

Designing an Alternative, Community Integrated Model of Residential Aged Care for People Living with Dementia: Nominal Group Technique and Thematic Analysis

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Abstract.

Background: Small-scale models of dementia care are a potential solution to deinstitutionalize residential aged care and have been associated with improved resident outcomes, including quality of life and reduced hospitalizations for people living with dementia.

Objective: This study aimed to generate strategies and ideas on how homes for people living with dementia in a village setting within a suburban community, could be designed and function without external boundaries. In particular, how could residents of the village and members of the surrounding community access and engage safely and equitably so that interpersonal connections might be fostered?

Methods: Twenty-one participants provided an idea for discussion at three Nominal Group Technique workshops, including people living with dementia, carers or former carers, academics, researchers, and clinicians. Discussion and ranking of ideas were facilitated in each workshop, and qualitative data were analyzed thematically.

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Results: All three workshops highlighted the importance of a surrounding community invested in the village; education and dementia awareness training for staff, families, services, and the community; and the necessity for adequately and appropriately trained staff. An appropriate mission, vision, and values of the organization providing care were deemed essential to facilitate an inclusive culture that promotes dignity of risk and meaningful activities.

Conclusion: These principles can be used to develop an improved model of residential aged care for people living with dementia. In particular, inclusivity, enablement, and dignity of risk are essential principles for residents to live meaningful lives free from stigma in a village without external boundaries.

Keywords: Alzheimer’s disease, aged care, co-design, dementia, dementia care, dementia village, geriatrics, group homes, nursing, nursing homes

INTRODUCTION

Nationally and internationally, there are strong social pressures to deinstitutionalize residential care for people living with dementia, including Alzheimer’s disease [1]. Therefore, there is a focus on having people who have cause to draw on this high level of care residing in homes in the community [1]. These may be single dwellings or a cluster of homes in a village setting. In Australia, small-scale models of residential aged care have received greater attention in light of findings by the Royal Commission into Aged Care Quality and Safety. The Royal Commission was established in 2018 in response to increased public awareness of abuse and neglect of residents in aged care homes. The Commission identified multiple serious failures in the Australian aged care system, with the final Report, released in 2021, making 148 recommendations for reform including that the Australian Government support residential aged care providers to redesign the built environment and modify care models to enable them to “provide small-scale congregate living which facilitates the small household model of care” [2]. This has the potential to improve quality of life and health outcomes for people living with dementia who require more personalized care and support [1, 3–5]. These small-scale dementia care models often sit within community settings and aim to integrate residents with, rather than segregate them from, the surrounding neighborhood.

Small-scale dementia care homes typically accommodate six to fifteen people, consider residents’ personal preferences and privacy, recruit staff willing to get to know residents and engage in typical home activities such as preparing meals together, all attributes that may not be achievable in other environments [1]. Small-scale environments can increase meaningful engagement in everyday activities, access to the outdoors, quality of life, social interaction,

staff satisfaction, and resident-rated quality of care while also lowering hospitalization and emergency department presentations [1, 3–6]. Types of small-scale environments vary, from clustered homes within larger organizations to stand-alone houses in the community. Currently, small-scale care models in Australia focus on social engagement, relationship-building, and person-centered care, concepts that aim to maintain the dignity and respect of residents [5, 7, 8]. Small-scale dementia care can contribute to physical, cognitive, psychological, and social well-being and are often described as ‘enabling’ [4, 9]. ‘Enabling’ care environments aim to minimize disability, be flexible in care, and support the individual to engage in meaningful activities. There may also be reduced use of psychotropic medications [4, 7, 10].

The underlying principle is to enable people living with dementia to maximize their ability to live an autonomous lifestyle that supports their strengths, unique needs and preferences, and provides support from their family, friends, the care team and the wider community [7, 10]. The home and village environment are designed to be familiar to residents, supporting them to function optimally and maintain their capabilities. Residents are, therefore, less likely to feel trapped, imprisoned, or lost [10]. The homes are typically surrounded by gardens and accessible services such as a grocery store, a hairdresser, a café, and an early learning center. Typical design elements include appropriate orientation aids, gardens, water features, picnic areas, and environmental safety features both within homes and in the external setting. Safety features may include no steps and inconspicuous gates, doors, or fences that allow for some autonomy but reduce risk of harm.

This embraces the principle of ‘dignity of risk’, whereby people (of any level of cognitive impairment) can make choices and accept risks of potential consequences [11]. This challenges current paradigms where safety is often paramount but to the

potential detriment of people living meaningful lives with self-expression of identity and choice. However, because most of these villages are ‘gated’, seeking a balance between freedom of choice and protection from harm, they have been challenged as still being restrictive, segregating people living with dementia from the rest of the community [12].

There is not yet enough evidence to convince many organizations to completely shift to small-scale models, with a Cochrane review finding only six studies of low quality [1]. There are few examples of genuine integration of residential aged care homes for people living with dementia that are truly embedded into the community. Similarly, public involvement in developing and implementing these homes is not commonplace [12]. In particular, how to manage the levels of ‘openness’ and accessibility to services and other facilities in terms of locked doors, gates, and external boundaries in such care homes remains unclear [12]. In Australia, there are no villages designed to enable people living with dementia and located in a community without external boundaries, which would allow residents to be more integrated into the surrounding community as part of their daily lives.

The current study aims to assist in the proposed development of a purpose-built village named ‘The Neighbourhood, Canberra’ (TNC), which will be designed for people living with dementia in the greater Australian Capital Territory (ACT) region. The study aims to generate strategies and ideas on how a village could be co-designed to function without external boundaries, so that residents and community members can engage safely and equitably in all aspects of the open village.

METHODS

This study used a collaborative process named Nominal Group Technique (NGT) [13, 14]. This technique is commonly used to explore healthcare priorities and strategic problems to generate and develop appropriate and innovative ideas. NGT generates stakeholder perspectives in group discussions where participants have a common interest and the knowledge and experience to contribute. Each participant is given an equal opportunity to present their idea independently, and other group members are encouraged to respectfully ask questions if their idea requires clarification (Fig. 1). This process aims to prevent the domination of the discussion by one group

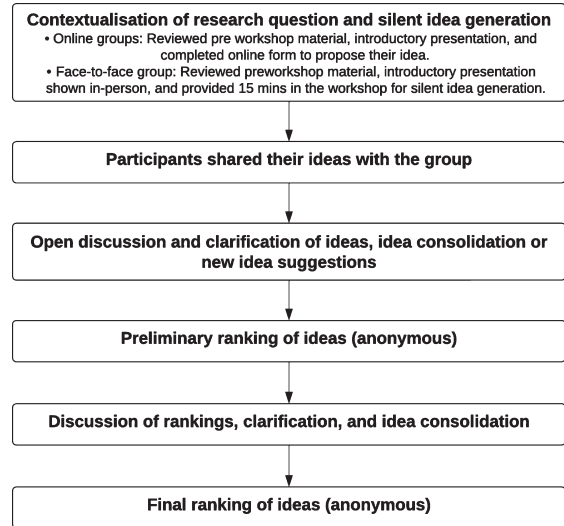


Fig. 1. Nominal Group Technique process.

member and encourages all members to participate and thus is constructive for use with members of the public alongside professional experts [14]. Ethics approval was obtained from the XXX Human Ethics Research Committee (HREC 2022.11728).

