand was situated in the midst of public parks and gardens, which by virtue of the visual connection to the facility, were easily and safely accessible by residents with their care workers or on their own depending on their ability levels.

Safety and security (both psychological for the resident, as well as special needs security such as for dementia care residents) was an important aspect that was noted to inhibit or enhance a resident's sense of coherence. Montefiore was a high security facility largely due to the security concerns pertaining to the Jewish community. The enhanced security measures were seen as critical for residents many of whom were holocaust survivors for their psychological wellbeing in leading a meaningful life knowing that their living environment was secure. It also was considered a high priority practical concern for the Jewish community in the current context of ethnic tensions. Therefore the design of the built form incorporates security barriers and other measures with community integration encouraged between the local community and the facility to take place within the facility. The availability of ample garden spaces accommodating for a variety of activities, as well as shops, restaurant, hydrotherapy pool and other amenities such as hair dresser and dentist within the facility enables community integration through the built form.

Dougherty shared direct access to the coffee shop which was also frequented by the public as well as the adjoining community centre. This greatly enhanced community integration with residents, through the provision of direct access for residents via a covered connection, which made it manageable even for higher care residents to navigate. This ease of access also enhanced their comprehensibility and meaningfulness by being connected to the larger community. Co-location with facilities such as the kindergarten adjacent Montefiore further enhanced community integration through encouraging intergenerational connections. However, it should be noted that all four case studies incorporated intergenerational activities in

conjunction with local schools. An example of the built environment aiding intergenerational activity is the vegetable patch within the facility grounds at Elanora which was tended to by the local school children who interacted with the residents in gardening activities. The general manager of Elanora as discussed in Chapter 7, commented on the participation by school children in gardening activities as meaningful to the residents. Its location within the facility grounds made it more manageable for the residents to engage, as well as comprehensible.

A physical environment that supports residents' *manageability* is discussed in Section 9.5. However, as stipulated in Psychosocially Supportive Design (Dilani 2008), it is not only the ecological aspects that provide for a manageable environment, it is also the supportive social environment that encourages one to engage, as well as the operational environment that caters to and enables activity and engagement through supportive interventions, such as specialised trained staff, equipment and appropriate organised activity.

10.3 A conceptual schema to support the delivery of the CI-RAC model

So far, this chapter has reviewed some of the key findings from the research that support the CI-RAC model developed following the literature review in Chapter 2, 3 and 4. The findings demonstrate the attributes of residential aged care that, it is argued, support the development of community integration within aged care facilities as well as between the internal and external communities that interact with residents. Examples from the four case studies have been used to illustrate how the three components of the model – the social, operational and built environments that comprise the care model of each facility – work to generate aspects broadly in line with community integration principles.

But it was clear from the interviews, especially those with the residents, that it was difficult to isolate the individual effects of the three components in practice. Rather, stakeholders and residents (and their families) perceived the model of care in a more holistic fashion, with aspects of each component acting to support or reinforce the other. In other words, the three-component model did not adequately convey the manner by which they worked together in an integrated way to deliver community integration outcomes in practice. Consequently, in this next section, the discussion is taken to a more abstract level by developing a schema that helps explain how the three components of the CI-RAC model work together to best achieve community integration.

The basic premise here is that these integrative cross-cutting dimensions need to be articulated in the design of a residential aged care facility in order to achieve the requisite level of community integration. The three dimensions of community integration that might be conceived of as weaving together the components of the CI-RAC model have been termed

permeability, *porosity* and *propinquity* – hereafter referred to as 'PPP'. These three dimensions can be best understood as working at a range of spatial and social scales across the five levels of community as defined in Section 10.1 (and Figure 10.1) to optimise residents' interaction and engagement both within the facility and with the outside community. The definition of community derived from the research therefore prompted a critical reflection on the initial CI-RAC model to better express how community integrated care is delivered through the interaction of the three components.

The PPP schema offers a useful set of assessment criteria or a checklist against which the management and design of an aged care faculty might be evaluated to ensure that an optimal outcome for residents is achieved. As will be clear, the PPP schema brings together aspects of all three components of the CI-RAC model, emphasising how they interact together at different scales of activity and engagement.

> ***Permeability*** refers to the social and spatial aspects of a facility that supports interaction between the facility itself and community beyond the front gate, especially in terms of allowing residents to move easily between these two worlds as well as supporting an interaction and accessibility from outside the facility. Therefore, *permeability* is used here to refer to the ability to pass through (or over) the boundary of the residential care facility property both socially and spatially.
>
> ***Porosity*** refers to the way the facility is organised and designed to support the building of social ties by enabling and/or regulating the level of either social interaction or privacy as desired by the residents. The definition of porosity is socially analogous to people being able to flow easily within an environment. The term porosity is therefore used here to refer to the ability of the care home to allow easy passage between spaces and people within the facility to support residents' preference and choice.
>
> ***Propinquity*** refers to the aspects of the facility that actively encourage residents to interact at a personal level, including aspects of the philosophy of the facility that encourage residents to build close social relationships and engage in communal activities. Reference could also be made to the behavioural field of 'proxemics' where propinquity has been applied to social and physical space. Broadly put, proxemics is "the branch of knowledge that deals with the amount of space that people feel is necessary to set between themselves and others" (The Merriam-Webster Dictionary 2018). Here the term can be thought of to include both the notions of social and physical nearness.

Arguably, a community integrated residential aged care facility should incorporate all three PPP dimensions to be considered to be successfully supporting community integration. The ways in which the four case studies responded to community integration in accordance with these three dimensions in conjunction with the components of the CI-RAC model are discussed below.

The schema below summarises a range of specific characteristics of the three components of CI-RAC against the three dimensions of effective community integration identified from examples drawn from the findings.

Figure 10.3 A Conceptual schema of community integration for residential aged care

Socio-spatial dimensions influencing community integration of a facility			
Community integration for residential aged care	Permeability	Porosity	Propinquity
Operational environment	Operational aspects that encourage access to and from the facility	Operational aspects that support movement and contact within the facility	Operational aspects that provide opportunities for residents to build social relations
Social environment	Aspects of the facility that support community interaction with the external community	Aspects of the facility that support community integration within the residential community	Aspects of the facility that engender positive and harmonious relations
Built environment	Physical aspects of the scheme that provide ease of access to and from the facility	Internal design aspects and layout within the facility that encourage activities and social encounters	Provision of spaces that support close interaction with residents and staff.

The following section explores how the three components of the CI-RAC model can incorporate the essential features of the three dimensions outlined above in more detail. Here we focus on

aspects of the four care models that illustrate how the three dimensions are incorporated to support the broad principles of community integration in practice.

10.3.1 Supportive operational environment

Permeability

Permeability of the operational environment is understood here to refer to those aspects of the policy and practice of management of the facility that encourage access to and from the facility that are supportive of and enable community integrated aged care relevant to that facility. This was largely an outcome of the philosophical bass of the care model itself such that the facility was set up and run to expose the residents to safe and manageable interactions with its external community. Some might have an open visitor approach, while others might have a much more managed approach to control the level of access, as noted above.

For example, having a volunteer base from the community was identified as particularly important by some stakeholder respondents, not only for participating in resident activities and providing support, but also supporting the financial model of facilities by taking on less specialised roles thereby leaving trained care workers to attend to needs of higher-care needs residents. Consequently, the volunteer base was identified as a key group which could aid in permeability, facilitating residents accessing the community as well as the community in the form of volunteers visiting the facility. The volunteer base was seen to be most effective when it was embedded in the operational structure. Particularly in higher needs care, the appropriateness and skill level of the volunteer base as well as their degree of commitment to deliver unpaid volunteer services was seen to be critical. However, if this was not closely monitored or managed a well-meaning volunteer base could easily be a hindrance rather than a facilitator of community. Hence it was noted that reliance on a volunteer base was not ideal, as it also required a high degree of management support. It was noted that the not for profit organisations included in this study relied more on volunteers and donations to meet their care model objectives, due to limited government funding. The organised, structured and supervised events and activities also contributed to creating permeability. An example are the intergenerational activities, such as regular visits by school children to the Elanora facility in tending the vegetable garden with residents.

Porosity

The *porosity* of the operational environment refers to those aspects of the organisation that support movement and contact within the facility. Provider philosophy was identified in Chapter 5 as the foundation of a community integrated care model which reflected the core

values of the organisation. Encouraging a porous internal environment could be seen to positively enhance the way care was delivered by supporting movement and contact within the facility. These aspects included the provision of services respecting an individual's dignity, individuality, privacy, choice and autonomy, as well as providing a sense of security to the resident in order to lead a life supportive of wellness. All these aspects resulted in an increase in confidence to take part in community integrated activities within the facility with the knowledge that they were looked after with constant access to specialised care when needed. Of the four case studies, for security reasons, Montefiore could be thought of having a high degree of *porosity* within the facility. In many ways, this could be seen as an 'introverted' care model in keeping with the gated community lifestyle of its residents and tight knit community nature of the local Jewish community. Despite a rather impervious exterior, a high degree of interaction and activity took place within the facility. Therefore, the provider philosophy in support of this approach was seen to be an integral aspect influencing the degree and success of community integration particularly within the facility.

Propinquity

The dimension of *propinquity* within the operational environment are those aspects that provide opportunities for residents to build social relations of their choice facilitated by the operational structure. As discussed in the resident findings Chapter 9, a key element in facilitating relationships and building community within the organisation, is also a recognition and respect for individual preferences, privacy and respect for resident choice, as much as encouraging social interaction and activity. Organised activities were seen as the primary mode of relationship building particularly in higher needs care as residents relied on a certain level of care support to enable them to socialise given higher care needs. So, for example, Elanora, with a resident population of 100, implemented a 'household' model of care whereby the social needs and care giving was delivered to smaller groups of like-minded residents. This approach can be seen as supporrting propinquity between a sub-group of residents. Similarly, Dougherty demonstrated that relationships were maintained through its 'ageing in place' model incorporating the ability of a resident to remain at the facility despite increased care needs, thereby retaining social ties and friendships over a longer period. Meaningful activity such as engaging in regular household chores or gardening built into the operational structure also facilitated *propinquity*.

10.3.2 A supportive social environment

Permeability

Permeability of the social environment includes the aspects of the facility that support community interaction with the external community. These include both the planned and unplanned opportunities for residents to engage with the external community. For example, as described in Chapter 9, one resident enjoyed his daily routine of walking to the nearby newsagent to buy the newspaper and interacting with the shop owner. This was an important daily activity for this resident which he suggested he would not engage in if he were to live in his own home as he is at risk of having a stroke. He is known as a resident of the care facility and is aware that the necessary care would be available immediately in the facility if he became ill and he feels safe engaging in this daily routine, which normalises his life.

Likewise, *permeability* of the social environment also includes the external community coming into the facility. The four case studies demonstrated *permeability* in this regard in different ways which could be planned or unplanned. Facilities such as Dougherty permitted a greater degree of unplanned visitors to the facility from the community, such as visitors from overseas to the conference centre nearby. Montefiore had a greater degree of planned social interactions largely with the local Jewish community, such as intergenerational activities with residents vising the local Jewish school, providing opportunities for the younger generation to hear the stories of their elders. Planned excursions to destinations were an activity that were observed in all four case studies engendering community integration. Group Homes arranged regular shopping trips for residents to the village centre. This activity was facilitated by the CEO of Group Homes who also conducted educational programs for the local community in the needs of higher care dementia residents, as social integration of the residents into the community was seen as a two-way process of the community accepting the residents as well as the residents being able to mingle socially with the local community.

Porosity

Porosity of the social environment represents those aspects of the facility that support community integration within the residential community. The four case studies valued this aspect as an integral part of community integration, from both resident and stakeholder perspectives. Indeed, at the outset of this research the internal resident community and its cohesiveness was not envisaged to be an important aspect of community integration, as the interaction with the local or external community was what was understood to be more relevant for community integration. However, the findings demonstrated that the importance of bonds

formed within the resident community was a key factor in facilitating CI-RAC. A resident at Dougherty noted that looking out for each other made the community within the facility a pleasant and harmonious one. She noted that her friend, a much younger resident who she looks upon as a brother, always came to fetch her if anything interesting was going on in the facility. At Elanora, an interviewed resident noted the importance of the social interaction within the resident knitting club which met once a week. A resident living with his wife who was in a higher care needs situation than he was, noted that he could socialise with people who were more mentally able by virtue of the facility accommodating different levels of care. Group Homes highlighted normal activity such as cooking, cleaning, ironing, gardening and other such activities in facilitating relationships amongst residents.

Propinquity

Noting the complex, multi-dimensional nature of who constitutes their community, it was important for residents to have choice in forming their relationships according to their own needs. The right of residents to choose the degree of social distance that meets their needs and desires at a particular point in time, denotes Altman's notion of privacy as selective control of access to the self or one's group (Altman 1976). In terms of the social environment it means having the freedom to choose the level of interaction appropriate to the circumstances.

Building social relationships primarily included meaningful activities with a focus on supporting and maintaining community cohesiveness, including relationships within the resident community. An example of this is the 'memory boxes' at Montefiore, which create individuality as the residents' could furnish them according to their preference. Therefore the individual memorabilia in the boxes also created points of conversation between residents as well as serving as visual way-finding cues. Other activities that aligned with this dimension included spiritual activity. At Dougherty, residents could participate in or not according to their individual faith, with provision made by the facility accordingly. This was noted to be a positive form of community integration by those who considered spiritual activity, and connecting to likeminded residents through spiritual activity, to be meaningful to their lives. Recognition of individual choice and preferences was noted to be key in spiritual engagement or non-engagement.

Aspects of educational activities provided for residents as well as staff, particularly those administering or receiving higher-needs care, created a more empathetic and understanding community within the facility. Education raises tolerance of behaviour patterns that go hand in hand with cognitive decline.

10.3.3 Supportive built environment

Permeability

A key aspect here is the ease of and opportunity for residents to access the external community as well as for people in the neighbourhood to access the facility. *Permeability* is therefore influenced by particular design features unique to each facility and was seen to be primarily facilitated by the location of the facility together with its care model. However, location alone was not seen to offer permeability unless the care model supported community interaction. Assuming that was the case, location greatly enhanced those opportunities offered by the care model of the facility. Dougherty and Elanora, by virtue of the safe accessways connecting the local shopping and other amenities to the facility, demonstrated a greater ease of access for residents to access the local community as well as the external community to access the facility. The new refurbishment underway at Dougherty at the time of this research was being undertaken with a specific focus on increasing community integration via common service facilities attached to the facility such as a community centre.

Montefiore on the contrary was a gated community, with its design features deliberately enhancing high security and inaccessibility by the local community at large. It should be noted however that this facility is located in the heart of the Jewish community in the Eastern Suburbs of Sydney. Therefore, by virtue of its location many families in the local community accessing the facility had relatives or friends living in the facility which provided them with security cleared access to the facility. Indeed, as noted above, within the walls of the facility is a hub of social activity, with the provision of shops, a café, restaurant, hydrotherapy pool, and manicured gardens designed for social interaction. The facilities could also be used by the external community visiting residents, as long as they had authorisation to enter the facility. Group Homes did not have specifically designed access ways linking to the community as its care model supported social interaction exactly as one would within their own home. Its location within a residential enclave within proximity to the village centre, however, facilitated *permeability*. As referred to in Chapter 7, the residents were often invited by a neighbour for tea, when she saw other residents from her window going for a walk every day. Therefore, the visibility of the neighbourhood with residences opening out to the street front without high walls, made this familiarity possible.

Porosity

The dimension of porosity included the internal design elements and layout within the facility that encourage activities and social encounters. These included indoor spaces that were inviting

with ample access to natural light as well as outdoor areas. Views out to the street and community activity, where residents could observe, created a sense of connection to the outside world. Views out to greenery, even in the high-density facilities, were achieved through the introduction of courtyards and landscaped spaces. These spaces were seen to generate much interaction, including being used for cross-generational interaction, with school children taking part in gardening programs with seniors.

Ambulatory access and ease of 'way-finding' with familiar 'prompts' were other features that were incorporated into all case studies, to reduce the institutional feel of the facilities, and create spaces that were familiar and conducive for interaction between residents and visitors. Group Homes, Australia, was designed around an open plan kitchen which was accessible to residents as the heart of the home. The memory boxes incorporated into the design of Montefiore noted above, also supported wayfinding by reminding people which is their room. Dougherty Apartments introduced a variety of spaces for residents where they could either congregate or spend in solitude, such as the library, games rooms, multipurpose rooms, garden and courtyard spaces. Elanora was designed with an emphasis on integration with the surrounding area, with its built form reflecting the scale and feel of the adjacent buildings, creating a sense of community integration. In addition, it was designed with excellent connectivity to the shopping centre via well-lit ambulatory pathways for residents to access the external community. The café spaces at Elanora and Montefiore were strategically placed at their entrances to create a high degree of activity and integration with residents and the outside community. Dougherty apartments further had direct covered access to the adjacent community centre café which was also used by the general community.

