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Article

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The nursing home as a hub: boundary work as a key to community health promotion

Charlotte Wegener[1,*], Marianne Storm[2], and Elisabeth Willumsen[2]

[1]Department of Communication and Psychology, Aalborg University, Teglgaards Plads 1, DK-9000 Aalborg, Denmark and [2]Department of Public Health, University of Stavanger, Stavanger, Norway

[*]Corresponding author: E-mail: cw@ipk.aau.dk

Summary

This article considers ways in which a nursing home can come to serve as a hub for community health promotion. Inspired by the term 'boundary crossing' (Akkerman and Bakker. Boundary crossing and boundary objects. Rev Educ Res 2011;81:132–69), we suggest the notion of 'boundary work' to illustrate how a nursing home arranges community activities and includes a wide range of participants. In health research, a 'hub' refers to a space in which activities and expertise are 'bound together' over time. The concept of the hub indicates that health organizations have the power to become centres for health promotion by initiating new collaborations and opening up initiatives in two-way processes with the local community. The term 'boundary work' supports a perspective that dissolves organizational, professional and conceptual boundaries and directs attention towards social inclusion as a key to community health promotion in and beyond institutionalized elderly care. The article is based on a 4-year-long practice-based study of social innovation in elderly care in Norway and Denmark. Empirical illustrations show boundary work in which a nursing home comes to serve as a hub. We discuss a flexible framework for understanding, mapping and planning participatory approaches for health and wellbeing (South et al. An evidence-based framework on community-centred approaches for health: England, UK. Health Promot Int 2019;34:356–66) and briefly connect these approaches to the concept of social innovation as a possible future research path.

INTRODUCTION: ELDERLY CARE AND PARTICIPATORY PRACTICES

In Nordic countries, public sector nursing homes providing 24/7 residential care are the primary organizational setting for care and nursing when one can no longer live at home (Hvid and Kamp, 2012). These nursing homes differ in staffing, but staff are generally a combination of registered nurses, licensed nurse practitioners and unskilled personnel. Whatever their skill levels, it falls to everyone to handle ever more complex tasks in what has been termed a 'care crisis' (Hansen and Dahl, 2021). Demographic projections predict an ageing population that faces multiple morbidities and thus more varied and extended care needs (Prince *et al.*, 2015). This demographic shift is a matter of global concern, and one that nations in the Global North are ill-equipped to address (Rouzet *et al.*, 2019). Moreover, many elderly people in nursing homes experience loneliness, which has both physical and psycho-social consequences (Berg-Weger and Morley, 2020). This cluster of challenges has been labelled the triple challenge of health care, consisting of an ageing population, costly technology and rising public expectations (Bevan, 2012). To address increased pressure and complexity, elderly care has been professionalized, and various forms of participatory practice have been initiated, including increased involvement of care recipients, relatives and volunteers (Hvid and Kamp, 2012). Participatory practices can take many forms, but these practices share the democratic ideal that everyone has the ability and should have the possibility to play an active and engaged part in society, as reflected in the Nordic Act on Non-Formal Education and Democratic Voluntary Activity (Kulturministeriet, 2015). Thus, participation in a Nordic context as addressed in this

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article aims at empowering not only professionals but also nursing home residents, their relatives, local citizens and volunteers by making it possible for them to take part in the creation of health.

The conception of 'health' in this regard follows the World Health Organization (WHO), as it includes physical, mental and social well-being and not merely the absence of disease. In the following, we refer to this cluster of ideas as 'community health promotion'. We suggest that the nursing home holds the potential for becoming a hub for community health promotion as new participants are invited in, and nursing home residents and staff engage in local activities outside the institutional setting in two-way processes of mutual interest. Here, we will focus on how a nursing home takes part in and provides access to activities of mutual interest and benefit, and how different forms of participation can promote health in both the nursing home and the community. The research questions we explore are: *How do residents, staff and managers at a nursing home and people in the local community participate in different kinds of boundary work? In which ways do these participatory practices contribute to the nursing home's status as a 'hub?'*

The theoretical inspiration is divided into two sections: first, the relevance and actuality of health promotion as a participatory practice is outlined; second, we explain the term boundary work. Then we describe the project, the case and analytical approach with three illustrations and then show three different aspects of boundary work. The first concerns the boundary between formal and informal work; the second concerns the role of brokers and the third indicates a participatory practice in which the nursing home serves as a hub in the community.

