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Designing Wellbeing in Elderly Care Homes

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(eds.)**

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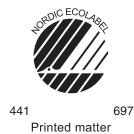
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Foreword: Introducing Orientations

This book focuses on issues of wellbeing and design in the elderly care home context. In the title of the book 'design' has a double meaning. First and foremost, we want to address the design of concrete physical environments for care. The wellbeing of elderly people has been acknowledged as the main target of care, but the effect of the physical care environment on wellbeing has received little attention in both research and practice. Secondly, design also refers here to a more abstract level of designing and managing wellbeing in elderly care. Thus the main aim of the book is to integrate multidisciplinary knowledge about different theoretical backgrounds and empirical studies in order to further develop elderly care to meet the diverse wellbeing needs of multiple actors of the field. Contextually the book focuses on elderly care homes. Care homes as an important part of elderly care are a rich and meaningful research context including various paradoxical issues related to ethical, political and economic challenges both nationally and internationally.

This book owes its existence to fruitful co-operation among researchers and development experts from the Nordic Countries and the UK. Some of the authors had co-operated earlier on research concentrating on elderly care or design, but the research project “Constructing wellbeing in elderly care – organization, design and management as key elements” (CoWell), led by Professor Sari Rissanen of the University of Eastern Finland and funded by the Academy of Finland, did a great deal to integrate research knowledge for this book. Researcher meetings and care home visits during the project in Kuopio 2009 and Helsinki 2010 (Finland), in Copenhagen 2010 (Denmark) and in Oslo 2012 (Norway) were important discussion arenas for knowledge exchange. In addition to the CoWell project, these research seminars were in part made possible through the networks of researchers led by Professor Susann Vihma (Aalto University) and by Research Director Mia Vabø (NOVA, Norwegian Social Research).

This book brings together a series of chapters and is divided into four parts: ‘Reframing Care: Discourses and Context’, ‘Living in Care: Questioning Conventions’, ‘Working in Care: Balancing Contradictions’ and ‘Looking at Design: Confronting Expectations’. The content of the book is based on the previously mentioned network of researchers and their empirical research focusing on elderly care homes and, in particular, on the attempt to bring to the fore some critical themes which are not necessarily generally acknowledged in elderly care research. A further attempt is to merge knowledge from different disciplines while the scientific backgrounds of the authors include such disciplines as anthropology, design, health and social management sciences, economics, public health, social psychology, sociology, social policy and social work.

Most of the chapters include empirical results of studies conducted in various Nordic countries and the UK. Here, however, the description of the methodology of the studies (e.g. ethnography, user workshops, photograph-based focus group interviews, discourse analysis) has been given less prominence. The intended readership of this book will hopefully include many different kinds of readers including, for instance, care workers, designers, managers and policymakers; all of whom themselves also represent the senior citizens of the future. Therefore most space in the book is devoted to the results of the studies and their practical and societal implications for the design of elderly care – in the multifold interpretations of this concept.

The first part of the book, ‘Reframing Care: Discourses and Context’ describes essential concepts and discourses prevailing in the care field, which have their roots in the history of elderly care.

The first chapter of Part One summarizes the preceding discussion on the concepts of wellbeing and environment and their sub-concepts in elderly care. Further, some theoretical frameworks and methodological orientations connected to these concepts are presented. Thus this

chapter, written by Sari Rissanen, also serves in part to provide a framework for the book, aspiring to combine multi-disciplinary knowledge about wellbeing and the care environment.

The second chapter focuses on the concept and discourses of home and homelikeness. These concepts are highly relevant for the topic of the book because achieving a homelike atmosphere has been the primary aim in designing elderly care homes in many countries in recent decades. The problem is how such an atmosphere can be realized in different places. Susann Vihma raises different interpretations of this concept in design processes for critical discussion. In addition this chapter includes a brief presentation of current ideas in design research.

In the following chapter Leena Viinisalo-Heiskanen and Anneli Hujala scrutinize how one important actor group in elderly care design, architects, talk about elderly people with dementia. Based on a discourse analysis of interviews with four Finnish architects, the chapter outlines how these planners of housing constitute the social reality of old people and dementia. From the agency perspective, elderly people are produced as passive objects and as an anonymous mass about whom the architects themselves know very little. Even though the results of this limited study cannot be generalized, the chapter raises important questions about whether the discourses identified in the study do serve to mirror the “secondary” position of old people in society.