Study context

The current study aims to assist in the proposed development of a purpose-built village designed for people living with dementia in the greater Australian Capital Territory (ACT) region (<https://www.theneighbourhoodcanberra.com.au/>). TNC is a not-for-profit association consisting of local volunteers interested in dementia care and with experience caring for people living with dementia. A unique aspect of TNC is that it aims to foster genuine human connection with the community in which it is located. By having an authentic connection to the community and encouraging intergenerational connections, TNC has a goal of setting a foundation for a nurturing, loving and meaningful life for residents. TNC is proposed to have 15 small-scale residential homes of six people per home in a village setting, with services for residents and the local community, including a café, shops, childcare center, health facilities, and other on-site services. An aspiration of TNC is to be an open village, without external boundaries, and a built environment designed to maximize permeability between the homes, services, and local community. Collaborating with an innovative and forward-thinking aged care provider is essential for TNC to realize their

Table 1
Guide for silent idea generation [39]

What needs to be in place to ensure that people living with dementia can engage safely and equitably in all aspects of the Neighbourhood?	
<i>*For example, café, shops, library, restaurant, fitness center, childcare center, classrooms, hairdresser</i>	
Name your idea	<i>My idea is called . . .</i>
Explain your idea	<i>My idea is . . .</i>
Summarize the benefits	<i>My idea would be good because . . .</i>
Identify the obstacles	<i>The main obstacles to be overcome before the idea would work would be . . .</i>

190 vision. It is anticipated that the outcomes of the
191 current study will support the establishment and co-
192 design of a village for people living with dementia
193 who have cause to draw on a high level of care embed-
194 ded in the local community.

195 *Participants*

196 An expert panel was convened, including people
197 living with dementia, carers or former carers of peo-
198 ple living with dementia, people working in aged
199 care, and academics with expertise in gerontology
200 and clinical experience. A purposive sample was
201 identified, and individuals were contacted and invited
202 to participate by email. The sampling aimed to recruit
203 people who would be familiar with, or able to under-
204 stand the concept of, small-scale and village-style
205 dementia care and who would have well-informed
206 ideas and suggestions to guide the principles, prac-
207 tice, and design. All participants provided written
208 consent.

209 *Procedure*

210 NGT recommends no more than 9 people per
211 group, therefore, multiple workshops were planned
212 to ensure a range of viewpoints across and between
213 stakeholders. Two online and one face-to-face work-
214 shop were offered to participants. The allocation to
215 groups was conducted based on the preferences and
216 availability of participants. Conducting NGT work-
217 shops online has become more common during the
218 COVID-19 pandemic [15], enabling people living
219 outside the ACT region to participate. This was also
220 useful for people in the ACT region who had schedul-
221 ing conflicts with the face-to-face workshop.

222 Participants were provided with an information
223 guide prior to the scheduled workshops, which pre-
224 sented background information with a two-page
225 summary of currently available evidence, the aim
226 of the workshops, a brief description of the NGT
227 process, and recommended additional reading. The

228 information guide was designed to be accessible to
229 all participants and was written in plain language. A
230 visual summary was also provided in the form of a
231 Microsoft PowerPoint presentation, which included
232 orientation to the project, examples of villages for
233 people with dementia, an introduction to TNC, and
234 an explanation and contextualization of the research
235 question and NGT process.

236 Each group was facilitated by an experienced occu-
237 pational therapy clinician and two academics familiar
238 with the NGT process and with experience working
239 in and researching dementia care. The facilitators had
240 met most of the group members prior to the interview
241 in a professional capacity, and the participants were
242 aware of the facilitators’ roles in the research project.
243 The question proposed to all groups was:

244 *What needs to be in place to ensure that peo-*
245 *ple living with dementia can engage safely and*
246 *equitably in all aspects of the Neighbourhood?*

247 Participants were asked to consider their idea fur-
248 ther using prompts as displayed in Table 1. There
249 were slight differences between the face-to-face and
250 online groups, with the online groups being asked
251 to do additional preparation in the form of watching
252 the Microsoft PowerPoint presentation to reduce the
253 time spent online (Fig. 1). During each workshop,
254 additional time, rephrasing of questions, and direct
255 time for quieter members were used to support the
256 diversity of experience of group members and their
257 communication needs. The NGT methodology was
258 used to minimize the impact of power imbalances
259 by giving equal time opportunity to express their
260 views. Moreover, each participant was introduced
261 by a researcher without reference to qualifications.
262 All researchers, clinicians, and service providers who
263 participated were experienced in working with peo-
264 ple living with dementia and accustomed to creating
265 equitable and relaxed forums for human-to-human
266 interaction. Each workshop was audio-recorded, tran-
267 scribed verbatim, and checked for accuracy by a
268 facilitator. Each online workshop lasted 90 min, and

the face-to-face workshop lasted three hours. Participants living with dementia received support from their carer or other participants when needed. The facilitators took notes during each workshop.

Data analysis (NGT)

Each participant, in turn, presented their preliminary ideas to their group, and a record of these was captured. Discussion ensued, and the group collated, debated, and refined the ideas with assistance from facilitators. Common or similar ideas were formed into combined suggestions based on consensus. Preliminary voting was used to rank the original ideas and to facilitate further discussion before final voting within each workshop group. Subsequently, a final list of three ranked ideas were agreed upon in each workshop. There are no agreed-upon levels of acceptable consensus for NGTs, and pragmatically, a consensus level of two-thirds (or 66%) was considered appropriate [16, 17].

Data analysis (thematic analysis)

The ideas from each participant, final ideas, and transcripts were analyzed using a reflexive thematic approach. The analysis used the six-phase process for data engagement, coding, and theme development, as Braun and Clarke (2020) described. This included three researchers (ND, HH, and SI) undertaking data familiarization, systematic data coding, generation of initial themes from coded data, developing and reviewing themes, refining, defining and naming themes, and writing the report [18]. Each participant was sent a summary of the results of the workshops and a preliminary thematic analysis for member checking. Comments were invited on whether the participants felt that the representation of the ideas from their workshop were accurate. To ensure best practice for qualitative research, we adhered to the “Consolidated criteria for reporting qualitative research (COREQ)” reporting guidelines [19].

RESULTS

The purposive sampling process included 30 people. In total, 22 people agreed to participate. Five people did not participate due to non-response, and two were not available/declined. One person agreed to participate but withdrew due to unforeseen circumstances, leaving 21 participants (70%). Three NGT

groups were scheduled. Participants located in the ACT region were invited to attend the face-to-face NGT workshop, while those in other cities or unable to attend the face-to-face NGT workshop participated via Zoom. Some ACT participants chose to participate via Zoom. All participants are involved in either aged care and/or dementia research, providing care and support services for people living with dementia, or having lived experience or caring for a person with dementia. Consensus from each group is presented prior to presenting the themes from the qualitative analysis of statements and workshop transcripts. Participant roles and codes for the quotes featured in the thematic analysis are presented in Table 2.

Consensus from the NGT workshop

The original ideas generated by participants were about increasing dementia awareness and education in the local community ($n = 6$); an inclusive and flexible culture that is deinstitutionalized ($n = 4$); staffing and care that encourages meaningful activities and engagement ($n = 3$); a support and training framework for all people associated with the village ($n = 1$); placemaking/creating inclusive public spaces valued by the people who use them ($n = 1$); using technology to make shared memories with family ($n = 1$); a focus on intergenerational relationships ($n = 1$); freedom and safety with help from technology ($n = 1$); balancing safety and a human rights-based approach ($n = 1$); a safe and navigable physical environment ($n = 1$), and community gardens ($n = 1$).

Following discussion and preliminary and final voting, all three groups highlighted the importance of the community surrounding the village as critical to its success. Education, culture, and staffing were also common ideas considered and discussed by each group, with some similarities and differences. The top three ideas from each group are presented in Table 3. The similarity between the final ideas was noted by several participants in their email responses to the preliminary report indicating resonance. In particular, this related to the need for the right number of staff with an appropriate level of education to support the culture needed for a village for people living with dementia without an external boundary. This was raised in different ways but with similar meanings and words used across workshops by participants. Many participants were adamant that without appropriate staffing, targeted education, and the right culture, the vision could not be achieved.