Propinquity

The dimension of *propinquity* supporting community integration, is the provision of spaces that support different levels of interaction with residents and staff of the facility according to the needs and wishes of residents. Particularly in higher needs care environments, a sense of safety for residents choosing to engage in activities and circulate in the internal community appeared to facilitate resident movement without fear of falls and other risks that prevented them from active engagement. A built environment designed to enable residents to safely access and engage in activity, was noted as a positive feature of living in a care facility supportive of community integration principles of care.

Many higher needs care residents including some of those residents interviewed even though incapacitated, noted that they enjoyed having a variety of spaces that they could socialise in even though their movement was restricted. Simply to sit in the sun as observed by one resident

(Chapter 9) was a pleasant activity. The common spaces at Elanora were varied such as the internal café, lounge rooms, and outdoor BBQ areas for meeting up with visitors. Group Homes had a spacious kitchen with ample seating and alcoves, as well as a spacious lounge room and landscaped gardens offering diverse spatial opportunities for socialising.

10.4 Conclusion

In examining what constitutes 'community', in community integrated aged care, an original contribution of this research is presented in the form of a four layered conceptualisation of community (Figure 10.1 Layers of community in community integration). This conceptualisation is based on the empirical evidence of the groups of community that constituted the resident views of community, as well as those views of the management and care workers of the facility. With the individual resident as the starting point, the first layer of community for residents was the internal resident community. The second later is the staff, family and service provider community. The third layer is the local community, with the fifth layer being the wider external community. The findings demonstrate that irrespective of declining ability levels of higher care needs residents, all five layers of community had relevance to the residents. However, the nature in which they engaged within those layers, and indeed across the five layers were unique to each resident.

The chapter then discussed the main contribution of this research, the CI-RAC model in its application based on salutogenic theory, across the four case study facilities. The CI-RAC model presented in Chapter 4 (Figure 4.1) and reviewed in this chapter (Figure 10.1) represents the author's attempt to conceptualise the factors that support community integrated residential aged care. The key characteristics of community integrated aged care are identified in this model as working through the three main aspects of operational environment, social environment and built environment of the facility. The first component of the CI-RAC model, is noted as a nexus of relationships driving community integrated residential aged care. The findings suggested the Baby Boomer generation who are likely to demand a more socially engaged and cohesive lifestyle, and secondly the perceived benefits from a wider range of stakeholders involved in the sector, in catering to the needs of this growing demography were significant drivers of community integrated aged care. Salutogenic theory and Active Ageing policy, as presented through the conceptual model of CI-RAC were demonstrated in terms of the benefits of community integrated aged care, to residents and their families, as well as stakeholders.

The impact of community integration on aged care delivery models and practice, is addressed through the second level of the CI-RAC model. In response to the drivers of community

integrated residential aged care, the organisational philosophy, culture and policy then responds to that demand in providing supportive care models. Corresponding with salutogenic theory and Psychosocially Supportive Design, the central element adopted in the community integration initiatives of the selected case studies was the focus on a resident's ability rather than their disability level. Filtering through the layer of statutory regulation, the CI-RAC model demonstrates the validity of three interconnected components that work together in the delivery of successful community integrated aged care. These three components are a supportive social environment, a supportive operational environment, and a supportive built environment. This chapter presented the various ways in which the case studies responded within all three interconnected environments, demonstrating that all three environments are of relevance in creating community integration. The discussion demonstrated that the nature and extent to which the care model performed within the three components were varied, however all three components were addressed in unison, based on enhancing a person's sense of coherence (SOC) through *manageability, comprehensibility and meaningfulness*, across all three components. This discussion then presented in a tabulated form, the main points derived from the research in how the three supportive environments against the three aspects of salutogenic theory, were addressed.

However, it became apparent from the interviews, especially those with the residents, that the three-component model did not adequately convey the manner by which they worked in an integrated way to deliver the principles of community integration. Consequently, three cross-cutting socio-spatial dimensions of permeability, porosity and propinquity were proposed that attempt to encapsulate how the model works in an integrated way to deliver a range of positive community engagement outcomes. In essence, they represent the ways in which the three key domains of the CI-RAC model work together in practice. This final redefined CI-RAC model therefore brings together the findings of this research into a cohesive understanding of community integrated care that could be applied in the practice, policy and design of residential aged care, as a further original contribution of this research. In doing so, the three research questions are answered in the proceeding conclusion chapter, together with the contribution to knowledge and the originality of the study. The CI-RAC model together with the PPP schema, as well as the conceptualisation of community in the context of residential aged care, discussed in this chapter further contribute to the concluding discussion of the significance and implications of this research, it's limitations, and future directions.

Chapter 11: Conclusion

Despite the recent policy emphasis on ageing in place in one's own home, population ageing amongst the growing baby boomer generation will be accompanied by an increasing number of people requiring complex and specialised higher needs care, especially for dementia, which are more appropriately delivered within a residential aged care environment (AIHW 2016; Brodaty et al. 2005; Davis et al. 2009; DVA Architects 2014; Dementia Australia 2019). It is not financially viable to deliver these kinds of services within one's own home with the required levels of support whether funded privately by individuals or by government. The new generation of baby boomers entering older age will also have higher expectations of care providers, wanting to be more active and engaged with society (Buckley et al. 2013; Knickman and Snell 2002; Martin et al. 2009; Quine and Carter 2006) . As the recent Royal Commission into Aged Care Quality and Safety has revealed, there is considerable community and professional disquiet about traditional models of residential care (Royal Commission into Aged Care Quality and Safety 2019c) .

In further support of the researcher's position, this report states "The Royal Commission into Aged Care Quality and Safety's Interim Report has found the aged care system fails to meet the needs of its older, vulnerable, citizens. It does not deliver uniformly safe and quality care, is unkind and uncaring towards older people and, in too many instances, it neglects them. The findings of this inquiry led Commissioners Richard Tracey AM, RFD, QC and Lynelle Briggs's AO who led the investigation into Australia's aged care system to describe the aged care system as "a shocking tale of neglect", stating that "the neglect that we have found in this Royal Commission, to date, is far from the best that can be done. Rather, it is a sad and shocking system that diminishes Australia as a nation" and "found that a fundamental overhaul of the design, objectives, regulation and funding of aged care in Australia is required" (Royal Commission into Aged Care Quality and Safety 2019b).

Relevant to the need for greater social and community integration, the report further states that:

> "We have heard countless stories about how much people grieve for all they have lost when they arrive in residential care. They become 'just a resident', just another body to be washed, fed and mobilised, their value defined by the amount of funding they bring with them. They become infantilised, lose autonomy, and are prevented from making decisions or doing physical things that were routine when they lived at home, on the grounds that they 'could hurt themselves'. They lose their basic rights to take risks, to choose what to do in their day, to live a life as close as possible to their previous home

> and community. There is no joy in this… We have heard substantial direct evidence about what can happen to older people once they move into residential care. The case studies have given us invaluable insights into the vulnerability and isolation of older people in care" (Royal Commission into Aged Care Quality and Safety 2019a, p. 4).

These findings of the Royal Commission into Aged Care indicate the necessity for innovative models of care, such as those addressed in this study, particularly in higher needs care, which promote resident's health and wellbeing. There are many international models of care which have presented new approaches that are more integrated into the community to support active ageing and engagement in society for their residents. For example, the literature review earlier in this thesis outlined six international exemplars which featured aspects of such integrated approaches (see Chapter 4.6 Precedents for community integrated aged care).

Following a review of developments in gerontological theory in Chapter 2 and drawing on these innovative international exemplars, salutogenic theory and its application in psychologically supportive design was identified as the foundational theoretical framework for this research. Based on the literature review, a conceptually informed Community Integrated Residential Aged Care (CI-RAC) model was proposed in Chapter 4 though which, it was argued, the full spectrum of salutogenic principles could be operationalised. This was articulated through three 'environmental domains' – *supportive operational, social and built environments* – which sought to encapsulate the range of organisational capabilities that together could facilitate the delivery of a care service based on salutogenic principles. The CI-RAC model also provided the analytical framework for the analysis of community integration of the four case study facilities selected for this research and presented in Chapters 6 to 9.

Following a review of the findings in Chapter 10, a further refinement to the conceptual CI-RAC model was proposed in the form of a cross-cutting schema which sought to express how the three domains interacted both within and beyond the care facility to deliver community integrated care in practice. This schema includes three 'modes' of community integration – *permeability, porosity* and *propinquity* – operating across the three domains of the CI-RAC model. Despite some differences in scale, institutional policy and care models, the case study facilities were found to have a strong alignment with salutogenic principles and psychologically supportive design which the revised CI-RAC model captured. Importantly, the thesis expands the latter's focus on the built environment to include the both the social and operational environments of an integrated care facility and their important inter-relationships.

By utilising care models in residential aged care that are integrated into communities, as demonstrated in this research, the residents can have their needs addressed with the necessary care support and structure available in formal residential aged care and yet remain in touch with the wider society. With an increasing number of the Australian population coming from a culturally diverse population, and one where relatives no longer live close to the parental home, those not having family living within close proximity are likely to increase. This will impact on a person's ability to rely on support from a partner or other family member taking on the role of the primary care giver.

The CI-RAC model proposed in this research attempts to incorporate the principles that bring residential aged care into better integration with the surrounding community, however community may be defined. As the findings showed, not only is 'community' perceived as a multi-scalar concept by residents and staff of care facilities reflecting levels of engagement both within and beyond the facility itself, but also the significance of these varied interpretations of what community meant varied significantly between participant groups. The three PPP 'modes' were developed to capture this multi-scalar and variable understanding of community revealed by the research.

In essence, this research has argued that while residential aged care is rapidly moving towards a higher-needs care model, community integration is even more relevant in cases of increasing cognitive-decline. Consistent with gerontological theory, this research argues that integration into community is important for maintaining a life of dignity, health and well-being for residents particularly for those with higher-care needs. Hence the focus on ensuring those cared for in their own homes remain actively engaged.

But many in this increasing demographic are in danger of isolation and lack of appropriate care if they were to age in place in their own homes, especially with escalating levels of dementia especially towards the end of their lives (Sixsmith and Sixsmith 2008; Robins et al. 2018). The empirical findings of this research likewise corroborated this evidence. As noted in Sections 7.2, 9.3, 9.4, and 9.6 of this thesis, activity and integration of older people with higher care needs into the community required a higher degree of management and constant formal care which can be delivered feasibly and economically through a residential aged care facility (Chapters 6, 7, 8 and 9). Identification of the different levels of community engagement and the corresponding variety and nature of activity according to individual ability levels and preferences were identified as important aspects of adopting a community integrated care model.

The community integration initiatives adopted by the care models in the case studies are not necessarily individually unique to a community integrated model of care. Nevertheless, community integration, by virtue of its complexity, involves addressing all the layers of community as illustrated in Figure 10.1, in harmony rather than as separate elements. This was achieved in varying degrees in all four case studies by actively incorporating a range of different layers of community into their care models although some had only partially embraced some elements of the full CI-RAC model.

11.1 Research Questions

This study set out to answer three inter-related questions which are discussed next.

Research Question 1: How have residential aged care delivery models in NSW incorporated the principles of community integration?

As discussed in Chapter 10.2.2, Community integration of the selected case studies had a strong focus on a resident's ability rather than their disability level. The literature review revealed that the development of gerontologocal theory culminating in the selection of salutogenic theory as the foundational theoretical framework for this research was indeed applicable successfully in the community integration of residential aged care. Particularly within the higher care needs sector, residential aged care models demonstrated community integration incorporating an active ageing paradigm as one that delivered health and wellbeing outcomes that were positively supported by respondents the research. However, due to specialised care needs, this study revealed that community integration initiatives required careful consideration and incorporation into the care model. Three domains of community integration were identified: a supportive organisational environment, a supportive social environment, and a supportive built environment. These three domains as discussed in Section 4.7 were interrelated components that work together rather than function as separate entities in order to deliver community integration based on the salutogenic principles of *manageability, comprehensibility* and *meaningfulness* in enhancing a person's Sense of Coherence. However, the delivery of care to residents through the care model within these three components of the supportive operational, social, and built environments were subject to the filter of the statutory regulations as demonstrated through the conceptual model of CI-RAC.

Part of the answer to this research question involved establishing how those involved (residents and staff) understood what the term 'community' meant to them. Based on the empirical evidence of the stakeholder and resident and/or family member interviews, an understanding of what constituted 'community' was presented in a diagrammatic form (Figure 10.1 Layers of community in community integration). It was revealed as discussed in Chapters 6-9, that a

broader understanding of community is essential in the delivery of community integrated care that addresses the various levels and meaning of community to each individual or group. The care delivery therefore took the form of organised activities, a variety of activities to suit individual needs, normalised activity, as well as specialised care worker support enabling higher needs care residents to stay engaged in community activities. However, the success of community integration as demonstrated in this study is not merely the availability of activities or facilities, rather the delivery of care sensitive to the different layers of community, and its application across the three identified domains of community integration as presented in the CI-RAC model; a supportive operational, social and built environment. In addition, the overlay of the PPP schema, further reveals the nature of community engagement of community integration initiatives and function of the facility.

Research Question 2: How do care receivers perceive the value of community integration?

As discussed in Chapter 9 residents and their families, viewed the value of community integration of residential aged care as highly favourable. In particular, residents and their interviewed family members expressed the importance of activity (within their capability) helping to maintain their independence (Section 9.4). They also noted that this contributed to a better quality of life, as residents were enabled through a supportive social, operational and built environment to engage in activities which were not manageable living in their own domestic environments due to higher care needs (Sections 9.3, 9.4, and 9.5). The families in turn, enjoyed peace of mind that their parents or loved ones were well looked after and were maintaining connections with society instead of being isolated and forgotten. This is consistent with developments in gerontological theory as discussed in Chapter 2 of this thesis, and in particular salutogenic theory and its three components of *manageability, comprehensibility* and *meaningfulness* that enhance a person's SOC in the delivery of better health and wellbeing outcomes. Community integration was seen to emphasise the engagement in meaningful activity of older individuals with its proven positive effects for biological function as well as meeting emotional and social needs. The residents and families also noted the maintenance of independence in whatever limited capacity, even in higher care needs such as dementia, was enabled by living in residential aged care that was community integrated. This was noted to be so as formal care had specialised staff, equipment, and capacity to incorporate activity and engagement that was otherwise not feasible in maintaining one's independence without that support. Therefore, due to the provision of specialised care and support, a resident's quality of life was enhanced by supporting their *manageability, comprehensibility* and *meaningfulness* which in line with salutogenic theory, contributed to their SOC.

Research Question 3: How well are the needs of high-care residents accommodated in the practice of community integration principles?

It was the stakeholders' view that residents with higher-needs care often required shorter lengths of stay due to later ages of admission. Even though it could be argued that in these circumstances, a resident's ability to integrate into the community is far reduced and is therefore not a priority, the findings of this research indicated that, on the contrary, community integration was important. As discussed in the findings chapters (Chapters 6 to 9), both from the stakeholders as well as the residents and their family members' perspectives, the value of integrating higher-needs care residents into the community was demonstrated not only to be healthier for residents but also valued by their families as well as relevant for local communities and wider society.

The stakeholder findings discussed in Chapters 6 to 8, noted the need for specialised care and continuous support in facilitating higher care needs residents to be engaged in activity and maintain social connections. In a societal context, provision of specialised care on a daily basis was not seen as viable for each individual ageing in their own homes. Additionally, stakeholders expressed the view that older individuals who required higher care are at increased risk of isolation due to their inability to stay engaged socially. Ageing in a community integrated residential aged care setting was, however, seen as beneficial in supporting the concept of active ageing, as well as ageing with dignity due to the availability of appropriate levels of car. (Chapter 6).

Community integration further recognises the importance of positive ageing by facilitating social and community interaction of older individuals who would otherwise be unable to experience similar levels of interaction without the support offered by a community integrated care model. Therefore, community integration of high-needs care residents is an essential humanitarian model where ageing is not viewed as a stereotype or as a disability, but seen as a diverse and complex condition, recognising the basic human need of community by all, irrespective of their care level. It is evident from these findings that community integration is not only a theoretical concern, but it also needs to be enhanced operationally, through investigating the methods aged care providers adopt in addressing the apparent conundrum of reconciling increased levels of disability with community integration.