In the last chapter of Part One Anders Næss, Anders Kvale Havig and Mia Vabø reframe the history of nursing homes in light of Norwegian experiences, which include at least some of the same features as in other Western countries, especially in other Nordic countries. The title of the historical review chapter, ‘Contested Spaces – The Perpetual Quest for Change in Norwegian Nursing Homes’, aptly reflects the continuous cultural change of the care field, also including the constant battle for cure and care in elderly care. These changes and battles have a significant effect on both living and working in care homes and also on the design of care environments, which are the content of the next parts of this book.

The second part of the book, ‘Living in Care: Questioning Conventions’, brings to light interesting knowledge about what everyday life in elderly care homes looks and feels like. The main focus is on the perspective of residents and aims to describe what kind of places care homes are to live in and to question and criticize conventional thinking about the wellbeing of elderly people.

The chapter ‘Becoming “a Good Nursing Home Resident”’ written by Jens Kofod takes us into the lives of elderly residents in that phase of life when they have left their own homes and have arrived in the nursing home. This ethnography-based study renders the lived experiences of Danish elderly people almost tangible by an intimate touch describing residents’ personal disappointments and successes regarding their everyday lives in a nursing home. It also addresses the challenging creation of the relation between residents and staff.

In the chapter 'A Good Old Age. Life as a Nursing Home Resident in Denmark' Louise Scheel Thomassen calls into question the conventional Western understanding of wellbeing by asking whether being active and independent is really the only way to age well. Thomassen claims that the widely accepted idea of active aging is reflected in the organization of care, in the interaction between staff and residents as well as in the architecture of care homes. The author emphasizes that a frail and sick body is an integral part of life for elderly people. Being helped by others and surrendering the responsibility for one's body to somebody else is natural and sometimes even desirable. The notion of elderly people's right to be frail and sick challenges our conventional thinking about a good old (active) age. Thomassen introduces the concept of "passive activity" and underlines elderly people's own desire to decide what is good for them.

The senses and sensory experiences of elderly residents are in the key role in the next chapter by Anneli Hujala and Sari Rissanen, 'Organizational Aesthetics – a New Dimension of Wellbeing?'. The authors interpret the environments of Finnish care homes from the perspective of organizational aesthetics. Instead of being a place with a feeling of life, some care homes unfortunately seem to be 'sensory voids', places with very few opportunities for everyday sensory experiences, such as the smells of good food and sounds associated with "home". In order to enhance the holistic wellbeing of elderly residents, it is important to recognize the significance of the multi-sensory dimensions of everyday life and pay attention to the aesthetic world of care homes.

The scope of the three articles of the second part of the book is not restricted to the perspectives of residents. Kofod, describing the reciprocal relations between residents and staff, and Thomassen, emphasizing the chances for staff to influence how good ageing is defined, raise the important role of care workers in the construction of wellbeing. Further, Hujala and Rissanen consider the physical environment from the perspective of care workers by pointing out the aesthetic shortcomings of elderly care homes as working environments. These articles form a transition into Part Three, which focuses specifically on questions of working in elderly care homes.

The third part of the book, 'Working in Care: Balancing Contradictions' brings to the fore some specific issues in care work. The chapters in this part focus on the perspectives of staff and managers, describing, for example, what sort of working environments care homes offer in a changing world with its challenges of balancing between a traditional and new picture of care work and care workers.

Laura Alalauri and Anneli Hujala rely on social constructionism in contemplating how the social reality of care work is constituted in Finnish care homes. By analysing their focus group interviews with a discursive orientation the authors give a voice to care workers of diverse ethnic origins. The discourses identified in the study, the humanistic

discourse, the familistic discourse, the discourse of excellent care and the discourse of conflicting values, describe the mundane nature of care work in a multicultural care community. In addition, language problems in general and institutional inequalities related to multiculturalism are considered as a challenge for elderly care management.

Palle Storm takes a fresh approach to normative and stereotyped conventions in care as something traditionally connected to women and femininity. On the basis of his study based on interviews with female and male care workers in Swedish nursing homes, Storm discusses the interplay between the categories of gender, ethnicity and sexuality and addresses the challenges and limitations this interplay presents to individual care workers in the everyday lives as care workers. The normative picture of a “real care worker” is changing. Gentle and caring characteristics as the virtues of a care worker are being replaced by new categories – such as physically strong, rational and efficient male care workers and homosexuals who are much appreciated by co-workers.