Table 2
Participants of NGT Workshops

Code	Workshop 1 (Online)			Workshop 2 (Face-to-face)			Workshop 3 (Online)		
	Role	Location	Code	Role	Location	Code	Role	Code	Location
R1	Researcher/Psychologist	NSW	S1	Service Provider/Nurse	ACT	R6	Researcher		TAS
C1	Carer	TAS	P1	Person with Dementia	ACT	R7	Researcher/Occupational Therapist		NSW
R2	Researcher/Geriatrian	NSW	S2	Service Provider	ACT	R8	Researcher		NSW
R3	Researcher/Aged Care	NSW	C2	Carer	ACT	C4	Carer		QLD
R4	Researcher	ACT	P2	Person with Dementia	ACT	P3	Person with Dementia		QLD
R5	Researcher	UK	C3	Carer	ACT	S4	Service Provider		ACT
			S3	Service Provider	ACT	R9	Researcher/Nurse		ACT
			L1	Local Politician	ACT				

ACT, Australian Capital Territory; NSW, New South Wales; QLD, Queensland; TAS, Tasmania; UK, United Kingdom.

Thematic analysis

To provide a more nuanced analysis of the discourse when deciding consensus statements, a thematic analysis of the three workshop transcripts was performed to provide insights into the thoughts, opinions, and experiences of participants. The main themes were 1) A surrounding community that is invested in the village; 2) Education of all people at all levels of the village community; 3) Care staff who promote an enabling person-centered care environment; 4) The organizational mission, vision and values promote an inclusive culture; 5) The village should allow residents to engage in meaningful activities, and 6) The built environment is designed to enable maximum engagement.

Theme 1: A surrounding community that is invested in the village

This theme had strong support during the discussion across all three groups and is aligned with the top-ranked idea in two NGT groups: “Train the community” and “Dementia friends in the community”. One participant summarized this theme:

“I think the local community is going to require some preparation, and I think this will require quite a lot of investment of time and resources. . . . But, what we have not yet done anywhere, to the best of my knowledge, is really get the surrounding community to fully embrace and accept and almost rejoice in the fact that within the community, there are a group of people who happen to have dementia” (R8).

Participants expressed that early and ongoing communication and consultation with the local community was essential to maximize their engagement and acceptance of the village. It is “essential to do the groundwork to ensure that we do get buy-in from everyone” (R2). Communication should occur before establishment, which would allow the local community members to have their concerns addressed. One participant suggested to “set up some forums so that the neighborhood can be fully informed about the nature of the facility itself and the actual size of it and what is going to be the concrete details” (R8).

Another participant (R5) stated that communicating with the surrounding local community also provided an opportunity to “talk about the values and purpose of the [village]”. Participants raised the need to market the village and its facilities (shops

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Table 3
Top three consensus ideas

Idea	Description
Top three ideas – NGT 1	
1 Train the community	Community members and businesses need to be trained on how to engage with people living with dementia and understand their complexities. Genuine care and empathy from the community needs to be fostered – not only from staff and families. This will require an embedded communication strategy within the local community.
2 Inclusive culture and environment	Set norms for inclusivity, respect, and tolerance for everyone within the community. There should be communal spaces for everyone, and potential environmental triggers should be considered (e.g., music, lighting, ambiance) to create a safe, respectful and peaceful vibe. The physical environment should enable intergenerational relationships and stimulate memories and learning through different mediums including art, music, and technology.
3 Staff and the context of care	Staff should be supported to create and enable a relaxed environment and model of care, and to enable dignity of risk. It is essential this is supported by technology and the physical environment.
Top three ideas – NGT 2	
1 The culture	The culture of care needs to be enabling for staff. There should be flexible and appropriate staffing ratios (depending on the needs of the person). It is essential to find the right staff, who want to be part of a family, while providing person-centered care.
2 Support & training framework	A framework of support should be in place for all stakeholders to ensure residents have dignity of risk and choice. Hubs of support should be in place to engage with internal and external stakeholders to fosters a collaborative, inclusive culture, with education at various levels.
3 Whole community culture	All people in the community (staff, people working at facilities, surrounding communities) should be educated on dementia so that the village can meet the needs of all – no need for fear. The built environment must be safe and accessible to all users and appeal to people in the community. The design of the grounds should promote good health, social interaction, and good nutrition [community gardens – the harvest can be used by on-site facilities] and address the needs of culturally diverse groups.
Top three ideas – NGT 3	
1 Dementia friends in the community	Integration with the community will only be achieved with acceptance of the idea by the community. This will require a long-term systematic approach that includes 1) information and engagement with the community, 2) education and resources on dementia and person-centered care, 3) Community education about the model of care and potential triggers for behavior. Along with safety features built into the environment, having a dementia friendly community will help balance safety along with human rights and legal responsibilities.
2 Staffing for meaningful and accessible engagement	Workforce must be resourced to “go with the flow” of the person with dementia and to facilitate choices and tailored experiences that suit their skills, interests, communication styles, and mood. This requires a skilled and nuanced approach. More than “dementia aware” or “dementia friendly”, it should be “dementia enabling”. This approach should include jobs within the facilities for people living with dementia to provide a sense of purpose and reduce social isolation.
3 Deinstitutionalize staff and family	Education, guidelines, and policies need to be in place to support deinstitutionalization – with an overarching goal of promoting dignity of risk and a person-centered care approach that can overcome behavioral and safety concerns of staff and families.

412 and garden areas) to the local community: “it is all
413 about marketing what we’ve got on-site as well and
414 how well we can integrate that” (S2) to foster their
415 engagement.

416 Defining the local community and understanding
417 their needs was also seen as an important considera-
418 tion of successful marketing (R1).

419 *Theme 2: Education of all people at every level*
420 *of the village and community*

421 Several different groups of people will engage
422 in the proposed open village for people living with
423 dementia, including the residents, families, staff,

424 businesses, and the surrounding community. The
425 level of knowledge of dementia and the subsequent
426 learning needs of the different groups of people will
427 be divergent and need to be considered: “It’s not a
428 given that all people think the same . . . I think basic
429 training would be central to all stakeholders” (S3).

430 Education was seen as an essential way to address
431 all the needs of the different groups and a way to:
432 “emphasize that people with dementia can still have
433 choice about what they want to do . . . and to promote
434 basically that idea of dignity of risk” (R6).

435 “There is big training and little training and
436 you’ve got to kind of like, understand the motiva-
437 tors of people using those spaces, all the different

438 groups and . . . understand the concerns and how
439 much training they want to do....all different types
440 of training” (R1).

441 While directing people towards existing formal
442 educational resources was considered valuable, this
443 could also be about general media or posters within
444 the community, for example, guides to communica-
445 tion aids, environmental cues, and vignettes about the
446 people living in the village.

447 *Subtheme 1: The local community*

448 Participants thought that education and training in
449 the local community could promote the benefits of
450 a dementia-enabling village and contribute to the de-
451 stigmatization of aging and dementia. In that way, the
452 village is an opportunity to educate the population.
453 For example:

454 “ . . . people still have a very narrow mind of what
455 [dementia] is and [they think] that it’s just forget-
456 ting things and repeating things. They don’t seem
457 to understand, a lot of the complexities, change of
458 personalities, just even...the way to communicate
459 with somebody [with dementia], in a language
460 that they can relate to” (C1).

461 This education would need to be an ongoing open
462 dialogue between the aged care provider and the local
463 community for “disseminating information . . . about
464 what that experience is like, what dementia is like”
465 (R3). One participant stated that using the lived expe-
466 rience of a person with dementia in the form of
467 vignettes may help educate the local community and
468 “alleviate or tackle” (R5) stigma.

469 Participants discussed utilizing established pro-
470 grams, such as the Dementia Australia ‘Dementia
471 Friendly Communities’ initiative, whereby commu-
472 nity members, alliances, and organizations can sign
473 up online and commit themselves to the campaign.
474 “If we could set the goal of every third person in
475 the immediate neighborhood, being an active demen-
476 tia friend, I think it’d be a very high success”
477 (R8). “Everybody has to do the University of Tas-
478 mania Dementia courses” (S1). “Let’s try to use the
479 resources and skills which we have” (R8). However,
480 education in the local community may be challeng-
481 ing: “. . . some of the obstacles might be time or cost
482 of implementing training and whether the people are
483 willing to participate” (C1).