Inspired by a flexible framework for understanding, mapping and planning participatory approaches for health and wellbeing (South *et al.*, 2019), we discuss the relevance of community health promotion through boundary work and possible future roles of nursing homes in community health promotion.

THEORETICAL INSPIRATION

A participatory approach to community health promotion

The WHO highlights participation and community as key areas in health promotion (World Health Organization, 2019). A variety of ways exist of working with the community to empower citizens and develop their capacity to participate in shared activities, something that can involve individuals, groups and organizations such as nursing homes. Community development entails initiating processes to achieve change identified by the citizens themselves and in which both volunteers and service providers can participate (Pitchford, 2008). The 'community' is not just the place we live in; it can be understood as the social networks and the way people connect with and communicate with each other (Fairbrother *et al.*, 2013). The community includes relationships, personal ties, services, cultural and other social activities, identities and interests that bind people together and give them a sense of belonging to a place (South, 2015; Green *et al.*, 2019; South *et al.*, 2019). Community resources also include literacy, intergenerational solidarity, community cohesion, voluntary groups and physical, environmental and economic resources as well as public or private organizations engaging with the community (South *et al.*, 2019).

South *et al.* (2019) have conducted a scoping review to provide an overview of the diversity of community health promotion strategies. The review presents four categories of community health promotion across professional and organizational boundaries of relevance to nursing homes: (i) *Strengthening and developing the community* by developing citizen capacity, resources and social networks in order to interact with and influence health determinants in the living environment and local environment of which nursing homes are part; (ii) *Volunteer and peer* approaches to strengthen the individual's resources by providing advice, information and support, or to reinforce social networks and organize activities that can contribute to health in the community. Example initiatives could include support and training for volunteers and peers in health-related roles in the nursing home; (iii) *Collaborations and partnerships* in which citizens in the community and in the nursing home (residents and/or professionals) collaborate to identify needs and to implement and evaluate initiatives; (iv) *Securing access to community resources* by connecting citizens with resources, help services, group activities and voluntary work that can meet health needs and contribute to community participation.

For the individual resident, care professional or citizen, engagement in their community can lead to increased health literacy in the form of knowledge, awareness and skills, changes in health behaviour, better self-care and reduced social isolation (South, 2015; South *et al.*, 2019). The local community can thus become more robust when individuals' sense of belonging, trust and social network are strengthened, and when new social and material practices are developed. Change can come about through health promotion processes such as collaboration and leadership, community engagement and participation, organizational changes that go toward improving access to services and to changing them as well as to designing and implementing new types of service if needed (South,

2015; South *et al*., 2019) What these processes may look like and how they are developed over time will be exemplified in the three illustrations below.

Boundary work and brokers

To better understand the nature of boundary work, we will now address the term 'boundary' and link it briefly to learning and social innovation. According to Engeström and Miettinen (1999, p. 7), the term boundary can be found in the traditions of symbolic-interactionist studies, contextual and cultural theories within psychology and situated learning in communities of practice within education, and is closely linked to the concept of *practice* within sociology. These perspectives all represent the idea that systems are intertwined and that a focus on a singular, relatively isolated system (such as a nursing home) is not sufficient to get to grips with diversity, constant movement and change (Engeström and Miettinen, 1999). Additionally, boundaries often figure as a concept and metaphor associated with learning and innovation as shown by Akkerman and Bakker (2011), who in their literature survey of the term 'boundary crossing' show that boundaries become apparent when people attempt to mobilize themselves to collaborate and learn from each other across increasingly specialized practices. The boundary thus represents a conception of innovation as closely linked to learning (Fuller *et al*., 2018). We refer to this here as social innovation. The concept of social innovation involves social *means* for change such as collaboration and learning while also highlighting the social *needs* that are addressed by means of innovation such as well-being and social inclusion. Thus, social innovation emphasises value-creation beyond fiscal growth, such as better health, well-being and safety (Husebø *et al*., 2021). Similarly, through an exploration of the concept of 'growth', Sennett (1997) showed how systems can grow by becoming more open, so that their boundaries become 'febrile' and new forms arise with no overall coordination. Boundary work can take the form of top-down formalized collaboration between public, private or voluntary sector organizations in the community. They can also evolve bottom-up in an informal collaboration initiated by nursing home managers, care professionals, residents or relatives and citizens in the community. As we shall see below, boundary work evolves over time through relationships and the development of trust between participants who acknowledge the value of difference while working together (Levkoe and Stack-Cutler, 2018).