The managers of care homes are responsible for the wellbeing of both elderly residents and staff members, but what about the wellbeing of the managers themselves? By asking “How are you, manager?” Kaija Kokkonen draws attention to a topic that is seldom addressed in the practices and research on elderly care. On the basis of a literature review of articles on care managers’ work-related wellbeing, Kokkonen considers the demands and resources for managers’ wellbeing in the elderly care context. At the end of the chapter the connections between physical environment and wellbeing are considered from managers’ perspectives, for instance in the form of increased use of virtual management and information and communication technology.

The fourth part, ‘Looking at Design: Confronting Expectations’ delves into wellbeing issues from a design perspective. This part discusses the various design challenges, such as shortcomings in the physical environments of care homes and increasing use of ICT. Some ways to respond to these challenges are proposed, too, by developing design guidelines, applying an understanding of positive psychology and increasing interaction between diverse actors in care.

Designing environments for supporting wellbeing in care homes is a challenging task indeed. In many countries there are a variety of national guidelines and regulations intended to ensure a minimum quality level for elderly residents and their care. Mirja Kälviäinen makes a significant contribution in the chapter ‘The Match between Design Guidelines and Care Home Reality’ by compiling information on existing care home design guidelines from Finland, Denmark, the UK and the USA. The chapter includes a photograph-based group interview study, where design guidelines are compared to Finnish care home reality. Altogether the chapter defines concrete positive and negative elements and characteristics of care environments and describes how in

practice these are ‘translated’ and concretized into a positive care home atmosphere.

The second chapter describes the physical environments of Finnish care homes using the design and care recommendations as an analytic tool in the description. The authors, Hannele Komu, Sari Rissanen and Mirja Kälviäinen, also pay attention to the omnipresent question whether there are differences between the quality of physical settings in publicly and privately owned organizations. In light of their observations of eight public and nine private care settings, the authors point out some pronounced characteristics of physical settings related to the physical, social and mental wellbeing of both residents and staff members.

In the third chapter, MariAnne Karlsson of Sweden tackles a topical and important issue, new technology, the contribution of which to wellbeing is still often dismissed in the context of elderly care. In care homes residents are often surrounded by diverse pieces of ‘gerontechnology’, such as safety alarms, bed alerts, fall detectors as well as information and communication technology. Karlsson presents both theoretical and empirical approaches that enhance the understanding of elderly users’ acceptance and adoption of new technology, as well as the requirements that the high age of users imposes on technology design. It is noteworthy that age-related ‘computer anxiety’ or ‘technophobia’ seems to be slowly disappearing. Nevertheless, the importance of familiarity and of turning new technology into something familiar that fits into the daily lives of elderly people is of importance in the design of the technological solutions of the future.

In the last chapter, Hugh Miller (UK) and Mirja Kälviäinen (Finland) consider and suggest ways by which ideas from the field of positive psychology might be applied to care home design. The authors suggest that, instead of focusing on removing what is unpleasant and difficult, it is essential to pay attention to more optimistic and holistic dimensions of good life. The potential of ‘deep satisfaction’ for enabling personal development may lead to long-term benefits that improve the quality of life of care home residents and staff members. Reflecting the principles of positive psychology against the data gathered through elderly users’ workshops in Finland, Miller and Kälviäinen identify a number of practical guidelines that might be used in designing wellbeing in care homes. However, as the authors state, the designer can only provide the scaffolds for a satisfying life. Promoting holistic wellbeing requires the co-operation of designers, staff members, residents, management and other actors in care homes.

The book ends with ‘Afterword: Managing Wellbeing’, where Sari Rissanen and Anneli Hujala stress that all the issues addressed in the book are important and relevant from the point of view of elderly care management. As an overall conclusion, these authors briefly consider the design of wellbeing from the perspective of management.

We want to express our warmest thanks to the two external peer reviewers, whose helpful comments made a valuable contribution to the final version of the book. Thanks are also due to Virginia Mattila for her most patient help with language editing throughout the writing process and to Tomi Snellman for translating Susann Vihma's article. We thank Anssi Kokkonen for his excellent work with the layout of this book and Pia Alapeteri for coordinating the publishing process. We gratefully acknowledge the Academy of Finland for making the CoWell research project and this publication possible. Furthermore, our thanks are due to the Department of Art at the Aalto University School of Art, Design and Architecture for financial support. We sincerely thank all the people in British, Danish, Finnish, Norwegian and Swedish elderly care homes who contributed to the studies reported in this book. Finally, we express our greatest thanks to the authors of the book for giving their expertise on designing wellbeing of elderly care.