484 The participants thought that many community
485 members would want to contribute in these ways,
486 as well as recognition that many will not be inter-

487 ested, ambivalent, or actively hostile – ‘not in my
488 backyard’.

489 *Subtheme 2: Care and support staff*

490 Unsurprisingly, education about dementia for care
491 and support staff was considered necessary, but of
492 particular interest was the focus on aspects such as
493 dignity of risk, enabling and empowering people liv-
494 ing with dementia to make choices, well-developed
495 communication skills, and a person-centered model
496 of care.

497 “In terms of you hearing words like dignity and
498 genuine connection. There’s a need for training
499 around that and . . . I think attracting the right
500 people” (S3).

501 “[S]killed staff in having the abilities and com-
502 munication skills and rapport development, and
503 knowing the people to be able to support that
504 engagement, whether that’s . . . employment and
505 the remuneration or working with the childcare
506 workers, because all of all of it needs to be actu-
507 ally staffed” (R9).

508 Staff who may be used to providing task-driven,
509 time-based care may have difficulty adapting to a new
510 way of doing things where residents are provided
511 choices around personal hygiene, meals, activities,
512 and going out into the community. Therefore, select-
513 ing the ‘right’ staff, who have a willingness to learn
514 and be adaptable to ongoing training will be critical
515 to retaining staff.

516 *Subtheme 3: Families*

517 Educating the family of residents about dementia
518 and dignity of risk was also discussed, recogniz-
519 ing that family members could be worried about the
520 safety for residents living in a village without external
521 boundaries.

522 “Train families about what it’s like to live with a
523 dementia . . . so that they won’t be worried about
524 that, they will know. I would hope that the staff and
525 the family are dementia friendly as well” (P3).

526 When discussing the open village concept, one
527 participant stated that “obstacles would be possibly
528 family and I’d be concerned that this was a reck-
529 less thing to do, unless there were safeguards” (C2).
530 Participant R6 suggested that many family mem-
531 bers would be expecting the ‘safety’ of a traditional
532 aged care setting and may need education about the

533 principles of ‘dignity of risk’ and awareness of con-
534 sequences.

535 *Subtheme 4: Business stakeholders and services*

536 Along with the other groups in the village, it was
537 felt important to “*not just talk[ing] about support and*
538 *training staff and the model of care, but also support*
539 *and training to the other stakeholders*” (S3), includ-
540 ing those that decide to set up a business in the village.
541 This is because they will have regular interaction with
542 the people living with dementia utilizing the different
543 facilities and will be making decisions that affect the
544 ‘dementia-friendliness’ of the space.

545 “*Who’s going to be using this communal*
546 *space...think about all the needs of those groups of*
547 *people separately in terms of how much education*
548 *and support they need*” (R1).

549 “*If this community [village] is going to have small*
550 *businesses around, then they need to understand*
551 *what might happen if people with dementia come*
552 *in and they get confused*” (C1).

553 Providing knowledge about dementia, how to com-
554 municate with a person with dementia, and how to
555 manage any issues of concern would be necessary for
556 successful engagement between services accessible
557 to the community and residents.

558 *Theme 3: The organizational mission, vision and*
559 *values promote an inclusive culture*

560 Important to the operation of this village is a cul-
561 ture based on inclusivity and enablement of choices
562 for people living with dementia that acknowledges
563 dignity of risk, respect, and tolerance, and embraces
564 an intergenerational philosophy (S1, S2).

565 *Subtheme 1: Culture of the organization*

566 The culture of the organization operating the vil-
567 lage should enable the vision and purpose of the
568 village to be realized. This culture needs to be embed-
569 ded in the organization at establishment of the village
570 and requires a radical change in thinking from pre-
571 existing cultures that may be present in other aged
572 care contexts.

573 “*There’s a tremendous amount of work that’s*
574 *been done in disability in this area, you know, the*
575 *great deinstitutionalization and normalization of*
576 *disability in the community. So, I guess it is . . . a*
577 *piece of work around education to get both staff*

578 *and family . . . more attuned to not working like*
579 *an institutional all the time.”* (R6)

580 This organizational culture can be developed
581 through the organizational mission, vision and values,
582 policies, and procedures.

583 “*At the risk of it ending up like any other residen-*
584 *tial aged care home, if we don’t set the mission*
585 *and vision and philosophy now, and then do*
586 *360 feedback and constant monitoring...Like you*
587 *know, not to say, ‘here’s the culture, let’s go!’.*
588 *You’re going to have to monitor that for the rest*
589 *of the time.”* (S1)

590 “*We need to set an inclusive culture in The Neigh-*
591 *bourhood and have ways to actively nudge people*
592 *towards the culture. That is, we need to set norms*
593 *for inclusivity and respect and helpfulness and*
594 *tolerance for everyone who was part of the com-*
595 *munity”* (R1).

596 One participant thought, “*it’s important for every-*
597 *one to feel a sense of place, a sense of ownership.”*
598 (R5). This included the residents, the family, the care
599 and support staff, the local community, and the busi-
600 ness stakeholders:

601 “*So not just the staff of the homes, but also*
602 *your hairdresser, your supermarket, your bar. So,*
603 *they’ve all got it, but we’ve all got to be on the*
604 *same page.”* (S1)

605 However, one participant believed a major chal-
606 lenge is “*to get organizations to become dementia*
607 *friendly”* (C4). Another thought it was important for
608 management to listen to what is happening on the
609 ground by considering feedback from family mem-
610 bers, residents, and staff as a process of establishing
611 and maintaining the culture (C1).

612 *Subtheme 2: Policies and procedures that enable*
613 *dignity of risk*

614 The village structures, policies, and processes need
615 to allow practices that enable residents to engage in
616 the village and to make choices in all aspects of their
617 lives. The organization’s policies will be important
618 to promote dignity of risk. One participant who man-
619 ages a local group home described her approach to
620 enabling dignity of risk by having the family sign a
621 waiver:

622 “*[W]e just decided that we would support exactly*
623 *what she did the day before she moved in, which*
624 *was go[ing] for long bike rides every day, multiple*

625 *times. I got the family to sign a risk form to say*
 626 *that if she gets hit by traffic and gets lost, that’s*
 627 *the risk that they’re willing to take on behalf of*
 628 *[name] and she whizzes off every day. She can’t*
 629 *read stop signs. She drives into Woolworths on*
 630 *her trike even during COVID” (S1).*

631 However, participants suggested this would be a
 632 delicate balancing act requiring strong relationships
 633 with family members who accept that the conse-
 634 quences are better than the alternative of “a lack of
 635 freedom of movement” (R9).

636 “[T]here is...the yin and the yang, to what degree
 637 are we going to be putting up the rights of people
 638 with dementia to do what they want to do daily,
 639 even though that might put them at risk? Versus
 640 what are . . . the moral and probably legal respon-
 641 sibilities of the organization to protect that from
 642 that risk” (R6).

643 “I think we probably agree with (R6) in the sense
 644 that, you know, people should be able to do what
 645 they want to do within their safety and...the idea
 646 is not to say ‘no, you can’t do it’, but it’s about
 647 yes and how we can do it to make it as safe as
 648 possible” (S4).

649 This balancing of dignity of risk versus safety was
 650 an important topic in the workshops. A participant
 651 living with dementia (P1) and a carer (C4), as well
 652 as a researcher with knowledge of Australia’s first
 653 village for people living with dementia in Tasmania
 654 (R6), felt there is a point where the risks of not having
 655 an external boundary could become too great and the
 656 care providers will have a duty to ensure they are safe.

657 *Theme 4: Care staff who promote an enabling* 658 *person-centered care environment*

659 The funding and staffing models and the number
 660 of staff were considered important to achieving an
 661 open village without external boundaries. The fund-
 662 ing model was considered critical to whether staff can
 663 sustain the model of care:

664 “[It is] absolutely about the resourcing of care.
 665 And yes, it’s about training people in person-
 666 centered [care] and is about having enough
 667 staff that they can . . . walk with that person they
 668 enable . . . [t]hat’s about deinstitutionalization,
 669 but it is also about resourcing” (R9).