The CI-RAC model developed in this research offers a useful aid in examining the extent of community integration and how well the needs of high care residents are accommodated in the practice of community integration across the three components of a supportive social, operational and built environment. In turn, the PPP schema of permeability, porosity and

propinquity developed in this research (Chapter 10.4) could also serve as an evaluative tool to assess the efficiency of community integration applied across the different concepts of community identified in the research.

11.2 The contribution to knowledge and the originality of the study

Although many older individuals would prefer to age in their own homes, the unpredictable nature of ageing means that not all will be able to do so until the end of life. The reality is that the need for residential aged care is increasing with people living longer than ever before, but not necessarily in good health. This research contributes to addressing the challenge of integrating a growing aged population with increasing cognitive decline into society. Given that older people today, particularly the baby boomer generation, are characterised by greater independence and significant financial power compared to previous generations, new models of care, practice and policy, must be explored to ensure better health and wellbeing outcomes for residents, their families and society at large. This research has addressed the seemingly opposing forces of frailty and higher cognitive decline of residents and their need to lead a meaningful life of dignity and activity through community integrated aged care. Although a financial analysis of the various models was not in the scope of this research, the responses to the interviews by stakeholders as well as residents and their families (Chapter 6 to 9) suggest that any additional financial burden on management may be outweighed by the benefits to residents, families, providers and society at large.

Much research exists in the area of ageing in place in one's own home as a model of community integration. However, that research does not adequately address the needs of a growing population who are unable to age in their own home but have some ability to maintain social connectivity. As Rijnaard et al. note (2016, p. 2), in the case of older adults residing in care homes, "to date, the exact elements that shape the physical, social, and organisation contexts are largely unknown". This research addresses this knowledge gap by demonstrating that successful community integration can effectively be built into care and management models to enable the incorporation of activities, volunteers and other service providers that can deliver the necessary support for residents.

To the knowledge of this researcher, a specific study of community integrated care models in residential aged care in the Australian context has not been previously undertaken. In addition, this research gained first-hand knowledge through insights obtained directly from residents and their families, as well as care workers, facility managers, aged care providers, industry leaders and facility designers. These insights validated the relevance and viability of community integration into residential aged care.

An important contribution of this research concerns the complexity of the many different layers of community that need to be considered in community integration. It notes that the five layers of community identified and the dynamics of interaction between them are unique to each individual. The diversity and complexity of community interaction is harnessed in this research to construct a conceptual CI-RAC model of community integration. Drawing on the findings of the four case studies, the CI-RAC model is then further developed through the PPP schema incorporating three modes of integration, referred to as permeability, porosity and propinquity which operate across the three organisational, social and built environments. The aggregate of these two structuring schemas comprise the revised CI-RAC model which is an original contribution to knowledge in the field of age care.

The contribution of this research also lies in addressing the challenge of integrating residential aged care into communities with supportive policy, as well as the need to rethink models of residential aged care facilities, by incorporating organisational, social and built environment factors that facilitate the principles of community integration. Indeed, the Australian Government Productivity Commission (2020) Report into aged care services includes an indicator addressing the objective of promoting wellbeing and independence of those living in residential aged care. The report defines 'wellbeing and independence in residential care' as the proportion of older people in residential aged care assessed as having a high quality of life. The Quality of life is defined as the degree to which an individual resident's wellbeing meets their personal expectations and those of their carers. The report states that "a high or increasing proportion of older people in residential aged care with high quality of life is desirable" (Australian Government Productivity Commission 2020, 14.31). However, this report (2020) also states that data are not yet available for reporting against this indicator. To this end, the proposed CI-RAC model makes a significant contribution if adopted in aged cae delivery models and practice, in achieving a desirable level of health and wellbeing outcomes leading to a higher quality of life through community integration. This research also highlights the need to increase awareness in society to address the needs of the rising numbers in the older population requiring higher needs care. It suggests that incorporating the needs of this cohort in a holistic model of community integration can help to create a healthier, more inclusive and socially sustainable society.

11.3 Significance

As noted in the Australian Government's Productivity Commission report of 2018, 23% of the population is expected to be over the age of 65 by mid-century (Australian Government Productivity Commission 2018). Increasingly higher numbers will have dementia and other conditions brought on by diabetes, strokes, and general illnesses associated with ageing. It is

therefore crucial for our society and our communities to be prepared for this eventuality. The baby boomer generation entering older age are having a significant impact on the economy and aged care system as they come with different expectations from previous generations. They also have significant financial power, and are noted for their independence, which makes a community integrated aged care approach significantly more attractive rather than the isolated and age segregated aged care models that are still largely the norm today (Bookman 2008; Cannuscio et al. 2003; Tronto 2000) .

The recent 'Aged Care Quality and Safety Commission', initiated by the Australian Government, however, is a step that can be seen as supportive of a community integrated approach to aged care (Ageing and Aged Care 2018). This is the nation's first *Independent Aged Care Quality and Safety Commission*, under the portfolio of Hon. Ken Wyatt, *Minister for Indigenous Health and Minister for Senior Australians and Aged Care* (The Australian Government Department of Health 2019). The Australian Federal Government released an interim report on 31 October 2019, with a final report due on 30 April 2020. The release of this final report however has been indefinitely postponed due to prevailing impacts of the COVID-19 pandemic, at the time of writing this thesis (Commonwealth Government of Australia 2020). Resulting from the findings of the interim report of the Royal Commission into Aged Care Quality and Safety, prime minister Morrison has expressed the view of "instilling a culture of respect towards elderly people", stating that "the royal commission will be the first step in re-establishing the trust that loved ones will be treated with dignity and with respect," (Australian Associated Press 2018).

The findings of this research clearly indicate how models of residential aged care that better reflect contemporary principles of community integration can be developed within current policy settings to provide for the dignity and respect to which the Prime Minster referred.. The value of such models is driven by the higher-care needs of the aged requiring specialised and constant care in residential settings in a way that will enable them to age in dignity.

The findings of this research are also relevant to care givers providing constant care at home to family members who are often not able to cope with the demands of specialised care but may be reluctant to admit their loved one to conventional residential aged care home where they risk being isolated and inactive. As has been demonstrated in the four case studies this research show that despite the declining physical and mental ability levels, there are significant potential benefits to residents, families and the community at large through a community integrated approach ensuring that our ageing population is not segregated and shut away from society, but rather remains incorporated into it according to their ability.

11.4 Limitations

This research was conducted using a sample of four case studies of aged care facilities that demonstrated aspects of community integration. Although they varied in size and locational context, as well as varied resident economic and cultural profiles, a limitation of the research is the absence of comparative analysis with conventional aged care facility cases which are not community integrated. This research is also largely qualitative. It presented a profile of residents based on information provided by the cases. However, the analysis of this resident profile was not equivalent to a full clinical analysis, but *indicative* of their physical and cognitive state. The findings were arrived at through interviews with residents, families, carers and management of facilities based on their own experiences. The health and well-being outcomes noted in this research, therefore, are based on self, and family reported responses as well as personal observations rather than on clinical data. This is a limitation of this research.

All four case-studies were based in New South Wales. This had the advantage of providing uniformity in state government policy in comparing the four different case studies which had some differences in their community integrated care-models. While aged care facilities in Australia are subject to national policy, it cannot be assumed that these findings would necessarily apply in other jurisdictions. Nevertheless, it can be argued that the overall findings and the CI-RAC model could be more generally applied to residential care provision across Australia, regardless of state or territory jurisdictional contexts (see below).

11.5 Implications for policy, practice and research

11.5.1 Government policy

Although the active ageing agenda has been promoted by the current discourse in Federal government policy, the findings of this research indicated that aged care providers, as well as families of residents, had strong views that policy did not adequately address the needs of the rapidly growing older population requiring higher-needs care who wish to stay engaged in society with its accompanying benefits. Hence, this research provides evidence for policy makers regarding the needs and views of a variety of stakeholders including, most importantly, residents and their families.

Policy supportive of community integration and the underlying principles of care at federal, state and local government level are also necessary in the reconciliation of higher-needs care and community integration of those residents. Policy is particularly important in identifying the adequacy and efficiency of funding instruments. The degree of funding was seen to have a direct impact on the ability of providers to implement community integration principles in their care models. This aspect was also highlighted in the report of the World Health Organisation policy

framework as discussed in Section 3.2. This suggests that if community integrated aged care is to become the norm, government funding models will need to be reviewed.

The current initiative of introducing consumer directed care was met with caution by management and providers of facilities who were concerned that residents at a higher level of care were not generally capable of making their own decisions about their care needs, but rather depended on their family to do so. Management and care workers also pointed out that families were often not adequately informed or had the required expertise to make such often complex decisions given the specialised higher care needs of residents. Furthermore, access to funding by residents and their families was often difficult and required professional assistance, which by necessity often was provided by the care home. This involved additional costs to the aged care facility by needing to employ staff to assist families in accessing government funding and identifying their entitlements. It was noted by stakeholders that a more holistic approach to aged care needs to be adopted given the increasing numbers of older people with higher-care needs who require institutionalised care. In view of this finding, it is hoped that this thesis and the analysis it provides, demonstrates a greater appreciation of how CDC's could be provided in a residential aged care setting.

11.5.2 Practice

It is evident that aged care provision is moving towards a market-based model which will need to cater to the growing demand of increasingly discerning consumers. This research provides evidence of the many benefits to residents and their families as well as providers and society at large of the adoption of a community integrated model of care. It provides evidence that families of residents who often make the decision for the resident to enter residential aged care, clearly value the benefits of staying engaged in society with social stimulation as part of the care package.

This study also demonstrates the importance of all three aspects of a supportive operational environment, a supportive social environment, and a supportive built environment, which should be addressed simultaneously to work together in delivering positive health and wellbeing outcomes through a community integrated approach to residential aged care. As demonstrated through the PPP schema, the three elements of *porosity, propinquity,* and *permeability,* can then further enhances an understanding of the dynamics of community integration within the three environments.

A community integrated model of care was shown to align closely with the management and care model for those facilities examined, with the potential for a healthier and more socially engaged resident population. Moreover, community integration had helped to raise the level of

understanding and acceptance by the surrounding community of the needs of people with dementia and those with considerable cognitive decline, imperative given a rapidly increasing ageing population. Providers have a greater responsibility for influencing trends in aged care provision and achieving a market advantage by gaining insight into the views and opinions of the spectrum of stakeholders and residents interviewed for this research.

11.5.3 Further research

Although this evidence provides valuable insights into the impact on health and wellbeing of residents, further research that measures those benefits utilising clinical data and a wider range of cases could provide additional evidence in understanding the significance and benefits of community integration to health and wellbeing. It would also be useful to further extend the CI-RAC model by developing it as an evaluation framework to assess how far aged care facilities align to the salutogenic principles embedded in the model. The model would need to be adapted to translate each of the three 'dimensions' into a range of measurable metrics against which a care facility might be assessed both quantitatively and qualitatively. The model could also be adapted as a management tool to assist care providers to move their model of care to better encapsulate salutogenic principles.

Since this research was restricted to the state of New South Wales, future research would benefit from a broader study of residential aged care across the country, or even internationally. The sampling group could also be increased, particularly to capture the views of a broader socio-economic range, as most residents interviewed for this research had access to private funding which gave them broader choice in residential aged care. A comparative study of facilities between those with and without community integrated care models, would also be useful in further determining the viability, benefits and relevance of community integration given higher-care needs. A suitable calibrated CI-RAC model could provide the basis for an evaluation methodology for such a comparative research project.

Finally, more in-depth and focused studies on different community integrated care models in measuring their social and economic efficiencies could be undertaken. Such comparative studies would be useful in determining which models provide the most benefit to residents, communities and society at large.

11.5.4 Looking forward

This research has explored a recently emerging type of residential aged care facility in Australia, considered to represent good practice in the integration of aged care with the community. Although community integrated aged care is well established in countries such as the Netherlands and Sweden, it has emerged relatively recently in Australia. Although this is a

concept that is supported by gerontological theory, the good practice examples in Australia are likely to be the exception rather than the norm.

The researcher recognises that there is a large majority of aged residential care facilities that are not well integrated with their communities and do not closely align with salutogenic principles, as the Royal Commission into Aged Care Quality has shown. Given the benefits to residents, their families, and larger society, the researcher looks forward to a future where community integration of aged care becomes the norm rather than the exception.

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Appendix 1: Case studies: A description of facilities and resident profiles.

As mentioned in Chapter 4, case studies of residential aged care facilities with good practice in community integration were used to test the utility of the three components of the social, operational and built environments, identified in the CI-RAC model. These four case studies served as the lenses through which the CI-RAC model is given expression in understanding community integration of residential aged care and its theoretical and philosophical underpinnings. They were chosen using a maximum variation sampling method, as described in Chapter 4 on methods. The focus varies in the geographical location and the neighbourhood type in which they are located, their degree of connectivity to the neighbourhood surroundings, their scale and form, the care model used as well as the resident profile. The purpose of this chapter is to give a description of the case studies for the contextual positioning of their differences and similarities in approaching their unique take on the nature of community integration. The case studies as already noted are all in the state of New South Wales in Australia, as noted below:

5. Dougherty Apartments, Chatswood.
6. Sir Moses Montefiore Jewish Home, Randwick.
7. Group Homes Australia, St. Ives.
8. Elanora, Shell Harbour.

The information pertaining to these case studies was obtained from the following sources:

- Published information on the aged care facility from the provider of the facility.
- Online published information on the aged care facility website, and local and federal government websites.
- Information received through in-depth interviews conducted for this research with managerial personnel of the facility as well as management of the provider of the facility.
- The researcher's personal observations of each facility. These observations are offered to enrich an understanding of the facilities.

The four case studies demonstrate four different models of care incorporating four different modes of community integration. Dougherty Apartments is a multi-story facility at the heart of the Chatswood commercial centre, with opportunities for visitors to come into the facility as well as for residents to access the neighbourhood. Montefiore in contrast demonstrates community integration within the compound. High security access controls who enters the facility by virtue of the importance of security placed within the Jewish community. Planned community and family interaction is a focal point built into the care model. The third case study, Group Homes Australia, in contrast to Montefiore which has a capacity for 300 residents, is a small domestic scale facility with only 6 residents. This facility is a high care facility for residents with dementia related diseases. Its approach to community integration is much like a

regular domestic environment. Strangers cannot access the facility from the community unless invited, however family members of residents are free to access the facility at any time of day, exactly as in a domestic home environment. The residents also access the village centre and shops with their carers located a short walking distance from the facility. The Elanora aged care facility is part of a new town centre development. Elanora therefore demonstrates how community integration can be incorporated into urban planning, thereby increasing opportunities for aged and impaired residents to be integrated into the local community by virtue of its proximity and direct access to the main new town centre of Shell Harbour.

The summary of the nature of the facilities in the table below is followed by a detailed description of each case in turn.

Table 1 Aged care facility comparison

Aged Care Facility Comparison Profile: Dougherty Apartments, Montefiore, Group Homes Australia, Elanora												
Name & Address	**Neighbourhood Category**	**Number of Residents**			**Number of Staff**			**Provider**	**Type**	**Size**			**Innovation**
		M	**F**	**Tot**	**Temp**	**Per mnt**	**Tot**			**No. of Rooms**	**Site Area**	**GFA**	
Dougherty Apartments Chatswood NSW 2067	Major Urban Centre	20	47	67	23	38	61	Dougherty Apartments Retirement village. Private NFP	Multi storey residential apartments	68: Hostel 44 self-care 44 Dept of Housing			• Community integration • Multicultural integration • Dementia Care • urban integration
Sir Moses Montefiore Jewish Home 36 Dangar Street Randwick 2031	Inner City Suburban	77	199	276	118	301	419	Sir Moses Montefiore Jewish Homes. Private, NFP	High density Residential Institution Resort	109: Nursing home 60: Dementia Care 107: Hostel Care:	3 Ha	25,000m2	• Faith based principles of care • Community integration • Prestige and reputation • Neighbourhood model of care • Day care & respite care • Dementia specific care • Intergenerational Integration
135 Killeaton Street Group Home	Suburban	0	6	6	7	7	14	Group Homes Australia	6-bedroom residential dwelling	6	980 m2	300m2	• Dementia Specific Care

St Ives NSW 2075									specialising in catering for dementia care housing for 6-8 residents.				• Home Environment: Functions, looks, smells like a 'home' • Focuses on life choice and relationships • Community integration through scale and appearance of home
Elanora 7-23 Wallaroo Drive Shellharbour City Centre NSW 2529	Regional Fringe	25	75	100			93	Uniting Care Ageing	Medium density Residential Institution	100			• Ageing in place: low care and on-site high care • Inspired care model • Public transport connectivity • Pastoral care

Each case study is described according to the below noted characteristics determining the nature of its community integration incorporating the role of the qualities of the built environment in affording the level of integration provided:

- **Philosophy of the aged care provider:** The mission statement of the provider.
- **History:** The history of the facility contributing to its practice of community integration.
- **Geographical location and neighbourhood type:** The location of the site within New South Wales, and the characteristics of its neighbourhood in terms of urban form, density and scale, and in relation to the local town/ village centre.
- **Connectivity**: The availability of public transport options and the proximity of road networks, and access routes to the facility from major public transport locations or nearest town/village centres.
- **The form of the facility and its visual relationship to the neighbourhood and surrounds:** The appearance of the facility and its relationship to the physical built environment features and the other buildings in the neighbourhood.
- **The resident profile:** Age, ability levels, gender, and social activities of resident population
- **The care model of the facility:** The nature of care delivery dealing with community integration.