Anneli Hujala, Sari Rissanen & Susann Vihma

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Reframing Care: *Discourses and Context*



Wellbeing and Environment – Concepts in the Elderly Care Home Context

Sari Rissanen

The aim of this chapter is to discuss the various definitions and aspects of wellbeing and environment concepts in elderly care. The research focusing on elderly people in different disciplines is extensive and on the increase. However, the multidisciplinary work in research or in practice remains somewhat weak and this is partly because of variation in the understanding of the main concepts in different disciplines. This chapter is therefore one attempt to collect some approaches to wellbeing and environment together to further the basic target of this book: wellbeing of elderly in care homes.

Attempt to cumulate and match knowledge

One indicator of the considerable amount of research on elderly people is that there is an ever increasing need for strategic steering in this research theme. One highly significant strategy paper including research on elderly people is *The Future of Ageing Research in Europe: A Road Map*, which was produced at the European level involving all of the major stakeholder groups and end users of ageing research. The Road Map outlines eight basic assumptions in aging research: multi-disciplinarity, user engagement, the life course perspective, person-environment perspective, the importance of diversity and intergenerational relationships, knowledge exchange and technological innovation (Futurage 2011). These assumptions are absolutely crucial, even if the focus of empirical research is on one area of the elderly care system, in this case care homes. In fact, for this chapter as well as for the whole book, the person-environment perspective, which was mentioned in Futurage as one basic assumption in aging research, has been a highly significant starting point.

Malcolm P. Cutchin (2005, 125) has stated that much gerontological research remains relatively undertheorized, and the complexity of person-environment relations as they pertain to older people, their caregivers, and wellbeing is a particular case in point. He sees an urgent need for theories that attempt to account for the complexity of such relations while avoiding the dualistic thinking (such as person-place) engendered by Descartes. In the same way Hans-Werner Wahl and Frieder R. Lang (2004, 2) have observed the separation of knowledge of the physical context and social context of aging. They have argued that spelling out links between the social and physical environment in terms of theory and empirical work would stimulate new and promising research avenues that have been neglected due to the schism of physical and social exerted in the day to day research practices. In addition, Liliane Rioux (2005, 242) has emphasized the importance of further studies concerning combinations of people/place/activity connected to elderly people's wellbeing in elderly care settings.

It is very easy to support the claims of Cutch, Wahl and Lang and of Rioux to focus on the different combinations of person-environment-wellbeing because different disciplines give some perspectives on this complexity of relations, but the integrative understanding is still quite weak. For instance, Elisabeth Burton and co-workers (2011) have stated that an integration of the health and built environment areas of expertise in terms of both research and practice is lacking at the moment. However, this is not enough; even more multidisciplinary orientation is needed (see also Benjamin et al. 2011). For instance, gerontology, psychology and social sciences have practice and research interests in this area. Furthermore, the mission of environmental gerontology within gerontology is its contributions to understanding the prototypical environment-related tasks of the ageing individual (see more in Lawton 1990; Wahl & Lang 2004, 7).

Yet another starting point to respond even partly to the research challenge of person-environment-wellbeing is at least to recognize the variation of main research concepts and some academic writers in this specific research area. In this chapter the main focus is on these issues, although the authors of the following chapters will mainly utilize their own theoretical backgrounds (e.g. design, health and social management, social work, sociology), scientific orientations (e.g. positivist, critical or feminist) and definitions in their contributions. However, this chapter includes those research concepts: wellbeing and environment and partly their sub-concepts and theoretical frameworks connected to them which were identified quite often in the process of this CoWell research project.

In addition, such multidisciplinary oriented research areas as person-environment-wellbeing in a specific context (elderly people in care homes in this case) needs a basic understanding of the research orientations before any more challenging study design can and should be produced. Jon Hendricks and Jason L. Powell (2009, 5) have used a very apt metaphor for this publication about that lack in social gerontology. They have stated that without a sound conceptual grounding and reflexive perspective, social gerontologists build little more than empirical molehills without any cumulative effect. Then they have gone further by saying, without abstracting scaffolding that facts cannot exist in a perceptual sense. Facts without a perceptual framework would have precious little cumulative effect, amounting to little more than a pile of bricks awaiting an architect. This chapter, and indeed the whole book, is one attempt to accumulate some frameworks together in the wellbeing and environment research of elderly people in the care home context.