In the establishment of such boundary work, brokers can make a difference (Wenger, 1998; Tennyson, 2005). Brokers are people who operate across boundaries to coordinate and combine knowledge, skills or organizational affiliations and budgets. They help to establish contact, relationships and trust, and they contribute to knowledge sharing to establish lasting collaborations and partnerships of mutual benefit to the parties. Tennyson has identified characteristics of brokers (Tennyson, 2005). They may be internal to the organization or external members of the community; they may be individuals or teams. Brokers may be proactive, initiating and building collaboration, or they may be reactive, coordinating and implementing decisions and partnerships on behalf of organizations (Levkoe and Stack-Cutler, 2018; Tennyson, 2005). Levkoe and Stack-Cutler (2018) observe that brokering activities may have different foci, take place on different platforms and be physical or virtual, and they may differ in the extent of the broker's involvement. The work done by these brokers can be understood as boundary work in itself but also as the facilitation of participatory practices contributing to the nursing home's status as a hub.

To sum up, we regard 'boundary' as a metaphor associated with the complex ways in which a community promotes health, as is our concern here. We also regard boundaries as a concrete phenomenon in the form of demarcations of buildings, professional knowledge and norms. Boundaries define what is regarded as internal and what as external, such as the tasks of an organization or a profession. 'Boundary' can be used to enquire and discuss, for example, which activities and responsibilities belong to the nursing home and which could involve external actors, how boundaries are perceived and how, in their practices, participants view opportunities and constraints in relation to moving or transcending a professional or organizational boundary.

EMPIRICAL DATA AND METHOD

Empirical data

The illustrations which will be presented below are part of a large pool of observational and interview data produced in a Research Council of Norway project (RCN No. 256647), 'Promoting social innovation within institution-based elderly care' (in Norwegian, 'Sosial innovasjon i sykehjem' or SIS), which aimed to explore how innovations came about and how any follow-up and implementation took place. Five nursing homes in five different municipalities in Norway and Denmark took part, each in collaboration with an associated educational and research institution. The five nursing homes were appointed by the municipalities as 'first movers' in terms of innovative initiatives and innovation capacity.

The empirical data from the project as a whole were derived from fieldwork, individual and group interviews, workshops with nursing home staff, and

project meetings. The research approach was inspired by abductive reasoning in nursing (see Karlsen *et al*., 2021), which allowed the researchers to be guided by events, impressions and shared stories encountered during the fieldwork and interviews.

This article draws specifically on data from one of the nursing homes, wherein the third author conducted fieldwork together with a colleague. Data include observations, conversations and research interviews with managers and staff conducted from December 2016 to October 2018. This nursing home is situated in a medium-sized urban municipality in Norway and provides permanent housing for residents with somatic and cognitive impairments along with short-term rehabilitation housing and acute aid. There are 89 staff members in various degrees of employment. A majority of staff members were nurses, whilst the remaining staff comprised licensed practitioner nurses or other employees with no professional qualifications. The data comprise notes from 8 days of field observations performed by the two researchers, sometimes together, sometimes separately, involving full days as well as shorter visits for specific activities (60 hr in total); two workshops with staff (approximately ten at each workshop); two seminars in the research group (including two to three researchers from each of the five research institutions); and two 1.5-hr individual interviews with managers. Interviews were digitally recorded, transcribed and anonymized. Thus, the main part of the data was produced through observations, while the remaining data stem from participatory activities (workshops and seminars) and interviews (3 hr in total).

Method

In the project as a whole, the research group conducted thorough, large-scale analyses of the data dealing with various aspects of social innovation, which was the overall theme of the project. The three illustrations in this article are rooted in this material, and we have selected them specifically to show different aspects of boundary work.

The first author of the article was a close collaborator with the third author during the entire project. The second author was invited to co-write the article due to her expertise in community health promotion. The theoretical inspirations explained above were important for our analyses, which relied on a combination of inductive and deductive approaches where the close empirical reading of the material moved towards a theory-driven analysis exemplified in the three illustrations. The data are presented as ‘illustrations’ to make up for the obvious limitation of using only one empirical site as the basis for theorizing. We thus emphasize that the contribution we aim to make is primarily theoretical. As these three illustrations represent findings from large-scale analyses of data from five empirical sites, we assume they are generalizable. However, more studies, and preferably longitudinal field observations, are needed to provide more detailed empirical evidence.