670 Staffing resources should be sufficient to allow
 671 staff to be flexible and responsive, and available to

672 support the level of dementia that the person is experi-
 673 encing. For example: “You’d have a care plan around
 674 every person. They [go] one-on-one to the café. The
 675 person goes in a group in [this] setting” (S1). Staff
 676 who actively promote the organization’s mission,
 677 vision and values were deemed necessary and hav-
 678 ing “the right people involved, who are committed,
 679 really fostering that engagement and collaboration
 680 and the culture” (S3). Staff need to be “supported to
 681 enable and create a relaxed environment in the care
 682 contexts” with strategies to “make staff comfortable
 683 with the more open environment.” (R4).

684 Knowing the individual will also be a key strategy
 685 of person-centered care, enablement and developing
 686 meaningful activities and “is the foundation of every-
 687 thing” (S1). As presented in Theme 2, Subtheme 2
 688 by R9, an appropriate staffing model and knowledge
 689 of person-centered care can also help the resident to
 690 engage in a broad range of activities meaningfully.

691 The new model of care was recognized to present
 692 some challenges for staff “on a day-to-day poten-
 693 tially, sometimes hour-by-hour basis” (R4). This
 694 will be a challenge for staff who have experience
 695 working in traditional residential aged care facilities.
 696 However, one participant suggested employing only
 697 “switched-on dynamic team members that under-
 698 stand the modelling concept from the very beginning
 699 and removing those that don’t very quickly” (S1).
 700 However, it was recognized that if “this [model of
 701 care] gets bigger, Australia-wide, I just wonder where
 702 all those people are going to come from” (P2).

703 *Theme 5. Meaningful activities should meet the* 704 *needs of all individuals living in the village*

705 Meaningful engaging activities that offered indi-
 706 viduals choices were important to the functioning
 707 of the village and a way of maintaining a person’s
 708 dignity.

709 “[O]ne of the key ways of maintaining dignity
 710 for everyone in this situation is to be able to
 711 retain as much of your previous life – your life
 712 when you were completely well – as possible. And
 713 that’s been the most difficult thing about residen-
 714 tial care because everything goes, right down to
 715 the clothes you wear” (C2).

716 A participant said “the right environment and cul-
 717 ture can give the person with dementia a sense of
 718 self-esteem and purpose again” (P1).

719 An important consideration was for meaningful
 720 activities at an appropriate level for all people to be

721 able to engage, with inclusive and engaging commu- 770
 722 nication, ensuring that the instructions are simplified 771
 723 and an environment conducive to inclusivity. 772

724 *“[O]ne of the beauties of this kind of open com- 773
 725 munity...is that all of your everyday activities are 774
 726 there and available. But, just having them avail- 775
 727 able doesn’t mean they’re accessible to all people 776
 728 at their different stages of dementia...Something 777
 729 that the community would need is how you look at 778
 730 tailoring an activity throughout the community.” 779
 731 (R7). 780*

732 One former carer elaborated on the need to tailor 781
 733 the activities as *“People [with dementia] can so eas- 782
 734 ily get lost even with the carer, but you know. They’ve 783
 735 only got to turn their back to the carer. Oh, where did 784
 736 they go?”* (C2). Another former carer agreed, stat- 785
 737 ing that if their partner with dementia *“wanted to 786
 738 go off for a walk somewhere, I think I would rather 787
 739 somebody went with him.”* (C3). 788

740 The need to enable people to continue doing the 789
 741 things they did before moving into the village, to 790
 742 maintain their sense of dignity, independence and 791
 743 self-worth was discussed (C2). The importance of 792
 744 residents being able to leave the community was also 793
 745 discussed, such as with trips to the National Gallery 794
 746 of Australia, walking groups, and attending daycare 795
 747 canters (S1, S4). However, *“if a person is not able 796
 748 to go out anymore, then there should be something 797
 749 happening in the village or community center or 798
 750 whatever in the village to accommodate those people” 799
 751 (P3). 800*

752 Paid employment within the village and volunteer- 801
 753 ing within the community were discussed (P2, S4, 802
 754 R7) to address the needs of people living in the vil- 803
 755 lage, as these roles may promote better mental health. 804

756 *“Offer positions in those cafes and stores to the 805
 757 residents...guess that would keep the cost down, 806
 758 but it would give them some purpose as well as 807
 759 something to do and keep their brains engaged” 808
 760 (P2). 809*

761 *“My idea was, as people living with dementia 810
 762 still got a lot to offer the society and community 811
 763 around them. So, to take that knowledge that they 812
 764 want to be part of something better, but feel val- 813
 765 ued for what they [are] doing, was to give them 814
 766 some paid roles . . . So, for example . . . childcare 815
 767 or gardening”* (S4). 816

768 Enabling people from the community, particularly 817
 769 across generations, to engage with residents on-site 818

770 was seen as an important meaningful activity. One 771
 772 participant said *“people [with dementia] are inher- 773
 774 ently lonely, and they’ve lost the village”* (S1). While 774
 775 there is planned to be a childcare center on-site, inter- 775
 776 generational engagement was seen to be important 776
 777 to change *“the culture forever about being with our 777
 778 elders who are living with dementia.”* (S1). Partic- 778
 779 ipants also suggested that residents may be able to 779
 780 assist other community members with babysitting 780
 781 (S4, R7) or shopping (R7). 781

782 Several participants in the face-to-face group dis- 782
 783 cussed the importance of the outdoors and gardens 783
 784 and having a community garden in the village to bring 784
 785 people together (S1, S2, C3, L1). 785

786 *“Gardening, ensuring that [people living with 786
 787 dementia are involved] at every point along 787
 788 the spectrum from purchasing plants, choos- 788
 789 ing and purchasing plants in a . . . nursery type 789
 790 environment, to planting and nurturing plants. 790
 791 Harvesting, whether it’s flowers and fruit or veg- 791
 792 etables, whatever and then potentially cooking 792
 793 and nutrition classes. It could be multigenera- 793
 794 tional involving the childcare center or nearby 794
 795 primary schools”* (L1). 795

796 *Theme 6. The built environment is designed to 796
 797 enable maximum engagement and safety 797*

798 *Subtheme 1: Built environment 798*

799 Developing an enabling, relaxed environment that 799
 800 supports an inclusive culture, was recognized as 800
 801 important across each workshop. Use of spatial, envi- 801
 802 ronmental and wayfinding information in the village 802
 803 may help individuals easily navigate the space. 803

804 *“[T]he environment needs to be easy to get 804
 805 around, visible from all parts of the village sign- 805
 806 posted, attractive with places of interest resting 806
 807 spots, greenery and perhaps animals, that sort 807
 808 of thing. And the benefits would be that it would 808
 809 encourage people to move around the village, 809
 810 exercise, enjoy the outdoor environment and reap 810
 811 the benefits of being in the outdoors, and they 811
 812 could easily find their way to shop services and 812
 813 things like that.”* (C3). 813

814 Spaces for interaction were considered essen- 814
 815 tial: *“[I]t has to be accessible and safe for all people, 815
 816 but it also has to be accessible and safe for people with 816
 817 dementia and without dementia”* (S2), and should be 817
 818 designed appropriately: *“[I]f children are also using 818
 819 the walking paths, you might have scooters or bicy- 819*

818 *cles, scooting around the village at the same time if*
 819 *someone was trying to go for a bit of a stroll” (C3).*

820 It was thought that the gardens and green spaces
 821 would be part of a central space, with buildings
 822 (including residential, businesses, and organizational
 823 facilities) located around the peripheries.