Case Study 1: Dougherty Apartments Chatswood

Philosophy of the aged care provider

The Dougherty mission statement states that the facility maximises the provision of high-quality care services and support for the aged in the local community in a safe and supportive environment. It commits to:

- "Mutual respect of and between all our stakeholders which supports the daily decision making and service provision.
- Provision of compassionate understanding and quality care for the aged in our community in a safe and secure environment.
- To be an employer of choice through education and staff development and fostering of ethical practices and a strong team culture.
- We will strive for continuous improvement.
- Through our transparency we will achieve the highest level of openness and integrity in all our dealings.
- Conduct a strategically and financially viable organisation.
- Respect each person's independence and choice and so maintain a sense of self dignity and worth". (Dougherty Apartments 2016)

History

Built in 1989, this facility was first envisaged to serve the local area of Chatswood for all the older people needing care irrespective of financial and social background. It was initiated by an ex-mayor of Willoughby council, the local council area within which Chatswood is located, Mr. Bob Dougherty and his wife. It was developed as a joint venture between Willoughby City Council, the NSW Department of Housing, and the Uniting Church Aged Care, with equal representation from all three bodies on its board of directors. The role of Uniting Aged Care, a not for profit age care provider, was purely advisory. The facility is now under the sole management of Dougherty Apartments. The vision of Mr. Bob Dougherty and his wife who championed the older population in the local Chatswood area, was to "have a facility where aged people, including the socially and financially disadvantaged, could reside in Chatswood" (Dougherty Apartments 2009). The land for this venture was donated by Willoughby Council, while the Department of Housing constructed the building on the proviso that a quota of the residential apartments were reserved for public housing tenants. (Dougherty Apartments 2009). This quota has been subject to change through the change of management over the years and is now unclear. Later, in 2006, Dougherty Apartments opened the 'Palmer Wing', a thirteen-bed communal living section to cater for people living with dementia and related illnesses. Ongoing building works at Dougherty are aimed at increasing the number of living units in the

dementia unit as well as initiatives to develop spaces both indoor and outdoor, facilitating community integration.

Geographical location and neighbourhood type

The Dougherty Apartments is located within 500 meters of the Chatswood commercial centre. Chatswood is a major urban centre in the Sydney metropolitan area with a railway transit station and shopping district inclusive of major financial institutions. The area is also a well-established residential neighbourhood. The commercial centre is within 10 kilometres from the Central Sydney CBD, connected by railway, bus, and road networks, less than half an hour by road, or 15 minutes by rail. Due to high land values, building development since the 1990s has seen the erection of many high-rise buildings, both residential and commercial, in and around the commercial centre of Chatswood. The neighbouring residential enclave where Dougherty Apartments is located consists of tree lined streets and a quiet low traffic environment which is likewise conducive for use by older mobility impaired persons. The road network with on-street parking as well as nearby parking stations, and parking provision in the nearby shopping centres, provides ease of vehicular access. It is rare to find an aged care facility which enjoys such close proximity to a commercial centre as well as being within an established residential neighbourhood, as land values in Sydney are very high. The prime location that Dougherty Apartments occupies is because the location was chosen and plans for the building of the facility commenced just before the building boom in the late 1980s, and the rapid development of the Chatswood commercial centre. Its proximity to the Sydney city CBD and links by railway, and accompanying residential growth of apartments and town houses shaped the present character of the neighbourhood (willoughby City Council). Figure 1 shows Dougherty Apartments shows the location of Dougherty Apartments in the neighbourhood, and figure 2 its immediate surroundings.

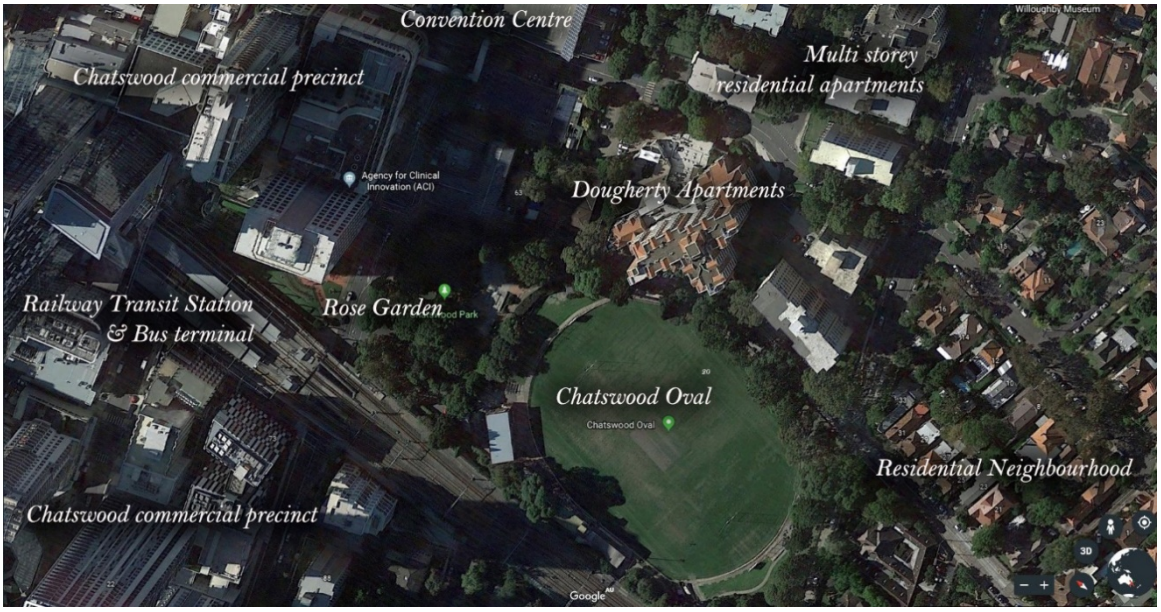


Figure 1 The location of Dougherty Apartments in its urban and neighbourhood setting. Source (Google Mapa 2018)

Connectivity

Figure 2 Context: The immediate surroundings of Dougherty Apartments. Source: (PTW Architects)

Dougherty Apartments, as can be seen in figure 2 is bounded by Orchard Road, Victor Street, and Park Lane. The public access to the main entry of the facility is via Victor Street. The rear entry to the facility off Orchard Road, was temporarily used as the main entrance to the facility at the time of this due to ongoing construction of the Victor street frontage of the facility to create a more community integrated transition between the public domain and the facility. The plans for this initiative include public accessible shops, health care facilities and community centre along ground floor entry, as well as landscape and street furniture to activate public interaction. Ample parking is available directly adjacent at the paid parking station, in addition to the private basement parking exclusively for visitors to Dougherty and adjacent community centre. On street parking is also available. Access to the major railway transit station and bus terminal is across a public park and Rose Garden, as shown on figure 1. For the able bodied the facility is a five-minute walk across the park to the public rail and bus transport stations. This access path was noted by the researcher to have evenly paved pathways, good lighting, park benches, making it suitable for use by the residents of Dougherty as well as wheelchair users and older persons with mobility impairments. The facility can also be seen by a person travelling along this path. This visual access of the facility also aids in orientating older residents in their surroundings. Across the facility from Orchard Street is the Chatswood oval shown in diagram 1, which forms the main green space for the residential neighbourhood. A pedestrian mall within the commercial centre of Chatswood further adds to the locational character being a safe and useable built environment for older people.

The form of the facility and relationship to the neighbourhood and surrounds

Figure 3 Exterior view of Dougherty Apartments from Victor Street. Source (Dougherty Apartments 2018)

Dougherty Apartments Chatswood, as shown in figure 3 is a multi-storey aged care facility, with nine levels of accommodation, containing 150 residential units. It promotes ageing in place within the facility by the inclusion of palliative care, dementia care, residential hostel care, and retirement self-care units. It houses a mixture of self-funded residents, partially government funded concessional residents, and fully public-funded residents (Department of Housing) in a configuration of units as below:

- 22 x resident funded 1bedroom self-care units
- 19 x resident funded 2bedroom self-care units
- 1 x resident funded 3bedroom self-care unit
- 38 x public funded 1bedroom self-care units
- 68 x residential care units (Including self-funded, concessional, and public funded)

The ongoing building works for an extension to Dougherty Apartments at the time this study was undertaken will see the addition of six two bedroom living units, a library and coffee shop, as well as a landscaped open space for relaxation and recreation. The aim was to increase the number of higher needs residents housed in the facility. In addition, it was to enhance the community integration opportunities for residents to maintain and encourage an active lifestyle within the facility and the wider community by the introduction of spaces accessible to the public such as an on-site medical centre, shops, café, and other such services.

The nine-storey structure of Dougherty apartments is in keeping with the urban form of Chatswood, marked by the high-rise skyline of the city centre. Although Chatswood has a rapidly changing skyline, it is also characterised as can be seen in figure 1 by tree lined streets and public parks with many stand-alone residential dwellings and medium density town houses around the city centre, reflecting its suburban residential history.

Private Areas

The private areas consist of a resident's bedroom and its attached bathroom. Bedrooms facing Orchard Road offer views out to the tree lined street or green spaces such as the oval, and other bedrooms face courtyards and greenery of the landscaped gardens of the facility. It was noted that there was good cross ventilation and natural light penetration to bedrooms. It was observed that community interaction also took place as a result of the visual access from the bedroom to the street below. Within the facility, an unspoken social interaction cue was when a resident's room door was left open, it meant that the resident did not mind visitors. There was good visual access into the room when the bedroom door was open but not directly to the bed, offering a level of privacy while also allowing people to access the room, with space for a chair in the room for any visitors. This arrangement offered a regulation of privacy. The attached toilets are all designed for accessibility with each resident having their own.

Common Areas for the residents and staff

Figure 4 Lounge area

Figure 5 In-house hair dressing salon

Common areas consist of corridors, lounge spaces, the dining area, activity rooms, and seating areas at reception, as shown in figure 6 the first-floor layout of the facility. The corridors were observed to have substantial natural light though windows. They did not however accommodate features such as small alcoves or sitting areas interspersed along the corridor, for the occasional unplanned meeting amongst residents, which are found to be useful in creating social interaction spaces such as demonstrated at the National Center for the Humanities in North Carolina. These spaces were shown to create social interaction and activate transitory spaces such as corridors contributing to a social engagement (Lang and Moleski 2010) .

Figure 6 First Floor Plan, Dougherty Refurbishment. Source: (PTW Architects)

The activity areas shown in figure 4 and figure 8 were used throughout the day by residents and visitors for interaction. The rooms had direct visual and physical access to outdoor landscaped areas. Dining areas shown in figure 7, and 9 were noted by the researcher to be a hub of activity at mealtimes, and served as a meeting place for residents. Due to privacy and ethical reasons, photographs within the facility of residents in capturing these interactions was not permitted. Although the facility does not have an industrial kitchen, a small kitchenette fitted for food storage, heating and serving facilities was used for daily food service. The meals were served over the counter, with a range of staff members from management to care workers, participating in the serving of food to residents. The dedicated activity rooms and library shown in figure 11 were similarly well used, and open for all residents to use. One of the activity rooms contains a large blackboard where such activities as word games can be put up for anyone to take part as a group or individually. A resident was observed by the researcher to be enjoying a word game by herself, in this activity room. The rooms while offering specific activities, as can be seen in figure 8 also offered group seating and nonspecific areas where one could use as they wished. The entry was controlled by a safety lock, with visual access through its large glass doors. A large common area with seating connected to the reception point, allowed for the safety of residents as well as a more public meeting place or waiting area for residents who were waiting to be picked up for an outing, or simply to sit and observe the street outside. A resident community meeting was observed taking place in this area by the researcher during a visit to the facility. Ad shown in figure 5 a hair dressing salon is incorporated adjacent the lobby of the facility. The coffee shop in the adjacent community centre, although not situated within the facility, is accessible via a covered walkway.

Figure 7 Dining room (Dougherty Apartments 2018)

Figure 8 Lounge room. (Dougherty Apartments 2018)

Figure 9 Dining room. (Dougherty Apartments 2018)

Figure 510 Library. (Dougherty Apartments 2018)

Outdoor Areas

Outdoor areas consisted of courtyard (figure 14), paved and shaded seating areas (Figure 13) and landscaped gardens (Figure 11and 12). Although the garden areas were at the time of conducting the research interviews had limited accessibility due to major construction work taking place at the facility, the limited garden spaces were nevertheless used by the residents on a regular basis. Residents were seen to water plants, as well as enjoy the outdoor covered seating area.

Figure 11 Gardening areas at entry. (Dougherty Apartments 2018)

Figure 12 Courtyard (Dougherty Apartments 2018)

Figure 13 Courtyard (Dougherty Apartments 2018)

Figure 14 Outdoor seating (Dougherty Apartments 2018)

Common areas for residents and surrounding community

The common areas used by the residents of the facility and by the neighbourhood and visitors were the public parks, tree lined streets of the residential neighbourhood, and the Chatswood

shopping centre. The main entry to the Dougherty Apartments shown in Figure 11 provides views onto the tree lined Victor Street with direct access to and of Chatswood's residential neighbourhoods; it, in turn, connects with the more heavily trafficked Chatswood commercial centre. This hierarchy of streets effectively breaks down the volume of traffic and creates a distinctly quieter and perceivably safer street for residents. It should also be noted that the building work at the Dougherty apartments was intended to increase the use of outdoor areas and community interaction by offering more opportunity for residents to interact with each other as well as with the public. These incentives and facilities include extensive refurbishment to incorporate a library and outdoor recreational garden area accessible by the public. As shown in Figure 1, directly across Orchard Street from Dougherty is a small public park serving the largely residential neighbourhood. Being in full view of the facility, this park functioned as a transitory connection to the community. Even though this may not be used as a place of meeting by the residents of Dougherty, the visual connection to the park was enjoyed by them, and indeed contributed to the peaceful feel of the neighbourhood. Within close proximity to the facility is the 'Rose Garden' maintained by the local government council located adjacent to the Chatswood railway station. Its location shown in figure 1, is a manicured public park which was observed by the researcher to be used by a cross section of age groups consisting of mothers with toddlers in prams, children, young adults enjoying the sun, workers having a smoke, and many older people throughout the day. This park is designed with seating areas and shaded benches which was seen to facilitate community interaction. The train station and bus terminal is within fifty meters from the facility. Chatswood shopping centre, various services, ample coffee shops and restaurants, as well as the local cinema are all likewise within a five-minute walking distance from the facility. In addition, the Dougherty Apartments had many international visitors from the nearby conference centre. It was revealed to the researcher by the Chief Executive Officer of the facility that the interest from overseas visitors to the facility was due to Dougherty Apartments being regarded as a benchmark in Sydney for a successful aged care facility.

Resident Profile

Dougherty Aged Care facility is home to 150 residents. Of this total number, 68 residents live in the residential aged care facility, which includes dementia care and palliative care. The resident profile of Dougherty Apartments is documented in Table 1. This sample of the residents used in this research included five residents, chosen by the management of the facility according to the purposive sampling guidelines given by the researcher as described in the previous Chapter 4 detailing the methodology of this research (See Figure 4.1). Reflecting the demography of Chatswood with an increasing Chinese ethnic migrant population, seventy percent of current

residents to Dougherty at the time of this study as revealed in the interviews with management of the facility, were of Chinese background. Presenting a culturally sensitive policy framework in its care model towards accommodating the needs of the Chinese population has been important in resident activity and engagement with the community. This includes the incorporation of Mandarin and Cantonese speaking care workers. According to the Australian Bureau of Statistics, most migrants show a tendency to settle in major urban areas, with 97% of the Chinese migrant population choosing to live in apartment style accommodation. This trend for apartment style living could also be seen as a facilitator for the residents of Chinese background to provide ease of community integration due familiarity with living in major urban areas with an increasing density in population and built form (Australian Bureau of Statistics 2014). The resident profile of Dougherty Apartments is documented in table 2 below.