THREE ILLUSTRATIONS: NEW BOUNDARY WORK IN THE MAKING

The sensory garden: formal and informal boundary work

> A sensory garden, accessible to all residents from their rooms, has been established at the nursing home. The garden is enclosed by the building, which is U-shaped. The garden itself is beautiful and sunny, with paths, babbling water, flowerbeds, berry bushes and vegetables, and a little shelter with a barbecue. There are also hens that lay eggs in a little henhouse. Residents can join in collecting, cooking and eating the eggs. During fieldwork, we observe that both relatives and staff are involved in conversations and activities, as are local citizens. The garden is developing, and at some point the nursing home manager makes agreements with a gardening team who ‘adopt’ the sensory garden and take on responsibility for tending and weeding it. It turns out that the hens in the garden were a gift from a farmer in the community who went to see the garden and felt there should be hens there. The managers and the gardening team agree on a set of aims for the sensory garden designed to nurture it as a meeting place for internal and external participants. These aims are verbalized frequently at staff meetings and in communication with relatives and other visitors.

The sensory garden is an example of the boundaries between the nursing home and the community being blurred. The actual, material installation of the sensory garden is not in itself boundary work or a manifestation of the nursing home as a hub. Indeed, it is located within the physical boundary of the nursing home. However, the sensory garden provides a practice that invites boundary work. The sensory garden is not finished or ‘closed’, but is the beginning of a process that makes space for participants with diverse knowledge and resources (Akkerman and Bakker, 2011). This opens the door to new participants and new forms of collaboration while addressing the health needs of residents such as taking exercise, being outside and participating in activities. In this way, the gardening team and the friend who donated the hens contribute to growth as the sensory garden acquires new forms

with no overall coordination as to activities and elements, exactly as suggested by Sennett (1997) with the concept of 'growth' when systems grow by becoming more open.

In this way, the nursing home opened the way to boundary work between residents, relatives, staff and citizens. Opportunities for participation were provided, but people could decide for themselves the extent of their involvement. Informal boundary work was thus supplemented with a more formalized collaboration between the gardening team and the nursing home manager, creating a new health-promoting participatory practice over time (Levkoe and Stack-Cutler, 2018; South *et al.*, 2019).

Everyone must be seen: the characteristics of brokers

> During fieldwork, the local manager states on several occasions that everyone arriving at the nursing home should receive attention. She maintains that everyone should feel seen 'whether it's for five minutes or the rest of their life'. As field researchers, we noticed this in the way we were welcomed to the nursing home. As soon as we had arrived, the staff took the opportunity to make small talk about the pictures of local scenes on the walls, about furniture and old items they had received that were placed in various rooms, about activities they were involved in, about the sensory garden and so on. They proudly showed us what was going on in the nursing home, and they told stories and shared experiences with us. This was a way for them to include us and give us the opportunity to participate in anything from a conversation there and then to a greater involvement over time. We were received this way on several occasions, be it by the manager or by a staff member, and it seemed that this precept permeated the atmosphere. It was confirmed in the interviews that we did not get special treatment – this was indeed intentional and intended to include everybody.

It was a conscious precept of the manager and the staff that everyone coming to the nursing home should get attention and be seen so that they felt welcome and looked after. In line with Tennyson, the manager took on a highly conscious brokering role that transferred to her staff (Tennyson, 2005). Through her leadership and actions, and by continually talking about it, the manager was a role model of boundary work who inspired her staff to establish contact, relationships and trust. This made all visitors feel that they were being looked after via the employees' '5 min of attention'.

Thus, the nursing home—through tiny actions—created a feeling of being included and cared for, a sense that this was a good place to be for staff, residents and visitors. This can be perceived as a person-centred care environment preserving the integrity of residents while facilitating trust and social bonding (Davidson and Tondora, 2022). The desire to participate and contribute was established, and through this the nursing home attracted new external collaborative partners for health promotion activities. The activities are in line with Levkoe and Stack-Cutler's characteristics of brokers (Levkoe and Stack-Cutler, 2018), i.e. individuals, managers or teams who are proactive and who initiate and arrange dialogue, trust and collaboration.