824 *“In my mind, there’s going to be a central core*
 825 *to it, where the people actually live and it’s clear*
 826 *there’s going to be a lot of staff around. It’s going*
 827 *to be very familiar to the residents there. And*
 828 *that’s where they will spend, I suspect most of*
 829 *their time. And then there’s sort of more outer core*
 830 *where you’ve got the shared facilities, where peo-*
 831 *ple from a community come in, but again, there’s*
 832 *going to be staff and a lot of knowledgeable peo-*
 833 *ple in that sort of band” (R8).*

834 Participants (S1, R6, R8) expressed some uncer-
 835 tainty due to not knowing specific information about
 836 the space where the village will be built and about
 837 what recommendations may need to be made to
 838 address specific contextual issues:

839 *“[H]ighlighting how important the choice of the*
 840 *site is going to be. If you can, if you can find the*
 841 *right site where it is essentially a residential site.*
 842 *It’s not surrounded by motorways or roads with*
 843 *heavy lorries . . . It hasn’t got any railway lines*
 844 *or rivers to fall in. Then, you know, I think there*
 845 *is a much better chance of success” (R8).*

846 The inclusion of people other than those living with
 847 dementia was also raised:

848 *“[I]f there were other apartments available to*
 849 *rent that were not for people with dementia, and*
 850 *then it doesn’t become a dementia village, it*
 851 *becomes a dementia inclusive village and peo-*
 852 *ple with dementia happen to live in residential*
 853 *care” (R7).*

854 The internal village space design was also consid-
 855 ered important. Internal buildings need to be designed
 856 with an understanding of what the space is for, and
 857 how the space is used, including the music and
 858 lighting (S3). One participant suggested the inter-
 859 nal environment should be inspired by the Dutch
 860 who *“have this beautiful word, ‘gezellig’, which is*
 861 *sort of comfortable, relaxed homely. And it makes*
 862 *you want to be there” (R2).* This includes spaces
 863 where the community would be encouraged to visit
 864 and spend time: *“We need to design for a relaxed*
 865 *environment. We’re making a space where we want*

people to come and stay and interact with each other.”
 866 (R1). 867

868 Subtheme 2: Safety 868

869 Safety was an underlying concern across work-
 870 shops. Upskilling staff and the local community were
 871 seen necessary to manage safety. *“It does take a vil-*
 872 *lage to look after people with dementia” (C1)* and
 873 people in the community would *“have to be attentive*
 874 *to be there, and that’s a big one” (S1).*

875 A dementia-enabling community was seen to help
 876 keep the residents safe.

877 *“That that is the cushioning ground . . . to sup-*
 878 *port those individuals to return or to continue*
 879 *exploring or to contact a staff member that can*
 880 *then continue to go for that walk with that per-*
 881 *son obviously wants to go on . . . it’s about risk*
 882 *management and risk minimization and harm*
 883 *minimization, not risk removal. And I think that*
 884 *that can be really hard to communicate. I think*
 885 *we’re a very risk-averse society.” (R9)*

886 One participant was particularly concerned about
 887 safety, citing poor statistics for people living with
 888 dementia who get lost, but also said: *“I think if you can*
 889 *plan some of those things with the protocols with the*
 890 *staffing with the education, as well as the actual envi-*
 891 *ronment itself, that contributes to some of the safety*
 892 *concerns” (C4).*

893 *“I think there’s a huge amount of fear around the*
 894 *idea of people getting lost and wandering out of*
 895 *the place, but I think that – isn’t there also some*
 896 *evidence . . . that if you actually . . . unlock the*
 897 *doors . . . people don’t go, because there’s plenty*
 898 *to do within the village, it’s home. And why would*
 899 *you want to go?” (C3).*

900 Subtheme 3: Technology 900

901 Technology should also be embedded into the vil-
 902 lage in the initial build and utilized to support staff
 903 to enable a relaxed environment. It may also have the
 904 added benefit of reassuring families about the care
 905 and safety of their family members. For example,
 906 tracking devices were seen by some to have benefits
 907 *“A person could wear a watch or and [sic] if it had a*
 908 *location type device that would enable families to feel*
 909 *confident about their loved one leaving the facility”*
 910 (C2), and *“Technology that supports identifying falls,*
 911 *for example, means that the particular staff member*
 912 *didn’t have to feel anxious about it” (R4).*

913 However, others expressed concerns about relying
 914 on technology to help achieve the open village concept
 915 “We’re not sure because we get into areas where
 916 it becomes human rights issues if we put monitors on
 917 them and things like that” (C4).

918 *“I get concerned when we use more cameras for
 919 surveillance to try and maintain safety because,
 920 that’s still not [being] able to actually intervene,
 921 if there is a threat if somebody else is coming into
 922 that room or that building” (R9).*

923 DISCUSSION

924 The concept of an open village designed for people
 925 living with dementia with cause to draw on a
 926 high level of care was supported by participants. The
 927 NGT method was used as a form of idea generation
 928 to assist in planning a proposed village in the ACT
 929 region. There was no opposition to the concept. How-
 930 ever, some participants were apprehensive about how
 931 the safety of residents with dementia can be main-
 932 tained. The priorities of ranked ideas across the three
 933 groups were similar, focused on the community sur-
 934 rounding the village, education, and the development
 935 of an empowering organizational culture focused on
 936 inclusivity, person-centered care, and enabling peo-
 937 ple living with dementia the dignity of risk. Further
 938 analysis of the ideas and transcripts of discussions
 939 from each workshop revealed nuances of potential
 940 barriers to achieving the vision of a safe and equitable
 941 village.

942 One of the primary conclusions was the impor-
 943 tance of the support of the community surrounding
 944 the village. This support could be gathered by engag-
 945 ing the community before the first sod is turned over
 946 through communication about the development, val-
 947 ues of the organization (e.g., inclusion, enablement,
 948 and dignity of risk), and the potential benefits to
 949 local community members. Education of the local
 950 community about dementia was also deemed impor-
 951 tant, and using already established programs could
 952 address this need. Education may not only contribute
 953 to the destigmatization of dementia but also create
 954 ‘zones of safety’. This is important because while
 955 awareness and acceptance of dementia are increasing,
 956 stigma remains, and people in the surrounding com-
 957 munity may not want the village near their homes
 958 [12]. Education and communication may not only
 959 foster interest in the village but counteract the phe-

960 nomenon of NIMBYism (‘Not In My Back Yard’),
 961 a pejorative term used to describe opposition to the
 962 construction or development of something in one’s
 963 local area because of the perception it would reduce
 964 the quality of life of residents or be otherwise unde-
 965 sirable. Several participants raised the likelihood of
 966 NIMBYism occurring and the need for strategies to
 967 offset objections. NIMBYism is not new in Australia
 968 and was experienced during the deinstitutionaliza-
 969 tion and setting up of community care and group
 970 home initiatives in the 1990s for people with intel-
 971 lectual or psychosocial disabilities [20]. Therefore,
 972 anticipating local opposition has been described as
 973 just as important as the project concept, finding a
 974 site, and funding [21]. Other key strategies for engag-
 975 ing and educating the community may include using
 976 positive print, visual or social media where stories
 977 are used to put a face to the people who will live
 978 there. This may generate empathy with the audi-
 979 ence by getting them to reflect on their thoughts and
 980 connections to their own home and lives [22, 23],
 981 aligning with a suggestion by two participants to
 982 use vignettes to tell the story of people living with
 983 dementia.

984 Another key finding concerned strategies to engage
 985 with and educate potential on-site businesses and
 986 partners. Negative attitudes and lack of knowledge
 987 of dementia may affect the ability of the village to
 988 attract partners on-site and subsequently affect the
 989 viability of businesses and services. The staff of busi-
 990 nesses choosing to operate in the village will require
 991 education and training. This will be even more perti-
 992 nent if businesses engage people living with dementia
 993 in the workforce, as suggested by workshop partici-
 994 pants. Another strategy that may foster engagement in
 995 the village is involving potential businesses and ser-
 996 vices in the design. Previous initiatives for housing
 997 for people experiencing homelessness have designed
 998 the physical environment to add value to the local
 999 area through beautification and strategic building in
 1000 underinvested areas [24]. The vision for the village
 1001 to include a cafe, grocery store, hairdresser, child-
 1002 care, community gardens, and attractive landscaping
 1003 may serve this purpose. Further considerations for
 1004 engaging with the local community include appeal-
 1005 ing to higher-order beliefs and values by emphasizing
 1006 facts, anticipating and countering misinformation,
 1007 and working with proponents for high-quality demen-
 1008 tia care [22].