Table 2 Dougherty Apartments; Details of resident interviewees

Case Study: Dougherty Apartments, Chatswood. NSW											
Resident Profile							**Health Status**				
Resident	**Age**	**Gender**	**Relationship Status**	**Funding**	**Country of Birth**	**Length of Residence**	**PAS Score**	**Personal Care Level**	**Mental Capacity**	**Physical Capability Level**	**Activities**
Resident 1, 73, Male	73	M	Widower	Age Pension + Super Fund	Australia	3 Years	24	Minimal Assistance	Good comprehension, conversation and alert	Very good. Walks medium distances. No aids. Performs all personal care with supervision, following medical condition.	Weekly men's group Weekly trivia night Weekly walk to local news agent to buy newspaper
Resident 2, 75, Female	75	F	Never Married	Aged Pension	Australia	8 Years	24	All personal care assistance	Good comprehension, conversation and alert	Very weak, mostly incapacitated	No hobbies/ Activities
Resident 3, 100, Female	100	F	Widow	Aged Pension	Australia	3 Years	28	All personal care assistance	Good comprehension, conversation and alert	Walks short distances in doors unaided, not able to perform personal care tasks	Loves to get the paper read to her. Takes part in daily resident discussion groups.
Resident 4, 91, Female	91	F	Never Married	Self-funded	Australia	3 Years	22	All personal care assistance	Mentally adept: manages own finances but	Physically unable to do much due to: 1.Frequent falls leading to # shoulder now very	No regular hobbies or activities, but enjoys having a coffee at the coffee shop

									needs reassurance due to mental illness	fearful and unable to utilise shoulder. 2.Walks using frame very short distances.	
Resident 5, 61, Female	61	F	Never Married	Aged Pension. No independent funding.	Australia	2 Years	15	All personal care assistance	Advanced dementia	Normal cognition, but cannot remember how to perform personal care tasks or activities. (i.e. used to like sewing, but cannot remember)	Likes to go to all activities provided, If she cannot participate, she enjoys watching the activities.

The care model of the facility

Dougherty has an ageing in place model. That is, a resident entering into the facility is able to remain in the facility as their care needs advance with those specialised care being provided for on-site, including dementia care and palliative care. The care model also provides for specialised staff to support residents in their journey of advancing care needs. Planned activities for residents to encourage interaction with the community of residents are incorporated into the care model to enable community interaction particularly among the higher needs care resident community. However, planned activities are available to all residents and are popular amongst the residents. Figure 15 to 18 show planned activities amongst the resident community. Activities built into the care model to encourage interaction with the local and broader community range from the residents accessing the local and broader community (shown in Figure 19 and Figure 20) as well as the local community and volunteers accessing the facility, such as the weekly musical performance shown in Figure 16. Intergenerational activity is also encouraged by the care model in partnership with local primary schools, as shown in Figure 15. According to the care manager of Dougherty Apartments, the success of the socially integrated delivery of aged care at Dougherty was quite accidental. Its viability is due to its prime location which made the management structure and care model encouraging resident's participation in the life of the neighbourhood much easier to achieve. As a result, there is less stress on the financial model, in creating opportunities for community integration of its residents into the life of the surrounding neighbourhood and within the facility itself.

Figure 15 Intergenerational activity with school children

Figure 16 Weekly musical performance by a volunteer

Figure 17 Dancing classes for residents

Figure 18 Residents engaged in group games

Figure 19 Resident engagement in the local and broader community

Figure 20 Resident trips to special destinations

The care model also encourages residents of different care levels to co-exist rather than separating them according to care level and specialised needs. This means that integration between the different care groups, such as dementia care, residential care, palliative care, and self-care, are encouraged. This integration is further facilitated by specialised staff on hand to manage any situations which may cause occasional disruption. According to the chief executive officer, the concept further breaks down the physical barriers in the building with such facilities as common dining areas. The inclusion of dementia care in the regular residential care arrangements represents the vision that dementia is a normal process of ageing. This philosophy has broken down the usual strict line dividing self-care and hostel accommodation with co-located shared spaces. Special events such as Melbourne Cup day are advertised as open to all residents, and the more frequent everyday celebrations such as birthdays are also regarded as communal celebrations, incorporated into the care model.

With the integration of dementia care to a high degree with regular hostel accommodation, the resident community is educated about the character of special needs residents. The secure dementia care unit is specifically for those residents who have a habit of wandering off the premises for their own safety, although staff still strive to integrate them with the general resident community. For example, the 2014 Melbourne Cup event for the whole facility was held in the Dementia Care Unit, where different levels of residents all gathered giving the residents in the dementia specific unit to interact with other residents.

Case Study 2: Sir Moses Montefiore Jewish Home, Randwick.

Philosophy of the aged care provider

The Vision and mission statement of Montefiore is to develop, implement and promote best practice in all aspects of aged care by continuously reviewing and improving services, by enhancing the quality of life of older people incorporating the values of Jewish religion, culture and traditions. (Montefiore 2018). This includes a philosophy of living as advocated by the provider to be an overarching 'Philosophy of Living' (POL) that touches all areas of the organisation and how the provider delivers on person-directed care philosophy. The Montefiore care philosophy statement describes POL as representing the providers commitment to delivering the best possible care for each and every resident and client, by empowering them to live with choice, dignity and wellbeing (Montefiore 2018).

History

The Sir Moses Montefiore Jewish Homes is a leading aged care provider in Sydney, with a history of 120 years. The provider takes its name from Sir Moses Montefiore, an Englishman who devoted his time and resources to the community, civic affairs and welfare of the Jewish people (Montefiore Jewish Homes 2017). The first of the Montefiore Homes for the aged was located in premises at Dowling street, Moore Park, Sydney in 1889, followed by continuous development, expansion and moving of premises in its development history. The facility included in this research, is the newest facility of Montefiore Jewish homes, located in the inner Sydney Eastern City suburb of Randwick. Built in 2006 as an aged care facility to serve the Jewish community, its location was chosen to serve the large concentration of the Jewish migrant population in the Eastern suburbs of Sydney (Montefiore Jewish Homes 2017).

The Montefiore Randwick campus facility was designed to be a prominent building representing high-end community based aged care primarily funded by and intended to serve the local Jewish community (John Flower 2015). Its community integration mechanism derives from a model aligned with distinctly Jewish principles of enhancing the quality of life of the Jewish Aged Community, by providing an exceptional standard of care and embracing the richness of Jewish culture and tradition. (Montefiore 2018).

Geographical location and neighbourhood type

The suburb of Randwick lies within 6 kilometres of the Sydney city central business district (CBD). The suburb is home to many significant historical buildings, schools, and is in close proximity to the University of New South Wales Randwick campus. Three of the major hospitals

in Sydney, Prince of Wales Hospital, Royal Hospital for Women, and Sydney Children's Hospital, are also located in Randwick. In addition, the Royal Randwick Racecourse and Centennial Park are within a five to ten-minute walk from the facility. There are ten listed beaches in the Randwick local government area, including Bondi beach. Further, the Bondi Central Business District with its major shopping centre is within a ten-minute vehicle ride from the facility. The immediate neighbourhood of the facility has a mixture of standalone residences and medium density apartment blocks. Due to the demand for housing in the area by a large university student population, proximity to the city, proximity to essential quality services such as hospitals, proximity to beaches as well as the many other qualities, land values are at a premium. As stated in 'Jewish Sydney', the online gateway connecting members and organisations of the Sydney Jewish community, there are an estimated 50,000 people who identify with the Jewish faith in NSW, of which two thirds live in the Eastern suburbs of Vaucluse, Randwick, Bondi, and Double Bay areas. (Jewish Sydney 2018).

The draft Metropolitan Strategy for Sydney released in 2013, categorises Randwick as an 'Education and Health specialised precinct' (Rogers 2014, p. 84). This plan includes significantly increasing capacity for student and short-term housing, capacity for increased jobs, integration of multi-functional aspects of the Racecourse, and improved transport access to Sydney CBD. It is evident therefore that Randwick is a suburb with a building character which includes many institutions of prominence, including The University of New South Wales, Prince of Wales Hospital, and The Randwick Racecourse, and medium to high density residential housing comprising many high-rise apartment buildings and town houses.

Figure 21 The location of Montefiore Jewish home in its urban and neighbourhood setting

Connectivity

Randwick town centre is located 6.3 Km from the Sydney CBD, with vehicular access via Anzac Parade (shown in figure 21). It is not directly connected by a rail network, with the closest railway and bus interchange located 3.3 kilometres from the Randwick town centre, at Bondi Junction. Montefiore is primarily designed to be accessed by private vehicle, with provision for ample car parking on-site. The facility is however within short walking distance from the Randwick town centre as shown in Figure 21. Randwick town centre is connected by bus transport to its closest commercial hub of Bondi junction, as well as to the Sydney City CBD.

Therefore, although it is located in the heart of a well-established residential and town centre, visitors to and from the facility is strictly governed by the facility. Connectivity of the facility to services and community activity takes place mostly within the complex.

The Eastern suburbs of Sydney are the heartland of the Jewish community in NSW, with many synagogues and Jewish schools located within walking distance to the Montefiore Home (shown in Figure 21). Public bus transport to the Randwick town centre was observed as a positive feature for ease of care workers getting to and from work, who mostly relied on public transport.

The form of the facility and relationship to the neighbourhood and surrounds

The Montefiore Jewish Home is located approximately 900 metres from Randwick town centre. The site is at the corner of Dangar Street and King street, with Govett Lane to the rear of facility. The main entrance as shown in Figure 22 is via Dangar Street. The facility has a high security entrance with a boom gate with security personnel at entry to the grounds. In addition, it is also fitted with a call-in system to the reception of the facility for identification purposes prior to entering the grounds of the facility. Beyond the security point, the facility opens to landscaped gardens surrounding the residential complex. A multi-tiered parking station, pre-school and semi-public hydrotherapy pool are ancillary facilities to this aged care complex. The service access is via Govett Lane terminating in a large service dock, as well as provision for staff parking.

Figuer 22 shows the facility in context to its neighbourhood and surrounds, consisting mostly of multi-storey residential apartments as well as a few stand-alone residences. From street level, the height of the facility and facade is similar to the neighbouring buildings (shown in Figure 23). The now heavily planted gardens and street foliage also aids in the facility appearing less dominating, and indeed even blend into the neighbourhood. Figure 22 shows the early stages of the facility when the landscaping was not yet established.

The form of the facility is also a response to the unique circumstances of the Jewish community as well as the residents themselves who required a secure environment within which community activity could take place. The architecture of Montefiore therefore reflects an inward-looking community environment.

Figure 22 Montefiore Jewish Home, Randwick Campus. Source: (Montefiore Jewish Home 2017)

Figure 23 Exterior view, Montefiore Jewish Home. Source: (Montefiore Jewish Home 2017)

Private Areas

The private areas consist of bedroom and attached toilet. A typical bedroom is shown in Figures 24 and 25. The bedrooms generally offer a view out to a courtyard or the landscaped gardens of the facility. The entire facility including the bedrooms are mechanically ventilated but have direct natural light penetration from windows. The entry door to individual bedrooms along the corridors are offset, with the idea that residents do not look into each other's bedrooms when the door is open. This provides control of privacy for residents. As shown in figure 28, the entry to the bedrooms were personalised by 'memory boxes'; an alcove space which the resident could make their own, with their family photographs and memorabilia, giving the resident a sense of ownership of their space and degree of familiarity in differentiating their private space. Within the bedroom, many rooms had seating alcoves, bay windows, and seating areas for visitors and social interaction, as noted in figures 26 and 27. All rooms are equipped with an attached bathroom designed for ambulant access.

Figure 26 Bedroom (Montefiore Jewish Home 2017)

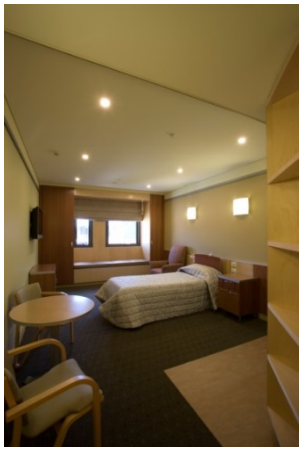


Figure 27 Bedroom (Montefiore Jewish Home 2017)

Common areas for community integration of residents and staff

Common areas consist of corridors (Figure 28), dining areas (Figure 29), lounge spaces (Figure 30), activity rooms including library (Figure 31) and games rooms (Figure 32), coffee shop, shops (Figure 33) and seating areas at reception, as shown in figures 37. The corridors were broken down to a specific special feel of intimacy, by the previously mentioned memory boxes at each entryway. As shown in figure 28, these alcoves also broke down the length of the corridor and were well lit with artificial light. At the end of each corridor was a common space with substantial natural light, equipped with television and groups of seating areas. Unplanned gatherings of small groups of residents were observed in these spaces, as well as supervised planned activities. It was observed that some residents had 'their favourite chair' a place where they sat regularly. A chance meeting between the son of a resident who was interviewed by the

researcher, and his mother was observed taking place along the corridor, following the interview.

Figure 28 'memory boxes' (Montefiore Jewish Home 2017)

Figure 29 Dining room (Montefiore Jewish Home 2017)

Figure 30 Coffee shop (Montefiore Jewish Home 2017)

Figure 31 Shops (Montefiore Jewish Home 2017)

Figure 32 Library (Montefiore Jewish Home 2017)

Figure 33 Ballard room (Montefiore Jewish Home 2017)

Outdoor Areas for community integration

Outdoor areas consisted of landscaped grounds and courtyards. All outdoor spaces are landscaped and designed with attractive planting and functional spaces, such as dementia-friendly meandering gardens as shown in figure 34, and shaded seating areas. It should be noted that many of the residents were holocaust survivors and, as such, security and providing a feeling of safety was of utmost importance to management and residents. Therefore, unique to

this case study, was the creation of a community within a community. The outdoor spaces were not designed to physically interact with the general community outside of the facility. Moreover, the gardens were designed with high walls which were planted sensitively to give the feel of expanse and greenery whilst being physically sheltered from the neighbourhood. Gardens and secure parkland are created within the compound in creating outdoor spaces for interaction for the Montefiore Community. Access to the compound is security regulated, though giving an expansive vibrant feel once inside the compound's large attractive reception and waiting area, with a view out to the entry through its expansive glass wall.

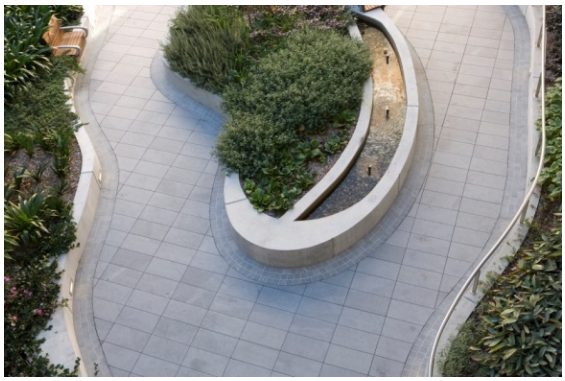


Figure 34 Landscaped internal courtyard (Montefiore Jewish Home 2017)

Areas for community integration with the local community and public

As interaction with the local community mostly took place within the premises of the facility with members of family or friends with authorisation to enter the facility, or alternatively personnel organised by the facility for entertainments or events, the common areas consist of the same spaces as the those described in common areas to residents. The spacious entry area and lobby with ample seating as shown in figures 35 and 37 is the focal transit space bridging the more resident focused areas and the first point of entry to the facility, where residents can meet with anyone that they may not necessarily want to invite to the living areas of the facility. The large coffee shop, goods store, dentist, orthodontist, hydrotherapy pool shown in Figure 5.40, and landscaped gardens were observed to create a vibrant community atmosphere for the residents, where residents could interact with each other as well as with visiting family and friends. The hydrotherapy pool facility shown in figure 36, is also on occasion accessible by selected members of the local community.

Figure 35 Entry to the facility (Montefiore Jewish Home 2017)

Figure 36 Hydrotherapy pool (Montefiore Jewish Home 2017)

Figure 37 Entry Lobby (Montefiore Jewish Home 2017)

The resident profile and interviewee details

Sir Moses Montefiore Home, Randwick campus, is home to 276 residents. All residents are in a residential aged care environment, with provision for dementia and other high needs care.

- Dementia care high needs: 30
- Dementia Care low needs: 30
- Nursing home: 109
- Residential hostel care: 107

The participants in this research included 5 residents from Montefiore Jewish Home Randwick, ranging in age from 64 years of age to 96 years of age, both male and female, ranging in cognitive and mental ability levels. The resident interweave profile at Montefiore is documented in Table 3 below.