A fashion show: the nursing home as a hub

> It began with the nursing home receiving a bag of old clothes, which caused great excitement among staff and residents alike. Chats and debates about the clothes, the way fashion had changed and other experiences became part of the small talk that everyone took part in as shown in the previous illustration. A couple of members of staff put the clothes on and showed them to the residents, who recognized the clothes from their own childhood and adolescence. The manager had the idea of letting more people see the clothes, and the idea of a fashion show emerged. She mentioned this to the municipal councillor, a woman, at a suitable opportunity. The councillor thought it was a splendid idea and was more than happy to be a model herself. The fashion show idea was passed on to both staff and relatives, with a request for more clothes from the 50s, 60s and 70s. Engagement was strong both within and outside the nursing home, involving many people who showed great creativity, and a raft of ideas came into being along the way.
>
> The nursing home then set out to organize the fashion show, involving participants from within the nursing home and from the community. Word of the show being planned got about the community, and several people got in touch to join in and contribute. On the day of the fashion show, it turned out to involve about 150 residents, staff and relatives, and the hall was packed. The nursing home had brought in a master of ceremonies from the local community. Just before the show began, it occurred to one staff member that they should have a photographer in place. A local photographer stepped in and took pictures free of charge. All those who were to be models – employees, employees' children, student nurses, trainees, university lecturers, secondary school pupils, firefighters from the local area and the chief executive of the local administration – had

> been to the nursing home in advance and tried on the outfits. The show opened with local firefighters wearing old uniforms. Outfits from the 50s, 60s and 70s were then shown, with music from each decade.

The fashion show became an opportunity for people to connect and an arena for social inclusion. The engagement and participation of different people led to new activities emerging in the course of the planning process as the event evolved from a bag of old clothes to a festive fashion show. As the activities grew and a string of participants joined in, the nursing home brought together and mobilized large parts of the local community who each played a part in making the fashion show unforgettable. The nursing home staff were quick to see the potential in a bag of old clothes. It started as informal boundary work with some people engaging in activities directed towards a certain group, and gradually expanded as the nursing home served as a hub. Such experiences of boundary work have the potential to become a recurrent tradition with potential health benefits for everyone involved.

DISCUSSION

Community health promotion through boundary work

Following the three illustrations of boundary work above, we will now use South's (2019) four categories of health promotion strategies—(i) Strengthening and developing the community; (ii) Volunteer and peer approaches; (iii) Collaborations and partnerships; (iv) Securing access to community resources—as an analytical framework that can help to identify different forms of boundary work between the nursing home and the community. Subsequently, we will discuss the future role of nursing homes in the community and the innovative potential herein.

The first category concerns *strengthening and developing the community* by developing citizen capacity, resources and social networks in order to interact with and influence health determinants (such as social inclusion) in the local environment of which the nursing home is part. The illustrations show that the nursing home gained a nodal function, actively creating networks and linking internal and external individuals and resources. Community participants get in touch with the nursing home and step in in various contexts, while the nursing home opens up the use of its own resources (staff and premises) to the community. The nursing home staff see the possibilities and allow the collaborative processes to evolve organically with little formal control, as in the case of the fashion show.

The second category, *volunteer and peer* approaches, emphasizes the use of brokers to provide advice and organize activities. Here, the nursing home has developed 'small talk', i.e. everyone should be seen and included, with all staff playing an active part in forging contacts and networks with relatives and other visitors. There are also volunteers acting as brokers in the community who establish contact with the nursing home. They are representatives of the gardening team, former relatives and 'friends' of the nursing home. They know they are welcome, and they are included and acknowledged.

The third category, *collaborations and partnerships*, in which citizens in the community and in the nursing home collaborate to identify needs and to implement and evaluate initiatives, is perhaps not as evident. As far as we could see, such collaboration was not all that apparent at the system level. During interviews, the nursing home manager explained that she often had meetings with the municipality and collaborative meetings with other nursing homes, at which needs and initiatives were discussed. While this boundary work was not visible during fieldwork and may be invisible to many of the people involved in the day-to-day activities, we suggest this attention to the intertwinement of systems as mentioned by Engeström and Miettinen (1999) was crucial for the hub coming into being. There is likely to be a large untapped potential here for working in a more formalized 'growth' (Sennett, 1997) by opening well-established organizational boundaries.