Wellbeing as a basic target

The most crucial starting point for the CoWell research project was the wellbeing concept and how it is understood in different disciplines. Wellbeing or happiness has been quite broadly accepted as the main target of existence. On a political level, in discussions and in research, for instance, concepts like successful ageing (e.g. Andrews 2009) or active ageing (e.g. Walker 2002; 2006, 83; WHO 2002) or ageing in place (e.g. Vasunilashorn et al. 2012) also aim at the wellbeing of elderly people. It is moreover significant to note that enhancing wellbeing may also be the target of research, as Futurage (2011, 5) mentioned, research should maximize its impact on the wellbeing of all Europeans as they age.

Figure 1 summarizes some sub-concepts, orientations, theoretical frameworks and methodological orientations for wellbeing, which will be discussed next.

The literature on wellbeing as a whole or on its subconcepts, such as quality of life, has identified many different definitions of wellbeing (e.g. Stanley & Cheek 2003; Ransome 2010; see also Miller & Kälviäinen in this book). For instance, the review of the literature of wellbeing and older people presented by Stanley and Cheek (2003) has shown that the definition of wellbeing is usually assumed, or is lacking in clarity, and a

range of similar terms, such as happiness and life satisfaction, are used interchangeably; second, wellbeing has been measured in research using various scales, which may not capture the complexity of the concept; and third, the voice of the older person is often absent from discussions of wellbeing.

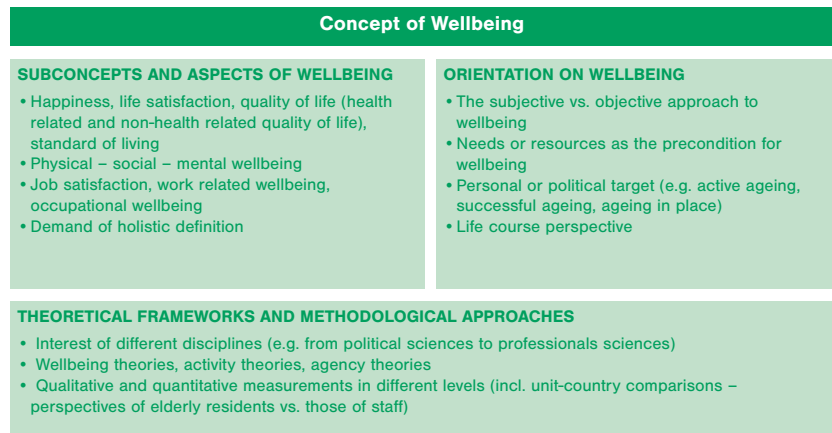


Figure 1. Concept of Wellbeing

Wellbeing has moreover quite often been divided into physical wellbeing (mainly physical needs), social wellbeing (mainly social activities) and mental (mainly psychological /spiritual issues) wellbeing. The reason for emphasizing these wellbeing areas is the research evidence of the significant impact of health (e.g. Smith et al. 2002), social and leisure activity (e.g. Adams et al. 2011) and balanced psychological/mental status (e.g. Arendt 2005; Yoon & Lee 2007; Momtaz et al. 2011) on overall wellbeing in later life. Likewise the concept of quality of life has often been divided into health-related quality of life or non-health related quality of life (e.g. Bowling 1998).

These wellbeing aspects have also been recognized in the multi-dimensional target concept of active ageing: “The process of optimising opportunities for health, participation and security in order to enhance quality of life as people age. Active ageing applies to both individuals and groups. It allows people to realise their potential for physical, social and mental wellbeing throughout their lives and to participate in society according to their needs, desires and capacities, while providing them with adequate protection, security and care when they require assistance” (WHO 2002, 12). The lesson of these different aspects of wellbeing for this book and its purpose is the remark that relation of environments and wellbeing should recognize and balance at the same time all these different wellbeing aspects. This demand for a holistic approach to wellbeing is based on the idea of the human being as an entity of physical, mental and social.

Traditionally the subjective and objective approaches to wellbeing have been distinguished. Life satisfaction and happiness concepts have been more often associated with the subjective approach and, for

instance, standard of living with the objective approach. To simplify, when the subjective approach focuses on people's subjective views, the objective approach focuses on lists of the goods (e.g. nutrition, housing, educational opportunities) necessary for the execution of a rational plan of life. The article by Marie Forgeard and co-workers (2011) gives a very relevant review of the subjective and objective approaches and their academic writers. Likewise the needs or resources which are preconditions for wellbeing have been a much discussed area in the wellbeing literature (e.g. Maslow 1970; Allardt 1999). Theoretically, besides wellbeing theories, for instance, activity theories (e.g. Adams et al. 2011) or agency theories (e.g. King & Calasanti 2009) have been used as a theoretical framework to understand the connections of elderly people with wellbeing. However, the environment connection has quite often been absent from activity or agency research.