1009 Following the Royal Commission into Aged Care
 1010 Quality and Safety, there has been a greater accep-
 1011 tance of the need to address the issues associated with

the built environment for people needing care, the models of care, and the organizational cultures within those environments [2]. Equipping staff and families of people living with dementia with knowledge about the benefits of appropriately built environments, person-centered care, and the fostering of interpersonal relationships were also highly valued by participants. The best way to build strong interpersonal relationships and meet individual needs and preferences is by having specific knowledge about each person [25, 26]. This can have many positive effects, including greater engagement in meaningful activities according to the preferences of the person living with dementia [25–27]. Staff can also enable each individual to engage in the built environment as appropriate to their cognitive and physical abilities [10, 26, 28]. However, changing established organizational cultures within typically risk-averse organizations can be difficult. Despite the acceptance of the principles of dignity of risk, there remains limited success in overcoming the preference for aged care providers to avoid financial and legal risk, leaving an imbalance between theory and practice [29]. Workshop participants discussed mechanisms to mitigate risk, including waivers. However, aged care providers cannot avoid all risks, including reputational risks [29]. This has led to a defensive approach where the default is to be cautious and avoid potential harm while prioritizing compliance and reporting standards.

Certain participants in this study repeatedly returned to the issue of balancing safety and individual choice. However, across workshops, there was not a clear distinction between the role or experience of participants and the concerns expressed. Several participants raised the risks of people living with dementia being free to move outside of the village into the local community and the requirement for adequate supervision by the staff. As such, other participants responded by highlighting the need for dignity of risk to be woven into all aspects of operations, management, staffing and community education for residents to be safe. In each workshop, the relatively small number of participants with concerns about safety were persuaded to a degree by other participants, that the vision could be achieved. Generally, issues raised about the community being able to access the village and overall safety, were outweighed by opinions emphasizing the role of education, staffing, and culture to minimize the risks. Participants also had concerns about known barriers to enabling dignity of risk including

lack of staff training and knowledge; inadequate staff ratios; poor communication between staff and family; a risk-averse physical environment; legal concerns; non-individualized care; and lack of accountability on respecting the rights of people living with dementia [29, 30]. Therefore, an open village without external boundaries would require community management and responsiveness to dignity of risk principles [31].

Small-scale residential care models are associated with fewer physical demands, lower workload, and job autonomy among staff [32]. Staff autonomy and satisfaction, in turn, affect retention and recruitment [33]. Some participants viewed the number of staff as secondary to the quality of staff, their knowledge and beliefs about dementia, and person-centered care. However, person-centered care requires flexibility and consistency in implementation, which relies on motivated staff, sufficient time, and sufficient staff numbers [27]. Currently, aged care staff in Australia are already experiencing high stress and cognitive burden due to multitasking and a range of workforce factors that prevent them from delivering truly person-centered care [34]. Small-scale residential dementia care is proposed as a way to potentially offset some of these challenges. However, known limitations of this in Australia include lack of availability and putative cost, even though in some instances, running costs may in fact be lower [35], and staff retention may be improved [8]. Additionally, small-scale care models such as the Green House and Green Care Farm models provide higher quality care than traditional aged care models [9, 36]. In addition, infection control may be better in these homes, as evidenced in the current COVID-19 pandemic [37]. There is a need for more research into psychosocial models of providing best practice dementia care which underpins the ability to provide small-scale homes that have a community focus.

To our knowledge, there is no research on village designs for people living with dementia where there are no external boundaries, nor are we aware of documented examples of clustered dementia care where residents have free access to the outdoors within a non-gated community. The present study presents views from a range of stakeholders pertaining to how a vision for an open village without external boundaries could potentially be achieved. To maximize the quality of life of people living with dementia, and to reduce stigma within local communities, innovative models of dementia care, supported by research, are urgently needed.

1115 *Limitations*

1116 It is important to note several limitations of this
 1117 study. The expertise within each group was different
 1118 and may have influenced the results in each group,
 1119 and the size of each group was different. While
 1120 this was a purposive sample, not all invited partic-
 1121 ipants agreed to participate, meaning the full scope
 1122 of perspectives may not have been considered. For
 1123 example, an architect declined to participate. How-
 1124 ever, this was offset by one participant being a global
 1125 expert on the built environment for people living with
 1126 dementia. In addition, while most of the researchers
 1127 who participated were also clinicians, there may
 1128 have been an over-representation of expertise from
 1129 academia. There was also an underrepresentation of
 1130 people familiar with aged care policy and regulatory
 1131 requirements. While not being representative of all
 1132 of the stakeholders who would be involved in the
 1133 development of a new village, the study was novel
 1134 and included a wide range of stakeholders, including
 1135 people with dementia and carers, to work towards
 1136 problem solving to improve the quality of demen-
 1137 tia care [38]. Interestingly, the top ideas from each
 1138 workshop were similar despite the variety of experi-
 1139 ences and expertise of participants across each group.
 1140 A strength of our study was including people with
 1141 knowledge of Australia’s first village for people liv-
 1142 ing with dementia in Tasmania. Our findings overlap
 1143 with Tierney et al. (2022), who researched Korongee
 1144 village for people living with dementia in Hobart,
 1145 Tasmania [7]. Tierney et al. (2022) also recognized
 1146 the need for education in the community, a safe
 1147 and enabling physical environment, and meaningful
 1148 activities, as expressed by 12 community members
 1149 in online focus groups. However, due to COVID-19,
 1150 none of the participants in this study had visited the
 1151 village.

1152 *Conclusion*

1153 Stakeholders and experts supported the concept
 1154 of a future village for people living with dementia
 1155 with minimal or no external boundaries, balancing
 1156 opportunity and risk. Critical to its success will be
 1157 educating the surrounding community and having
 1158 an organizational culture that can balance staffing
 1159 requirements and residents’ safety by maximizing the
 1160 dignity of risk and opportunity for meaningful activ-
 1161 ities for people living with dementia. A cohesive and
 1162 well-planned strategy incorporating all stakeholders
 1163 of the new village will be required for the type of

village being proposed to prove successful in advanc-
 ing the quality of residential care for people living
 with dementia in Australia and worldwide. Given
 the challenging environment, significant work and
 investment will be required to achieve the vision.
 However, this study demonstrates that it is a worthy
 pursuit with potential to transform residential care
 for people living with dementia and truly integrate it
 within a neighborhood.

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CONFLICT OF INTEREST

Nathan M D’Cunha, Jane Thompson, Sue Kurrle,
 and Nicole Smith are volunteer members of the Board
 of The Neighbourhood, Canberra. There are no other
 conflicts of interest to report.

DATA AVAILABILITY

Raw qualitative data is not available due to ethical
 requirements.