The fourth category was *securing access to community resources* by connecting citizens with resources, help services, group activities and voluntary work that can meet health needs and contribute to community participation. Here, the nursing home evolved into a hub while arranging activities and inviting participation that bound the nursing home and the local community together.

As we have shown, South's (2019) four categories can help identify different forms of health-promoting boundary work between the nursing home and the community. Moreover, the categories can serve as a framework for analysis and discussion of the balance between formal and informal boundary work. Part of what binds people together in boundary work and gives it direction are physical spaces that act as an invitation to boundary work, such as the sensory garden. Looking out at a sensory garden and spending time in it can provide sensory impressions through visual, auditory and tactile stimuli that encourage dialogue, social inclusion and good patient-carer relationships (Magnussen *et al.*, 2017). The same is true of the 'small talk' purposely and strategically used by nursing home staff acting as brokers, and of big events whose success depends on the practical help, knowledge and resources contributed by many participants, such as in the staging of the fashion show.

These activities are based on—and create—mutual trust and new social relationships between people in the nursing home and the local community, leading to new, improved practices within and outside the nursing home. As such, all participants become co-creators of health—for themselves and each other.

As we have aimed to illustrate, studying health promotion as boundary work is in many ways generative for understanding how people initiate change and create value for themselves and others. Boundaries are, however, 'malleable and dynamic constructs' (Akkerman and Bakker, 2011, p. 152), and we move in and out of different practices, often without even noticing any boundaries. What researchers might construe as boundary work may not be experienced as such by participants in a study. Boundaries are not just (if at all) *encountered*; they are primarily a conceptual framing, an analytical lens, or an experience of being inside or outside of certain practices. Thus, moving across different practices, professions and situations may not be perceived as boundary work as such; it may become so only through retrospective engagement in 'boundary thinking', as we have done here.

Despite these reservations, the notion of boundary work directs attention to the innovation potential of new forms of and new spaces for social inclusion and collaboration. Much innovation research indicates that innovation is rarely genuinely new, as the new can emerge from new ways of combining already-present knowledge, things or processes (Tanggaard and Wegener, 2016) or from the improvement of procedures over time (Wegener, 2016). Thus, it is not necessarily the individual elements that need to be rethought, but the way in which they are put together, or the new context in which they are being used. Boundary work is therefore potentially innovative because it provides favourable conditions for combining elements in new ways. A sensory garden did not solely provide residents with sensory experiences, but served as a welcoming space for guests while also providing room for gifts and novelty (the hens). Undivided attention was not reserved for the 'prominent guests', the researchers, but flowed unconditionally towards everyone (we might call it an ethics of social inclusion). A bag of old clothes was not just reused or recycled but sparked a brand-new activity (a fashion show).

The future role of nursing homes and the future of health promotion research

As we have shown, and as the World Health Organization (2019) highlights, participation and community are key areas in health promotion. This means that service providers must develop their professional skills and expertise and, equally, develop their capacity for participation and brokering (Pitchford, 2008; Author 3 and Other, 2018). While ongoing training and education is needed to handle ever-growing complexity, care professionals must be able to take part in different kinds of boundary work. An important debate in relation to the scaling-up of health promotion through boundary work is therefore what health training should consist of in future to handle the complexity of the so-called 'care crisis' (Hansen and Dahl, 2021).

Although we have here praised boundary work as key to health promotion leading to increased health literacy in the form of knowledge, awareness and skills, changes in health behaviour, better self-care and reduced social isolation (South, 2015; South *et al.*, 2019), the idea of health promotion through boundary work raises a number of dilemmas and possible problems. Where should the boundary between professionals and volunteers be drawn? Which kinds of boundary work are truly beneficial to nursing home residents, and which are (predominantly) beneficial to participants from the community? Who is to decide who crosses or dissolves which boundaries? Can a boundary be 'closed' and developing boundary work be stopped? Which resources are needed to support involvement in boundary work in a hard-pressed elderly care sector?