Table 3 Montefiore Jewish Home; Details of resident interviewees

Case Study 2: Montefiore Jewish Home, Randwick. NSW											
Resident Profile							Health Status				
Resident	Age	Gender	Relationship Status	Funding	Country of Birth	Length of Residence	PAS Score	Personal Care Level	Mental Capacity	Physical Capability Level	Activities
Resident 1	88	F	Widow	Private	Australia	6 years		Most Personal Care Assisted	Mild Dementia	Physically capable but has a fear of falling post hip fracture.	Shopping – goes out shopping with daughter for social stimulation - daughter does resident's shopping for her
Resident 2	86	F	Widow	Private	Australia	3 Years, 1 Month		Most Personal Care Assisted	Mild Dementia	Good	Very social and actively participates in the in-house activities. Also, involved in weekly community linked activities held out of the facility
Residents 3, (Couple)	96, M 92, F	M, F	Married Couple	Private	Poland	3.5 Months		Male, 96. Most personal Care assisted. Partially blind. Female, 92	Male, 96: Normal Female, 92: Dementia	Male, 96: Physically capable but poor vision limits what he is able to do. Female, 92: mobility frail and high falls risk	Male, 96: Daily socialises with others in the other units on site. Does not feel safe to travel outside the facility due to poor eyesight. Female, 92: Actively participates in the activities within the unit. Chooses

								Most Personal Care Assisted due to dementia			not to attend social events outside the unit without her husband – as she feels more secure.
Resident 4	93	F	Widow	Private	Australia	2.5 Years		All Personal Care Assisted	Advanced Frontal Lobe Dementia	(Personality, emotions, behaviour and speech)	Weekly Group Excursion by Bus Daily Walk
Resident 5	64	F	Married but separated	Private	Australia	1 Year, 10 months		All Personal Care Assisted	Fronto Temporal dementia (Changes in Personality & Behaviour. language loss	Physically fit and active	Due to psychiatric issues, has only recently joined in group activities such as movement to music. Has external companion that takes Norma out 2-3 times per week – to the park, out to restaurants, to the beach.

The care model of the facility

Built on faith-based principles, primarily catering to the Jewish community, its care model functions as a community within the larger Jewish local community of the Eastern suburbs of Sydney. Its care principles are closely aligned with its mission statement:

> *"To enhance the quality of life of older persons, by providing an exceptional standard of service and care, embracing the richness of Jewish religion, culture & tradition"*

The delivery of aged care services is based on its vision statement:

> *"To be the leader in the field of aged care. To develop, implement and promote best practice in all aspects of aged care by continuously reviewing and improving services".*

It is an inclusive care model, which offers continuity of care through the provision of five major levels of care;

- Hostel (or low-level care) for residents who require some assistance with daily activities
- Nursing Home (or high-level care) for frail or physically dependant residents requiring a higher level of nursing care
- High and low special care units for residents with dementia and other cognitive impairment requiring specialised care in a secure and caring environment
- Respite care for short term accommodation and provision of care in times of need
- Montefiore Home Care for people who need assistance to remain independent and active in their own homes (Montefiore Jewish Homes 2017).

Community integration has been achieved on site at Montefiore, through an internal interconnection with the adjoining day care centre and hydrotherapy pool open to all residents and day care visitors. On-site availability of dental services, hairdresser, and retail shopping, with a central coffee shop, offer additional connecting spaces for daily interaction between residents and services with ease of access. The neighbourhood model of living supports a care model which is contained to groups of residents forming sub communities, referred to as 'neighbourhoods' in the management model, within the larger community of the facility. The intention of the provision of smaller 'neighbourhoods' is to encourage the building of relationships between residents. Figure 38 to Figure 39 show residents engaged in activity within the facility, which are built into the management model.

An interdisciplinary model of care is utilised to integrate separate disciplines into a single consultation for care recipients. Integrated governance allows effective systems and processes to be in place to manage and monitor the delivery of care for residents and the wider community. - A large volunteer base from around the local neighbourhoods and eastern suburbs, mobilised for onsite activities and support as well as integration of the resident population with the local community, is a major aspect of the community integration initiatives at Montefiore. The facility's close proximity to Moriah College and the Emanuel School (large Jewish day schools), aids in its intergenerational integrative programs.

Figure 38 Individualised care for residents

(Montefiore Jewish Home 2017)

39 On-site health care facilities

(Montefiore Jewish Home 2017)

40 on-site physiotherapy facility

(Montefiore Jewish Home 2017)

Figure 41 Hydro-therapy pool

(Montefiore Jewish Home 2017)

Figure 42 Music room

(Montefiore Jewish Home 2017)

Figure 43 Coffee shop

(Montefiore Jewish Home 2017)

Case Study 3: Group Homes Australia. St Ives, NSW

Philosophy of aged care provider

Specialising in in-home care, respite care, dementia care, high-care, and palliative care, Group Homes Australia mandates a clinical ethos within their care philosophy to deliver care to residents that is individualised and within the comfort of a traditional home environment. Care delivery is designed for a typically six-bedroom residential dwelling which is centred on "a welcoming environment that values independence and resident involvement in the daily activities of the home. Our residents live with dignity and sense of purpose in a small scale environment" (Group Homes Australia. 2015). The ground floor plan of the facility is shown in figure 44.

Figure 44 Ground Floor Plan Group Homes Australia. Source: (Tamar Krebbs 2017)

History

The Group Homes concept is one that is specifically developed for those who are suffering from dementia and related diseases. It derives its name from providing "small domestic care settings which emphasize normalised living" (Verbeek et al. 2009, pp. 252–264). The home, located in Killeaton Street St Ives, is the first Group Home founded by Tamar Krebbs, the Chief Executive Officer of Group Homes Australia, which began operations in 2011. Since then, five more homes have been added to the Group Homes Australia portfolio, with two more in St Ives and one each in Warriewood, Rose Bay and Vaucluse. As shown in figure 45, Group Homes, Killeaton Street, is situated in close proximity to the St Ives village centre, and integrated into a well-established residential neighbourhood, of largely single houses with surrounding garden space. As shown in

figure 46, community integration has been achieved by the scale and appearance of the dwelling to integrate seamlessly into the neighbourhood reflecting the scale of surrounding single family dwellings and neighbourhood characteristics. As residents needs change, care requirements and regimes are altered accordingly to meet advancing needs. Krebbs notes that Group Homes is governed by the principle, 'if it functions like a home, looks like a home, and smells like a home, then it is a home'. The focus of the concept of Group Homes, is on life choice and relationships of specifically dementia care residents.

Geographical location and neighbourhood type

Group Homes Australia, is in the upper North Shore suburb of St. Ives adjacent to Ku-ring-gai Chase National Park. The suburb is located 18 kilometres from the Sydney City CBD. According to the 2011 census, 19.9% of the population in St. Ives is over the age of 65, with 83% of the households being family households, and 78.8% of those living in standalone houses (Australian Bureau of Statistics 2014). St Ives has its own village centre serving the local community as the main community hub.

Connectivity

The village centre of St Ives is located 23 kilometres north of the Central Business District of Sydney, with access off Mona Vale Road and Pacific Highway. Its nearest rail link is at Gordon located 4.2kilometeres from the village centre, accessible by public transport bus. As shown in figure 45, Group Homes Australia, at Killeaton Street is located approximately 900m from the village centre of St Ives, along tree lined streets and well-paved pathways offering easy access for older residents from the facility to the village centre.

Figure 45 context map, Group Homes Australia St. Ives, Village Centre and neighbourhood

The form of the facility and relationship to neighbourhood and surrounds

As shown in figure 46, in keeping with the neighbourhood characteristics, Group Homes is visually consistent with the scale of other residential homes in the neighbourhood as a standalone two storey brick dwelling, with a landscaped front and back garden.

Figure 46 Street front exterior of facility. Source: (Group Homes Australia. 2017)

Private Areas

The concept of Group Homes is "if it looks like a home, functions like a home, then it is a home" (Tamar Krebbs 2017). Reflecting this concept, the private areas consist of the resident's bedroom, with one of the six bedrooms with attached bathrooms, and the remaining five bedroom sharing three ambulant accessible bathrooms within close proximity to each bedroom. This six-bedroom facility is a renovated residential home to suit the specific needs of its high needs care resident cohort of six residents who are all diagnosed with a form of advanced dementia related illness. A typical bedroom is shown in figure 5.30. The bedrooms are very much the personal territory of each resident, with regular beds as opposed to hospital beds, and a choice of their own furniture or furniture supplied by the facility. Interestingly, contrary to what most regard as the importance of 'familiarity' to those suffering from dementia, most residents have opted for the appropriately upholstered furniture provided with special fabric for ease of cleaning and fitting in with the professionally decorated style and interior of the home, instead of bringing in the residents own furniture.

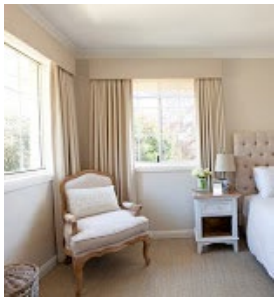


Figure 47 Typical bedroom. Source (Group Homes Australia. 2017)

Common Areas

As in a regular home, the common areas consist of all areas of the house except for the bedrooms, including dining room, living room, kitchen, and entry area, as well as the landscaped garden. These spaces are shown in figure 48a-f. The corridors are short lengths of connections with substantial natural light though windows. The common areas are professionally furnished and decorated in a neutral pallet of colours with artwork decorating the walls. The lounge areas were well used and filled with natural light. The living and dining room areas accommodated space for group gathering as well as alcoves and seating for privacy to sit quietly by oneself. The researcher observed a resident participating in ironing of clothes in front of the television in the living room, demonstrating the normalcy of functions as in a regular domestic environment. Residents were also observed watching a favourite television program together. Another resident was observed sitting at the kitchen counter with her visiting daughter having a cup of tea, while one resident was sitting quietly in another part of the kitchen playing a game on her iPad. Residents enjoying the garden were also observed. All residents in this home suffered from advanced dementia and were not capable of living on their own. Staff were not in uniform, which further lent itself to the normalcy of a regular household. The fully functioning kitchen was very much the heart of the house, with residents free to access it. This was seen to be the equivalent of the 'café' area in other case studies where residents tended to congregate to have a cup of tea or coffee as well as interact with other residents and visiting family. Although the entry door was secured with a combination lock, the families of residents were familiar with the combination, and were free to come in and go out as they pleased with no restrictions on visiting hours.

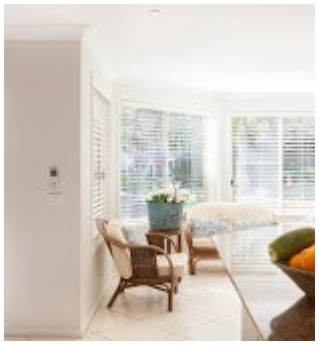


Figure 48a Kitchen seating

Figure 48b Lounge room

Figure 48c Dining room

Figures 48a-48c: Source (Group Homes Australia. 2017)

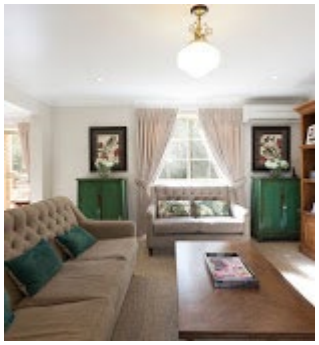


Figure 48d Lounge room

Figure 48e Entry foyer

Figure 48f Kitchen

Figures 48d-48f: Source (Group Homes Australia. 2017)

Outdoor Areas

The scale of the home is similar to the other homes in this residential neighbourhood. It does not have any signage and from its exterior blends in as a regular suburban family home, with front yard and a well laid out back garden as shown in figure 49a-d. The garden was seen to enhance greatly the bright interior common areas of the house - dining, kitchen and lounge room all with views out through expansive, outward-opening French windows. Residents were able to take part in planting and gardening activities, and contribute to the upkeep of the garden, as well as enjoy the outdoor spaces with visiting family, as shown in figure 49a.

Figure 49a Garden

Figure 49b clothes drying area

Figure 49c Garden seating

Figure 49d Landscaped gardens

Figures 49a-49d: Source: (Group Homes Australia. 2017)

Public Areas

The suburb of St. Ives is noted for its national parks and green belt. Tree lined streets with front yards of houses visually accessible to the street with no fencing or high walls is a noted feature. This feature lends itself well to the nature and extent of community integration. It was noted that residents are often invited to the homes of neighbours for afternoon tea, when out on their morning or evening walk around the neighbourhood. This is facilitated by the visual interaction with the streetscape and the residences in the neighbourhood. The local shopping centre is familiar to the residents who often go out on weekly shopping trips. It was noted that a resident formerly restricted to the confines of her bedroom in another facility due to aggression and wandering, medicated to manage her behaviour, was now a notably calm and happy individual, off medication, who took a walk by herself up the road and back with a carer watching unobtrusively from the home for her safety.

Figure 50 Street View of Group Homes Australia, St Ives. Source (Group Homes Australia. 2017)

Care Model: Dementia Specific Care

The Group Homes Care model is a dementia specific care model, which functions just as a regular home, with a group of 6 residents living in the six-bedroom home, with a high level of individualised care in a home environment. The care model is focused on the ability level of the

resident, rather than the disability level, supporting older people with dementia to live independently, in a home environment. Four of the six residents in the facility are from the local neighbourhood of St.Ives, with all four residents having immediate family living in close proximity to the facility. Figure 51 shows residents engaged in normal activity.

Figure 51 Advanced Dementia Care Residents Engaging in Normalised Activity. Source: (Group Homes Australia. 2017)

Resident Profile

Group Homes Australia provides care specifically for dementia care residents, with the ability of ageing in place including palliative care. The home in Killeaton Street, the case study of this research, comprises six residents in its six-bedroom home, although the management and care structure does allow for couples to live together. Killeaton Street currently is home to all female residents.

For the purpose of this research, five family members of residents from Group Homes Australia, Killeaton Street, St Ives, were interviewed, ranging in age from 78 to 84 years of age. The family members were all daughters of each resident. The residents' family members were chosen by the Group Homes Chief Executive Officer, Tamar Krebbs, for participation in the interview. Table 4 outlines the residents' profile and ability level.

Table 4 Group Homes Australia; Resident Details

Case Study: Group Homes Australia, 135 Killeaton Street, St. Ives											
Resident Profile							Health Status				
Resident	**Age**	**Gedr**	**Relatship Status**	**Funding**	**Country of Birth**	**Length of Res**	**PAS Score**	**Personal Care Lev.**	**Mental Capacity**	**Physical Capability Level**	**Activities**
Resident 1	78	F	Widow	Private	South Africa	18 months	25/30	Needs prompting with showering dressing and grooming,	Adrenoleuko dystrophy (ALD). Understand and can follow instructions	Walks unaided	Goes out with family to the hairdresser weekly, goes out to the movies, picnics, galleries beaches, weekly. Plays solitaire on IPad daily
Resident 2	87	F	Widow	Private	Germany	2 Years	15/30	Needs full assistance with showering dressing and grooming	Vascular Dementia (VD), cannot follow instructions. Can have a basic conversation of a few words. Cognition fluctuates	Walks with an aid and needs to sit in wheelchair at times.	Helps at the kitchen bench daily, enjoys getting involved with cooking, baking, drying dishes, goes to the hairdresser weekly, goes out to the movies, picnics, galleries beaches, weekly.

Resident 3	83	F	Widow	Private	Germany	2 Years	18/30	Needs prompting with personal care	Can have a discussion but has short term memory loss, is able to take instructions and comprehend	Walks unaided and is able to go for a short walk down the road on her own, staff stand out in the garden supervising.	Independence was important to resident - walks in the neighbourhood unaided up the street, enjoys getting involved with cooking, baking, drying dishes, goes to the hairdresser weekly, goes out to the movies, picnics, galleries beaches, weekly.
Resident 4	78	F	Widow	Private	Australia	2 Years	15/30	Needs to be auditory prompted with personal hygiene and grooming	Has severe short-term memory loss, can have an ongoing conversation that last for a few minutes, can be very repetitive	Walks unaided but needs supervision so she does not wander.	Likes to hang out laundry, likes to fold laundry, enjoys ironing, enjoys getting involved with cooking, baking, drying dishes, goes to the hairdresser weekly, goes out to the movies, picnics, galleries beaches, weekly.
Resident 5	82	F	Widow	Private	Australia	2 Years	0	Needs full assistance with all ADL	Loves to talk with anyone, has minimal comprehension	Walks unaided but needs supervision so she does not wander.	Likes to hang out laundry, fold laundry, enjoys ironing, enjoys getting involved with cooking, baking, drying dishes, goes to the hairdresser weekly, goes out to the movies, picnics, galleries beaches, weekly.