REFERENCES

- [1] Harrison SL, Dyer SM, Laver KE, Milte RK, Fleming R, Crotty M (2022) Physical environmental designs in residential care to improve quality of life of older people. *Cochrane Database Syst Rev* 3, CD012892.
- [2] Royal Commission into Aged Care Quality and Safety (2021) Final Report: Care, Dignity and Respect – Volume 1. <https://agedcare.royalcommission.gov.au/publications/final-report>, Last updated March 1, 2021, Accessed on October 6, 2022.
- [3] Brennan S, Doan T (2022) Small-scale living environments’ impact on positive behaviors and quality of life for residents with dementia. *J Aging Environ* 37, 181-201.
- [4] de Boer B, Beerens HC, Katterbach MA, Viduka M, Willemse BM, Verbeek H (2018) The physical environment of nursing homes for people with dementia: Traditional nursing homes, small-scale living facilities, and green care farms. *Healthcare (Basel)* 6, 137.
- [5] Gibson D, D’Cunha NM, Bail K, Isbel S (2022) Small scale dementia care in Australia: An implementation study of

- innovation in funding, technology and resident-led care. *British Society of Gerontology 51st Annual Conference: Better Futures for Older People-Towards Resilient and Inclusive Communities*.
- [6] Dyer S, Liu E, Gnanamanickam E, Milte R, Easton T, Harrison S, Bradley C, Ratcliffe J, Crotty M (2018) Clustered domestic residential aged care in Australia: Fewer hospitalisations and better quality of life. *Med J Aust* **208**, 433-438.
- [7] Tierney L, Doherty K, Breen J, Courtney-Pratt H (2022) Community expectations of a village for people living with dementia. *Health Soc Care Community* **30**, e5875-e5884.
- [8] Jilek R (2022) The Community Home Model – small scale community embedded residential aged care for people living with younger onset dementia. *Glob J Aging Geriatr Res* **2**, doi: 10.33552/GJAGR.2023.02.000527.
- [9] de Boer B, Hamers JPH, Zwakhalen SMG, Tan FES, Verbeek H (2017) Quality of care and quality of life of people with dementia living at green care farms: A cross-sectional study. *BMC Geriatr* **17**, 155.
- [10] Zeisel J, Bennett K, Fleming R (2020) World Alzheimer Report 2020: Design, dignity, dementia: Dementia-related design and the built environment. <https://www.alzint.org/resource/world-alzheimer-report-2020/> Last updated September 21, 2020, Accessed on October 29, 2022.
- [11] Ibrahim JE, Davis MC (2013) Impediments to applying the ‘dignity of risk’ principle in residential aged care services. *Australas J Ageing* **32**, 188-193.
- [12] Steele L, Swaffler K, Phillipson L, Fleming R (2019) Questioning segregation of people living with dementia in Australia: An international human rights approach to care homes. *Laws* **8**, 18.
- [13] Harvey N, Holmes CA (2012) Nominal group technique: An effective method for obtaining group consensus. *Int J Nurs Pract* **18**, 188-194.
- [14] McMillan SS, Kelly F, Sav A, Kendall E, King MA, Whitty JA, Wheeler AJ (2014) Using the Nominal Group Technique: How to analyse across multiple groups. *Health Serv Outcomes Res Methodol* **14**, 92-108.
- [15] Mason S, Ling J, Mosiou D, Arantzamendi M, Tserkezoglou AJ, Predoiu O, Payne S (2021) Undertaking research using online nominal group technique: Lessons from an international study (RESPACC). *J Palliat Med* **24**, 1867-1871.
- [16] McMillan SS, King M, Tully MP (2016) How to use the nominal group and Delphi techniques. *Int J Clin Pharm* **38**, 655-662.
- [17] Newham R, Weir N, Ferguson A, Bennie M (2022) Identifying the important outcomes to measure for pharmacy-led, clinical services within primary care: A nominal group technique approach. *Res Social Adm Pharm* **19**, 468-476.
- [18] Braun V, Clarke V (2021) One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qual Res Psychol* **18**, 328-352.
- [19] Tong A, Sainsbury P, Craig J (2007) Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *Int J Quality Health Care* **19**, 349-357.
- [20] Wiesel I, Whitzman C, Gleeson B, Bigby C (2019) The National Disability Insurance scheme in an urban context: Opportunities and challenges for Australian cities. *Urban Policy Res* **37**, 1-12.
- [21] Iglesias T (2002) Managing local opposition to affordable housing: A new approach to NIMBY. *J Affordable Housing Commun Dev Law* **12**, 78-122.
- [22] Rockne A (2018) *Not in my backyard: Using communications to shift “NIMBY” attitudes about affordable housing*. University of Minnesota.
- [23] Mingoya C (2015) *Building together: Tiny house villages for the homeless: A comparative case study*. Massachusetts Institute of Technology.
- [24] Evans K (2021) It takes a tiny house village: A comparative case study of barriers and strategies for the integration of tiny house villages for homeless persons in Missouri. *J Plan Educ Res*, doi: 10.1177/0739456X211041392.
- [25] Ericsson I, Kjellström S, Hellström I (2013) Creating relationships with persons with moderate to severe dementia. *Dementia (London)* **12**, 63-79.
- [26] Kim SK, Park M (2017) Effectiveness of person-centered care on people with dementia: A systematic review and meta-analysis. *Clin Interv Aging* **12**, 381-397.
- [27] Lee JY, Yang E, Lee KH (2022) Experiences of implementing person-centered care for individuals living with dementia among nursing staff within collaborative practices: A meta-synthesis. *Int J Nurs Stud* **138**, 104426.
- [28] de Witt L, Fortune D (2019) Relationship-centered dementia care: Insights from a community-based culture change coalition. *Dementia (London)* **18**, 1146-1165.
- [29] Courtney A, Iredale F, Heaven J, Tang E (2022) Dignity of risk in aged care. *Aust Health Law Bull* **30**, 111-114.
- [30] Woolford MH, de Lacy-Vawdon C, Bugeja L, Weller C, Ibrahim JE (2020) Applying dignity of risk principles to improve quality of life for vulnerable persons. *Int J Geriatr Psychiatry* **35**, 122-130.
- [31] Marsh P, Kelly L (2018) Dignity of risk in the community: A review of and reflections on the literature. *Health Risk Soc* **20**, 297-311.
- [32] Zwakhalen SM, Hamers JP, van Rossum E, Ambergen T, Kempen GI, Verbeek H (2018) Working in small-scale, homelike dementia care: Effects on staff burnout symptoms and job characteristics. A quasi-experimental, longitudinal study. *J Res Nurs* **23**, 109-122.
- [33] Hodgkin S, Warburton J, Savy P, Moore M (2017) Workforce crisis in residential aged care: Insights from rural, older workers. *Aust J Public Adm* **76**, 93-105.
- [34] Gibson D, Willis E, Merrick E, Redley B, Bail K (2022) High demand, high commitment work: What residential aged care staff actually do minute by minute: A participatory action study. *Nurs Inq*, e12545. <https://doi.org/10.1111/nin.12545>
- [35] Dyer S, van den Berg M, Barnett K, Brown A, Johnstone G, Laver K, Lowthian J, Maeder AJ, Meyer C, Moores C, Ogrin R, Parrella A, Ross T, Shulver W, Winsall M, Crotty M (2020) *Review of innovative models of aged care*. Royal Commission into Aged Care Quality and Safety. Flinders University. <https://agedcare.royalcommission.gov.au/publications/research-paper-3-review-innovative-model-s-aged-care>. Last updated January 24, 2020, Accessed on November 14, 2022.
- [36] Afendulis CC, Caudry DJ, O’Malley AJ, Kemper P, Grabowski DC, THRIVE Research Collaborative (2016) Green house adoption and nursing home quality. *Health Serv Res* **51**, 454-474.
- [37] Zimmerman S, Dumond-Stryker C, Tandan M, Preisser JS, Wretman CJ, Howell A, Ryan S (2021) Nontraditional small house nursing homes have fewer COVID-19 cases and deaths. *J Am Med Dir Assoc* **22**, 489-493.
- [38] Reeve E, Chenoweth L, Sawan M, Nguyen TA, Kalisch Ellett L, Gilmartin-Thomas J, Tan E, Sluggett JK, Quirke LS, Tran K, Ailabouni N, Cowan K, Sinclair R, de la Per-

- 1339 relle L, Deimel J, To J, Daly S, Whitehead C, Hilmer SN
1340 (2023) Consumer and healthcare professional led priority
1341 setting for quality use of medicines in people with demen-
1342 tia: Gathering unanswered research questions. *J Alzheimers
Dis* **91**, 933-960.
- [39] Bunn F, Burn AM, Goodman C, Robinson L, Rait G, Nor-
ton S, Bennett H, Poole M, Schoeman J, Brayne C (2016)
Health services and delivery research. In *Comorbidity and
dementia: A mixed-method study on improving health care
for people with dementia (CoDem)*, Southampton (UK).