Taking these and related questions into consideration, the linkage between boundary work and community health promotion opens up some interesting perspectives, both in theory and in practice. Research interest reflects a political interest in finding new answers to the question of how increased pressure on welfare systems can be managed. In a radical form of innovation, welfare is changing its character, coming to be regarded less as a service delivered by the public sector to citizens and more as something that emerges in participatory processes. In attempts to describe and promote this radical innovation, the concept of social innovation has grown in scope in the health and welfare literature (Husebø *et al.*, 2021) and often refers to new forms of organization and new designs of welfare solutions (Nicholls *et al.*, 2015). Social innovation is not a distinct discipline and does not have any particular organizational form. Rather, it is a 'loose movement founded on ideas: above all the idea that in the right circumstances people can make, shape and design their world, and more specifically, that they can invent and grow new forms of social organisation' (Nicholls *et al.*, 2015, in Foreword p. x). As such, social innovation places emphasis on the variety of sources from which development can arise and thus provides a mindset and a vocabulary for noticing and nurturing boundary work initiatives. We suggest that the concept of social innovation will prove fruitful in further conceptual studies of community health promotion.

CONCLUSION

The starting point for this article was to enquire how nursing homes can initiate and/or allow boundary work in their local communities. The three illustrations indicate various ways in which the nursing home can serve as a hub for health promotion by mobilizing participants in the community in shared activities, both internally and externally. Health promotion can arise from a form of contact and a way of talking to each other, a 'mindset', that facilitates participatory practices. Boundary work does not 'just' emerge because somebody offers a bag of old clothes or because a sensory garden is established. Activities that open the door to many participants create visibility in the local community, as the fashion show illustrates. It emerges by means of organic interaction that must have an informal character so that many people feel that they can contribute voluntarily and on their own terms. On the other hand, the success of a big event like the fashion show with substantial visibility and many people involved obviously relied on formalized management and tight coordination.

Boundary work binds people together and gives them a sense of belonging, something that has health benefits not only for the nursing home residents, but for all involved participants. What characterizes health promotion when we regard the nursing home as a potential hub? With a theoretical framework consisting of concepts from health promotion and the literature on the 'boundary' concept, and through data from the SIS project, we can point to the following.

Boundary work should not be 'perfect and finished' but should retain a certain degree of openness to new participants and new ideas (as in the sensory garden and the fashion show, for example). This openness can be understood as ongoing 'growth' (Sennett, 1997) balancing informal activities and a certain degree of formalization. Formalization is necessary in the form of management decisions and structures, as informal ideas and actions can otherwise lead to random, one-off activities that do not contribute to the nursing home's status as a hub.

Brokers are key, and the promotion of brokering can be seen as a key leadership skill and management strategy contributing to the development of forms of contact between staff, residents and relatives that invite friendly interest and social inclusion (as in 'everyone must be seen'). Brokering permeates the whole organization, and all staff engage in it. Although the manager plays a key role with her idea of setting an expectation of brokering, it is the staff who translate brokering into practice in their day-to-day work. It is in this reciprocity, the combining of top-down and bottom-up processes between managers and staff engaging in joint brokering, that this form of contact comes about.

Nursing homes, through initiating and allowing for boundary work, can play an active part in social innovation processes. Residents, staff and managers at the nursing home and citizens in the local community can cross, dissolve or merge established boundaries and contribute to the nursing home becoming a hub. It is in these dynamic collaborative processes and activities that take place, that we found potential for innovative ways of promoting health through social inclusion. In the illustrations and subsequent discussion, we have suggested that these strategies can be labelled as 'boundary work' which over time can contribute to the nursing home's status as a hub because differences are activated in new ways and previous boundary enforcements (e.g. which responsibilities belong to whom) are destabilized or dissolved.

The use of the boundary concept made it possible to analyse the ways in which different forms of social inclusion taking place between a variety of participants, and involving various materials and spaces, all contributed to the nursing home's status as a 'hub' for community health promotion.

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Ethical Approval

Ethical clearance was obtained before any project activities were initiated: The project was reported to Norwegian Centre for Research Data (NSD). The report and receipt were sent via email to the editor. Summing up, no person sensitive data were produced, that data cannot be traced back to individual participants, and that written informed consent was obtained from all participants before the study. NSD confirms the ethical approval of the project and that data treatment adheres to the requirements of the Personal Data Act.

Author Contributions

All authors contributed to the article in terms of study conception and design, data collection, analysis and interpretation of results, draft manuscript preparation, and revisions.

Conflict of Interest

The authors have no conflicts of interest to declare.

Data Availability

In accordance with the requirements of the Norwegian Centre for Research Data, data associated with the research project cannot be accessed.

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