Resident 6	90	F	Widow	Private	Australia	2 Years	0	Needs full assistance with all ADL	Loves to talk with anyone, Asks a lot of questions	Walks unaided but needs supervision so she does not wander.	Likes to hang out laundry, likes to fold laundry, enjoys ironing, enjoys getting involved with cooking, baking, drying dishes, goes to the hairdresser weekly, goes out to the movies, picnics, galleries beaches, weekly.

Case Study 4: Elanora, Shell Harbour.

Philosophy of the aged care provider

Uniting Care is one of Australia's leading aged care providers. Elanora Shell harbour incorporates the provider philosophy of 'inspired care' promoted by Uniting Care. Inspired care is defined as "respecting your [the resident's] inherent dignity and honour your [the resident's] capacity and desire to express who you [the resident] are, make decisions about the support you [the resident] receive, and participate and contribute as a member of the community (Uniting 2018).

History

Elanora was opened as a residential aged care facility in 2011, to serve the Shell Harbour community, as part of the Shell Harbour new city centre master plan. At the time of construction, the local Shell Harbour demographic data indicated a large, ageing Italian migrant population, who were the intended recipients. This was reflected in the choice of colour scheme of the facility to reflect a Mediterranean palette. Due to the Italian population traditionally having patronised another aged care facility in the area, and through subsequent increases in numbers of the Spanish migrant population, Elanora is also now home to 25% older Spanish migrants. Uniting Care Ageing is the single largest aged care provider in NSW and ACT, responsible for the Uniting Church's services for older people, particularly those who are disadvantaged, vulnerable, and isolated (Uniting Care Ageing Resident Handbook, 2014).

Geographical location and Neighbourhood Type

Shell Harbour is a town located in the outskirts of the greater Illawarra urban area, characterised by new housing estates of single dwellings on suburban residential land subdivisions, largely spurred by the recent development of the local Stockland Shopping Centre, the largest serving the entire Illawarra region. It is connected to Sydney by the South Coast Railway line and by direct freeway access, as well as the Illawarra regional airport giving access to air commute within the state.

Connectivity

Shell Harbour city centre is located 102.4km from Sydney CBD, via the M1 Motorway, and 20km from Wollongong CBD, connected via the Grand Pacific Drive. Its closest rail connection is the Oak Flats station situated 2km away, accessed by bus from the Shell Harbour City Centre and Shopping Village. It at the heart of the centre, with direct access to the complex, its commercial and retail heart, where people can shop, enjoy a meal, see a show and use government and

council services. As stated by the Shell Harbour City Council, “the city centre has further new development building plans to incorporate an auditorium, meeting areas, a city library, and museum. This development as shown in figure 52, is known as the “City Hub” is adjacent to the Stockland shopping complex, and will provide the previously mentioned features, as well as a civic square for public events, a Council Chamber and Council administration offices, and on-site parking” (Shellharbour City Council 2017).

figure 52 Elanora Shell Harbour location map with immediate surrounds (Shellharbour City Council 2017)

figure 53 Proposed new Shell Harbour town centre development (Shellharbour City Council 2017)

The form of the facility and relationship to the neighbourhood and surrounds

In keeping with the neighbourhood characteristics, Elanora is visually consistent with the overall built form of its surroundings characterised by the shopping centre as well as the planned expansion of the city centre. Its three-storey structure offers visual continuity with the adjacent residential dwellings. Figure 54 shows the street front view of the facility facing the shopping centre.

A variety of common spaces, a centrally located coffee shop with a view of the adjacent shopping centre, and a covered seating area outside the facility. The shopping centre could be accessed with ease via a paved, wheelchair-accessible pathway. Figure 55 shows the ground floor plan of the facility.

Figure 54 Elanora Shell Harbour. (Source: (John Flower 2015)

Figure 55 Elanora Layout Plan. (Source: (John Flower 2015)

Private Areas

Private areas consist of bedrooms and attached bath. The bedrooms had ample natural light with furnishings reflecting a comfortable and contemporary feel. Individuality was created through display of some personal belongings. Residents controlled their privacy by leaving their doors closed or open to the corridor, which indicated if they wished to have any social interaction or not. All rooms had an ambulant accessible attached bathroom.

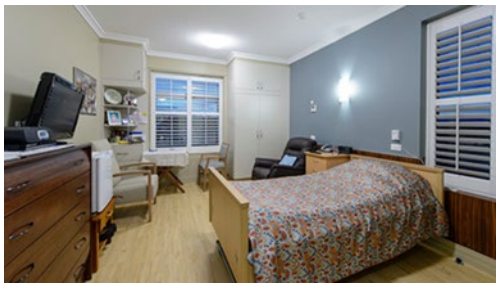


Figure 56 Elanora Layout Plan. Source: (John Flower 2015)

Common Areas

The corridors were filled with substantial natural light though generous windows, as well as light through the large atrium skylight. The common corridor space was tastefully furnished and decorated in keeping with the calm neutral palette of colours and artwork, seen throughout the facility. The corridors were observed to be vibrant spaces of social interaction with residents 'whizzing' around in their electric wheelchairs, and visiting each other in their rooms, the doors of many observed to be left open. The lounge areas were well used and filled with natural light, with common areas for gatherings of groups or privacy to sit quietly by oneself. The researcher observed residents interacting during mealtimes as well as watching a favourite television program together, or gazing out into the garden enjoying the birdlife outdoors. The 'café' within the premises operated by a private, sole business owner was seen to be a vibrant hub for the resident community. This space was seen to be used both by residents and staff, as well as visitors to the facility, being located right next to the entrance and reception area. The entrance was a light filled space with an inviting seating area with a view out to the neighbouring shopping village through its vast glass doors.

Figure 57 Entry foyer: (Calder Flower Architects 2017)

Figure 58 Lounge seating (Calder Flower Architects 2017)

Figure 59 Accessible corridor. Source: (Calder Flower Architects 2017)

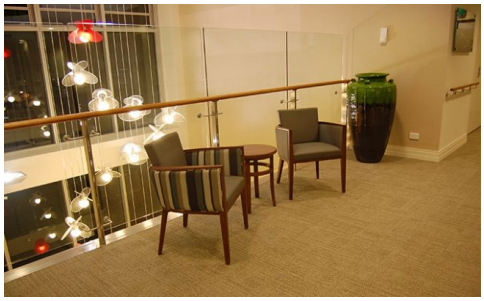


Figure 60 Longe. Source: (Calder Flower Architects 2017)

Figure 61 Games space. Source: (Calder Flower Architects 2017) 2017)

Figure 62 Dining room. Source: (Calder Flower Architects

Outdoor Areas

An indoor/outdoor covered area directly adjacent to the entry was created by the management because residents enjoyed using this space with a view of village. The residents therefore enjoyed being visually connected to the surrounding community, but within the safety and convenience of being in their own home.

Public Areas

The new Shell Harbour town centre is a new development, with many new housing estates and ongoing building of the commercial community centre, adjacent to Elanora. An access-way is designed for easy access for residents from Elanora across the road to the shopping centre. Integration with the adjoining Catholic Church was by shared parking facilities and a physical connection along a pathway connecting the two premises. The high visibility of the home in the neighbourhood was in keeping with the scale of the adjoining buildings. Figure 65 shows the shopping centre.

Future building works were also noted in establishing a self-care retirement facility adjacent to the residential care home. The model for this development includes co-location of facilities and services with a physical connection between the two developments.

Figure 65 Shopping centre (Uniting 2018)

The care model of the facility

The care model of Uniting Care Ageing service delivery is based on a Christian ethos of compassion and love for all. Its *Inspired Care* model, adopted at Elanora, seeks to enable the well-being of residents offering a service of care with courage, integrity, compassion and respect, whilst encouraging active connection to the local community. As stated by Uniting Care Ageing "as a ministry of the Uniting Church, we are committed to finding better ways to affirm life for all people, especially those who are old and vulnerable" (Uniting Care NSW. ACT).

Its location adjacent to the Shopping Complex enables the care model to encourage connection to the neighbourhood, enabling a dynamic integration into the social hub with ease. Active relationships with neighbourhood groups are continually developed and maintained. Currently

it associates with a childcare group for cross-generational interaction, as well as collaborating with other spiritual groups, such as facilitating a physical connection via a pathway for ease of access to the Catholic Church located close to the facility. The major feature of the care and management model of Elanora, the *Inspired Care* principle, also actively acknowledges and promotes a non-clinical physical environment. Figure 5.46 shows residents engaged in community activity.

Figure 66 Resident activity. (Uniting 2018)

Figure 67 Integenerational activity. (Uniting 2018)

Resident Profile

Elanora, Shell Harbour, is home to 100 residents, in its 100-bedroom facility. All residents are in a residential aged care environment, including high needs care leading on to palliative care, with provision for continuity of care. Of the 100 residents, 10 are dementia care needs residents. The residents include both sexes, with twenty-five percent male residents and seventy-five percent female residents. The majority ethnic group in the Elanora care facility is Spanish migrants, comprising twenty five percent.

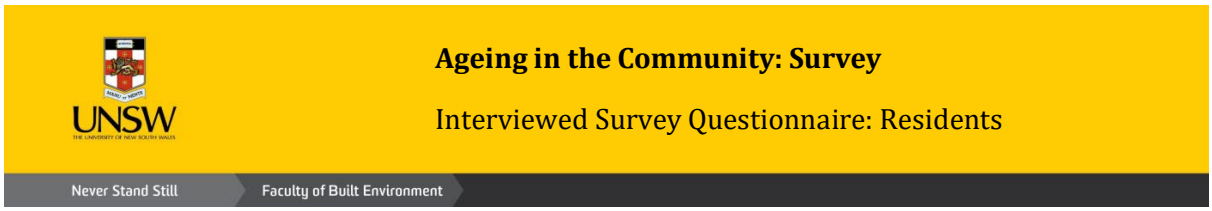
This research included 5 residents from Elanora, ranging in age from 81 to 86 years of age, including two male residents, and three female residents, with varying degrees of cognitive decline and resulting ability levels. See Table 5 below.

Table 5 Elanora Shell Harbour; Resident Details

Case Study 4: Elanora Shell Harbour, Resident Profile											
Resident Profile							Health Status				
Resident	Age	Gender	Relationship Status	Funding	Country of Birth	Length of residence	PAS Score	Personal Care Level	Mental Capacity	Physical Capability Level	Activities
Resident 1	83	F	Widow	Concessional	England, UK	6 months	5	Low	Alert & oriented	- Mobile with the aid of a wheelie walker	- Goes out frequently - Has many friends - Socialises within the home
Resident 2	86	F	Widow	Accommodation Fee	Ireland	9 Months	8	High	Alert & Oriented	- Mobile with the aid of Motorised wheel chair - Cannot walk due to paralysis following stroke	- Frequently goes out to access community and services in shopping centre
Resident 3	81	M	Divorced	Concessional	Australia	2.5 Years	5	Low	Alert and oriented	- Walks with wheelie walker - Most mobility by electric scooter	- Goes out to access community every day

Resident 4	85	M	Widowed	Concessional	Australia	2 years	10	High	Alert & Oriented	- Walks with wheelie aid	- Socialises within the home
Resident 5	84	F	Widow	Concessional	Australia	3 Years	6	High	Alert & Oriented	- Walks with wheelie walker	- Socialises within the home - Goes out to access community

Appendix 2: Resident interviewed survey questionnaire



Have Your Say

Ageing in the Community Survey.

What is this research about? We want to understand your needs and preferences about the location and design of the aged care home you live in. Your answers will help us to understand how people living in Aged care relate to the wider community and how the design and location of aged care homes can improve quality of life.

Who will participate in this survey? Five residents who live here.

Ensuring your privacy: Any information you give will be confidential. You will not be personally identified and the information you give us will only be used for research purposes. This research has received ethics approval from the University of NSW. University ethics panel approval no. 115055.

SECTION 1: First, some questions about your interaction with others, within and outside this home

Question 1: which of the following do you regard as your 'community'? *(Please tick one or more of the following)*

☐ Other residents who live with you

☐ People outside these premises in the local community

☐ Visitors/ non-residents to your home

☐ Visiting family and friends

☐ Other visitors/ professionals

☐ Other 1: *(please specify)*

☐ Other 2: *(Please specify)*

Question 02: How important is it for you to interact with:		**V. Important**	**Important**	**N/A**	**Not Important**	**Never**
1	Residents from within this home					
2	Visiting family					
3	Visiting friends					
4	Members of the local community outside this facility					
5	Spiritual community/ church group					
6	Other 1: (Please Specify)					
7	Other 2: (Please Specify)					

SECTION 2: Now some questions about living in this home

Question 03: How important to you is:		**V. Important**	**Important**	**N/A**	**Not Important**	**Never**
1	The location of this home					
2	Ability to have choice in selecting this home to live					
3	Personal care facilities available in this home					
4	Health care facilities available in this home					
5	Entertainment facilities available in this home					
6	Other 1: (Please Specify)					
7	Other 2: (Please Specify)					

Question 04: How often do you interact in the following ways with other residents of this home?		**V. Often**	**Often**	**Occasionally**	**Hardly**	**Never**
1	Meeting in indoor common areas of your home for group activities/ relaxation					
2	Meeting in outdoor common areas of your home for group activities/ relaxation					
3	Meeting in public parks/ recreational areas for relaxation and group activities					
4	Going to local restaurants					
5	Going to a local cafe					
6	Visiting local shops/ amenities					
7	Visiting a shopping centre					
8	Observing other people interacting					
9	Other 1: (Please Specify)					
10	Other 2: (Please Specify)					

Question 05: How often do you interact in the following ways with visiting friends/ family?		**V. Often**	**Often**	**Occasionally**	**Hardly**	**Never**
1	Meeting in indoor common areas of your home for group activities/ relaxation					
2	Meeting in outdoor common areas of your home for group activities/ relaxation					
3	Meeting in public parks/ recreational areas for relaxation and group activities					
4	Going to local restaurants					
5	Going to a local cafe					
6	Visiting local shops/ amenities					
7	Visiting a shopping centre					
8	Observing other people interacting					
9	Other 1: (Please Specify)					

10	Other 2: (Please Specify)					

Question 06: How often do you engage in the following ways with health professionals?		**V. Often**	**Often**	**Occasionally**	**Hardly**	**Never**
1	Medical services within this home, if available					
2	Using outdoor spaces in your home for physical therapy					
3	Visiting a medical centre in the local community					
4	Visiting a pharmacy in the local community					
5	Visiting a hospital for treatment					
6	Other 1: (Please Specify)					
7	Other 2: (Please Specify)					

Question 07: How often do you engage in the following ways with the following professional services in the community?		**V. Often**	**Often**	**Occasionally**	**Hardly**	**Never**
1	Medical and health related services					
2	Using legal services					
3	Learning and Educational services					
4	Accounting services					
5	Financial planning					
6	Fitness and exercise related services					
7	Counselling services					
8	Hair dressing/ grooming services					
9	Recreational services					
10	Other 1: (Please Specify)					
11	Other 2: (Please Specify)					

Question 08: How often do you engage with the local community in the following ways?		**V. Often**	**Often**	**Occasionally**	**Hardly**	**Never**
1	Meeting in the local church or place of worship					
2	Taking part in organised community activities					
3	Meeting in the local RSL					
4	Going out to social events					
5	Volunteering in community activities					
6	Taking part in children's activities or looking after children					
7	Interacting with people in shopping centres					
8	Interacting with people in outdoor public spaces. i.e. parks					
9	Observing other people interacting					
10	Other 1: (Please Specify)					
11	Other 2: (Please Specify)					

Question 09: How important are each of the following to your health and wellbeing?		**V. Important**	**Important**	**Occasionally**	**Hardly**	**Never**
1	Having a community of residents living with you					
2	Being close to shops and retail					
3	Being close to family					
4	Being close to friends					
5	Being close to church or spiritual community					
6	Going on excursions organised by this home to visit places of interest					
7	Activities organised with people coming into this home for entertainment and interaction					
8	Having the freedom to interact with local community					
9	Ease of access facilitating freedom to interact with the outside community (i.e. visiting local shops/ café)					
10	Other 1: (Please Specify)					

11	Other 2: (Please Specify)					

SECTION 3: Now, some questions about your preferences

Question 10: Would you like to have more interaction with other residents in this home?

☐ Yes ☐ No ☐ Don't know

Question 11: How often would you like to have more interaction in:		**V. Often**	**Often**	**Occasionally**	**Hardly**	**Never**
1	Indoor spaces inside your home					
2	Outdoor spaces within the premises of your home					
3	Coffee shop in the local community					
4	Restaurant in the local community					
5	Public park & other outdoor spaces in the community					
6	Religious institution in the local community					
7	Shopping centre in the local community					
8	Other 1: (Please Specify)					
9	Other 2: (Please Specify)					

Question 12: In which of the following places do you feel safe interacting with others?

(Please tick one or more of the following)

☐ Common indoor spaces within this home

☐ Common outdoor spaces within the premises of this home

☐ Café in the local community

☐ local shopping centre

☐ shops and other retail in the local community

☐ Other 1: *(please specify)*

☐ Other 2: *(Please specify)*

☐ None of the above

SECTION 4: Now, Some questions about your choice to live in this home

Question 13: Why did you choose this home? *(Please tick one or more of the following)*

☐ Cost / Affordability

☐ Proximity to family

☐ Design of building

☐ facilities provided

☐ Activities available

☐ Community engagement

☐ Familiar area

☐ Peaceful environment

☐ Convenience to retail and services

☐ Convenience to retail and services

☐ Other 1: *(please specify)*

☐ Other 2: *(Please specify)*

SECTION 4: Finally, Some information about you

Question 14: your gender? Male ☐ Female ☐

Question 15: Your relationship status?

☐ Married/partnered ☐ Never married ☐ Divorced/ Separated

☐ Widowed

Question 16: Your age group?

☐ <65 ☐ 65-69 ☐ 70-74 ☐ 75-79 ☐ 80-84 ☐85-89

☐ 90-94 ☐ 95+

Question 17: Your country of birth?_____

Question 18: Do you have a partner living in this home? Yes ☐ No☐

Question 19: Do you have a partner living outside of this home? Yes ☐ No☐

Question 20: What is your main source of income?

☐ Aged Pension ☐ Veterans Pension ☐ Disability Pension ☐ Private Funds

☐ Superannuation ☐Other: Please explain_____

Question 21:For how long have you lived in this area prior to moving into this home?____Years____Months

Question 22: At what age did you enter this home?_____Years

Question 23: Have you been in another home? ☐ Yes ☐No

Question 24: For how long have you been in this facility?_____Months_____Years

Question 25: Would you like to remain in this facility? ☐ Yes ☐ No ☐ Don't know

Please explain why _____-

_____

_____

Question 22:Is there anything else you want to say about living in this home and your involvement with the wider community?

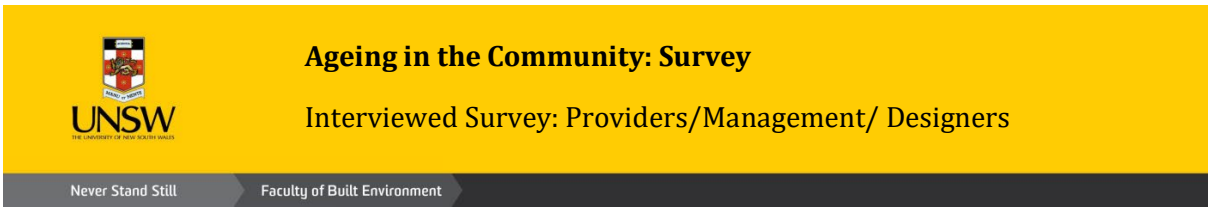
_____-

_____

_____

THANK YOU!

Appendix 3: Stakeholder interviewed survey questionnaire



Have Your Say

Ageing in the Community Survey.

What is this research about? We want to understand your needs and preferences about the location and design of the aged care home you live in. Your answers will help us to understand how people living in Aged care relate to the wider community and how the design and location of aged care homes can improve quality of life.

Who will participate in this survey? Aged care management

Ensuring your privacy: Any information you give will be confidential. The information you give us will only be used for research purposes. This research has received ethics approval from the University of NSW. University ethics panel approval no. 115055.

SECTION 1: First, some questions about your views on 'community integration' in the current climate of Australian aged care policy and practice

Question 01 In the context of an ageing population, what social, political, and economic forces are informing trends towards community integration of residential aged care?

_____

_____

_____

_____

_____

_____

Question 02 What is the impact of community integration on aged care delivery models and practice?

_____

_____

_____

_____

_____

_____

Question 03 What is the impact of community integration on financial and management models in aged care that are emerging in this environment?

_____

_____

_____

_____

_____

_____

Question 04 How can the growing proportion of residents with dementia and other high needs, be reconciled with community integration?

_____

_____

_____

_____

_____

_____

Question 05 What methods of community integration are currently being adopted in residential aged care?

_____

_____

_____

_____

_____

_____

Question 06 What are the benefits of community integration from a resident or their family's perspective?

_____

_____

_____

_____

_____

_____

Question 07 What are the key design and planning characteristics that facilitate community integration?

_____

_____

_____

_____

_____

_____

Question 08 What role does architectural design and urban planning/ design play in facilitating positive outcomes for older people?

_____

_____

_____

_____

_____

SECTION 2: Now some questions about your views of 'community interaction' of residents, within and outside this home

Question 9: which of the following do you regard as the 'community' in relation to this home? *(Please rank one or more of the following in order of importance. i.e. 1,2,3,4,….)*

☐ The community of residents within this home

☐ Staff of this home

☐ People outside these premises in the local community

☐ Visitors/ non-residents to this home

☐ Visiting family and friends

☐ Other visitors/ professionals

☐ Other 1: *(please specify)*

☐ Other 2: *(Please specify)*

Question 10: In terms of community integration, how important is:		**V.Important**	**Important**	**N/A**	**Not Important**	**Never**
1	Community integration as a strategy for residential aged care					
2	The location of this home					
3	The architectural design of this home					
4	The size of this home					
5	The 'home' like atmosphere of this home					
6	Opportunities for residents to interact with each other, in the local community					
7	Interaction with visiting family within the home					
8	Interaction with visiting family in the local community					
9	Interaction with visiting friends within the home					
10	Interaction with visiting friends in the local community					
11	Interaction with members of the community within this home					
12	Interaction with members of the community outside this facility					
13	Interaction with spiritual community/ church group outside this home					
14	Opportunity for spiritual activity within this home					
15	Other 1:(Please specify)					
16	Other 2:(Please specify)					
Comments						

Question 11: Does community integration between residents and members of the local community and visitors make a difference to the management of the home? *(If No, please proceed to Q13)*

☐ Yes ☐ No

Question 12: How does community integration between residents and members of the local community and visitors make a difference to the management of this home?

☐ Aids in emotional wellbeing of residents

☐ Aids in more diligent care by care workers

☐ Leads to disturbance in care routines of residents

☐ Leads to noise and disruption of peaceful atmosphere in the home

☐ Leads to an active vibrant atmosphere in the home

☐ Requires increased management diligence in safety and security

☐ Leads to higher cost of management

☐ Increase in positive profile of home

☐ Other 1: *(please specify)*

☐ Other 2: *(Please specify)*

Comments:_____
_____
_____
_____
_____

Question 13: Which of the following opportunities for social interaction do you think facilitates the integration of residential aged care with the general community?

☐ Should not facilitate integration

☐ Organised visits to shopping centres/ retail

☐ Organised visits to social institutions (RSL/ Bowling)

☐ Participation in activities in religious institutions

☐ Organised visits to the home by entertainers

☐ location of coffee shop/ retail within premises to encourage interaction with community

☐ Opportunities to access open spaces within the premises by local community.

☐ Installation of children's playground within premises to encourage cross generational interaction

☐ Other 1: *(please specify)*

☐ Other 2: *(Please specify)*

Comments:_____
_____
_____
_____
_____

Question 14: Which of the following policies and principles does this home have that encourage community integration?

☐ No policy initiatives for community integration. (Go to Question 17)

☐Choice and independence to residents

☐ Promotion of healthy lifestyle

☐ Age friendly building and design

☐ Educational programs for seniors

☐ Interaction with the outside community taking place in the local community

☐ Interaction with the outside community taking place within this home

☐ Other 1: *(please specify)*

☐ Other 2: *(Please specify)*

Comments:_____
_____
_____
_____
_____

Question 15: Which one of the following community integration opportunities are feasible within the financial model of this home?

☐ No opportunities for community integration

☐Choice and independence to residents

☐ Promotion of healthy lifestyle

☐ Age friendly building and design

☐ Educational programs for seniors

☐ Interaction with the outside community taking place in the local community

☐ Interaction with the outside community taking place within this home

☐ Other 1: *(please specify)*

☐ Other 2: *(Please specify)*

Comments:_____
_____
_____

_____

_____

Question 16: Which one of the following community integration opportunities are feasible within the management and care model of this home?

☐ Community integration opportunities are not feasible

☐Choice and independence to residents

☐ Promotion of healthy lifestyle

☐ Age friendly building and design

☐ Educational programs for seniors

☐ Interaction with the outside community taking place in the local community

☐ Interaction with the outside community taking place within this home

☐ Other 1: *(please specify)*

☐ Other 2: *(Please specify)*

Comments:_____

_____

_____

_____

_____

Question 17: Which of the following opportunities offered by this home encourage resident's health and wellbeing through community integration?

☐ Opportunities for members of the community to interact with residents within the home premises

☐ Opportunities for members of the community to interact with residents within the local community

☐ location of the home close to community amenities and retail

☐ Age friendly design with ease of access to local community

☐ management policy facilitating community integration

☐ Other 1: *(please specify)*

☐ Other 2: *(Please specify)*

Comments:_____
_____
_____
_____
_____

Question 18: Do you have residents who have transferred from another facility? *(if 'No' please proceed to Q.20)*

☐ Yes ☐ No

Question 19: Which of the following reasons do residents give for transferring to this home from another home? *(Please tick one or more of the following)*

☐ Cost / Affordability

☐ Proximity to family

☐ Design of building

☐ Facilities provided

☐ Activities available

☐ Community engagement

☐ Familiar area

☐ Peaceful environment

☐ Convenience to retail and services

☐ Religious specificity.

☐ Cultural specificity.

☐ Other 1: *(please specify)*

☐ Other 2: *(Please specify)*

Comments:_____

_____

_____

_____

_____

SECTION 3: Some questions about your choice to work in this home

Question 20: How important are each of the following community integration initiatives as a reason you choose to work in this home?		**V.Important**	**Important**	**N/A**	**Not Important**	**Never**
1	The location of this home					
2	The architectural design of this home					
3	The size of this home					
4	The 'home-like' atmosphere of this home					
5	Opportunities for residents to interact with each other within this home, in the local community					
6	Interaction with visiting family within the home					
7	Interaction with visiting family in the local community					
8	Interaction with visiting friends within the home					
9	Interaction with visiting friends in the local community					
10	Interaction with members of the community within this home					
11	Interaction with members of the community outside this facility					
12	Interaction with spiritual community/ church group outside this home					
13	Opportunity for spiritual activity within this home with local community					
14	Other 1:(Please specify)					
15	Other 2:(Please specify)					
Comments:						

Question 21: Do you have any other comments on community interaction and residential aged care?

_____

_____

____

Section 4: Some information about this home

Please refer Appendix:1: Aged Care Home profile table., & Appendix 2: Resident Profile table

THANK YOU!

Appendix 4: Exploratory discussions; Ethics approval,

THE UNIVERSITY OF NEW SOUTH WALES

FACULTY OF THE BUILT ENVIRONMENT

HUMAN RESEARCH ETHICS ADVISORY PANEL

Built Environment Human Research Ethics Advisory Panel

Date: *24 October 2013*

Applicant Name: Anjalika Wijesurendra

Faculty of the Built Environment

Re*: Community integrated Residential Aged Care; Implications for planning and design*

Reference Number: *135098*
Investigator: Anjalika Wijesurendra

At its meeting of , the Built Environment Human Research Ethics Advisory Panel was satisfied that this project, is of minimal ethical impact and meets the requirements as set out in the National Statement on Ethical Conduct in Human Research*. Please see the accompanying minutes from the panels meeting for notes regarding your research.

Having taken into account the advice of the Panel, the Deputy Vice-Chancellor (Research) has approved the project to proceed.

Your Head of School/Unit/Centre will be informed of this decision. This approval is valid for 12 months from the date of the meeting.

Yours sincerely

Russell Lowe
Panel Convenor
Built Environment Human Research Ethics Advisory Panel

Cc: Head, School of the Built Environment
* http:/www.nhmrc.gov.au

Appendix 5: In-depth interviewed questionnaire; Ethics approval

Built Environment Human Research Ethics Advisory Panel

Date: *5 June 2014*

Applicant Name: *Anjalika Wijesurendra*

Faculty of Built Environment

Re*: Community integrated Residential Aged Care: Implications for planning and Design. The case of the Australian Aged Care System.*

Reference Number: *145055*
Investigator: Anjalika Wijesurendra

At its meeting of 4/6/2014 the Built Environment Human Research Ethics Advisory Panel was satisfied that this project, is of minimal ethical impact and meets the requirements as set out in the National Statement on Ethical Conduct in Human Research*. Please see the accompanying minutes from the panels meeting for notes regarding your research.

Having taken into account the advice of the Panel, the Deputy Vice-Chancellor (Research) has approved the project to proceed.

This approval is valid for 5 years from the date of the meeting.

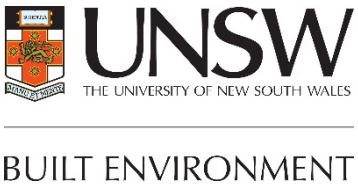
Yours sincerely

Russell Lowe
Panel Convenor
Built Environment Human Research Ethics Advisory Panel

* http:/www.nhmrc.gov.au

Appendix 6: Project information statement

PROJECT INFORMATION STATEMENT



Date: *18 May 2014*
Project Title: *Community Integrated Residential aged care; Implications for Planning and Design. The case of the Australian Aged Care system.*

Approval No.: ***145055***

Participant selection and purpose of study

You are invited to participate in a study of *the design of residential aged care facilities.* You were selected as a possible participant in this study because *you are a resident of / key stake holder in the field of residential aged care*

Description of study

If you decide to participate, I wish to request you to fill out a questionnaire detailing your views on residential aged care facilities that were selected for this research, in which you are a resident/ member of staff/ aged care provider/ designer. The questions relate to the factors influencing change in the aged care sector and how this is effecting the design and location of aged care facilities, and their integration into the community. I would like to request up to one hour of your time to conduct and record this interview. *As the provision of aged care is of growing importance here in Australia, as well as in a global context, due to the ageing of the population and its impact on policy and economy, this research has relevance for the aged care sector, in which you are a key participant. However, w*e cannot and do not guarantee or promise that you will receive any benefits from this study.

Confidentiality and disclosure of information

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission, or except as required by law. If you give us your permission, we plan to *publish* the results *as a PhD thesis undertaken at the University of New South Wales, and in relevant academic conferences and journals. In any publication, information will be provided in such a way that you cannot be identified.*

Your consent

Your decision whether or not to participate will not prejudice your future relations with The University of New South Wales or other participating organisations. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without prejudice by completing the statement below and returning this entire form to *Anjalika Wijesurendra. E Mail: a.wijesurendra@student.unsw.edu.au. PH: 02-93856373.*

If you have any questions, please feel free to ask *Anjalika Wijesurendra. E Mail: a.wijesurendra@student.unsw.edu.au. PH: 02-93856373, or my supervisor, Professor. Bruce Judd. Ph: 02-93856683.* If you have any additional questions later, *Professor. Bruce Judd. E Mail: b.judd@unsw.edu.au. Ph: 02-93856683* will be happy to answer them.

Kind Regards,

ANJALIKA WIJESURENDRA

REVOCATION OF CONSENT. Project Title: *Community Integrated Residential aged care; Implications for Planning and Design. The case of the Australian aged care system.*
(Please send this entire form to the above address.)
I hereby wish to withdraw my consent to participate in this research project. I understand that such withdrawal will not jeopardise my relationship with The University of New South Wales, other participating organisations or other professionals.

…… ……

Signature Please PRINT name Date

Appendix 7: Project consent form

PROJECT CONSENT FORM

THE UNIVERSITY OF NEW SOUTH WALES

BUILT ENVIRONMENT

Project Title: ***Community Integrated Residential Aged Care; Implications for Planning and Design. The case of the Australian aged care system***

You are making a decision whether or not to participate in a research project.

This PROJECT CONSENT FORM enables you to indicate your preparedness to participate in the project. By signing this form, your signature indicates that you have decided to participate.

You will be given a PROJECT INFORMATION STATEMENT that explains the project in detail, and that statement includes a revocation clause for you to use if you decide to withdraw your consent at some later stage. The PROJECT INFORMATION STATEMENT is your record of participation in the project.

This PROJECT CONSENT FORM will be retained by the researcher as evidence of your agreement to participate in this project.

Please complete the information in this box.

Please indicate which of the following options you agree to by ticking one of the following options:

☐ I consent to being quoted and identified

☐ I consent to being quoted but I do not want to be identified

.....
Signature of Research Participant

.....
Please PRINT name

.....
Date

Name of researcher: ***Anjalika Wijesurendra***