The attempt to increase wellbeing is not only the target of individuals, but also the target of many kinds of social and health care legislation and services systems. That way wellbeing can be explored at individual, group or society level. Besides the philosophical question of wellbeing, administrative and political sciences in particular have been interested in the connections of services systems and wellbeing or quality and equality issues while sciences such as psychology, nursing sciences or social work sciences have focused more on individual level questions in wellbeing.

These different theoretical frameworks already indicate that qualitative and quantitative research with different kinds of measurements for wellbeing is extensive, even that focusing on elderly people. In addition, the sub-concepts of wellbeing, such as quality of life (e.g. Vaarama et al. 2008; Räsänen 2011), have been extensively studied. One example from this research area is a Swedish study (Wilhelmson et al. 2005), which has shown that social relations, functional ability and activities may influence the quality of life of elderly people as much as health status. The emergence of this kind of results is important because the ageing discussion or even research seems to sometimes focus too much on diseases and health problems ignoring the other aspects of life in old age.

Some of the research measurements have included some items concerning housing as part of the living conditions of the elderly. Yet these items have been quite general (such as house type or size) or concerning out-of-home environments (e.g. Gale et al. 2011) and not focusing on the interior environments. For instance, Elizabeth Burton and co-workers (2011) have created objective built environment measures from front door to wider neighbourhood for investigating the links of built environment with older people's wellbeing. However, for the authors of this book interior environments are also important, especially when ageing takes place in care home contexts.

Finally, the wellbeing questions in working life, in this case in care homes, are a much studied area (see e.g. Edvardsson et al. 2011; Kokkonen

in this book) with numerous sub-concepts such as job satisfaction, work-related wellbeing or occupational wellbeing. These mostly quantitative studies comparing units or even countries have added our knowledge of staff's occupational wellbeing. For instance, the study by Teppo Kröger's research group (2009) on care workers in Nordic countries has shown that caring for older people in Finland is felt to be more burdensome, and that feelings of inadequacy were more common and the threat of violence the highest among the Nordic Countries. Altogether the understanding of the elderly care from a working life perspective is a very important issue also for this book (see more Kamp & Hvid 2012).

In this publication our interest is mainly in elderly people's wellbeing (Kofod and Thomassen in this book), but some chapters highlight the staff's or managers' views on occupational wellbeing (Kokkonen and Hujala & Rissanen in this book). The justification for this choice is the research evidence about the close connection of residents' and staff's satisfaction to each other (see Miller & Kälviäinen in this book). For instance, the literature review by van den Pol-Grevelink and co-workers (2012) has shown that person-centred care has a positive effect on a number of dimensions of caregivers' job satisfaction in care units.

From the perspective of elderly people and staff it is relevant to connect their wellbeing to different stages in the lifespan. Life course researchers have observed the significance of general and unique location in time and place affecting personal experiences (see more in Giele & Elder 1998). Is wellbeing something which includes similar issues in different stages of the lifespan or is there variation between life stages or people? Likewise it is possible to question occupational wellbeing in different life stages, between different people or in different working positions. It seems obvious that people's life styles have been quite stable in ageing but the difference in lifestyles between different people has increased in recent decades. In Finnish wellbeing research Antti Karisto (2002) has stated that chronological age will increasingly lose its predictive value. Maybe the increasing problems in defining aged people through specific chronological age groups also reveal something of the diversity of elderly people and their future wellbeing. Part of this diversity is the difficulties to have common, culturally accepted terms for elderly people (e.g. old people, the aged, seniors). Altogether it seems that the understanding of multiculturalism of elderly people and staff in care home contexts is still quite weak and the area needs further research (for more see chapters Storm and Alalauri & Hujala in this book).

Care homes as environments for wellbeing

Figure 2 presents some sub-concepts, orientations, theoretical frameworks and methodological approaches connected to the environment concept.

The first very practical problem is the unclear definitions for places where elderly people are living besides their own homes (see e.g. Scott-Webber & Koebel 2001). These places are called, for instance, assisted

living communities/environments, care homes, care housing, care institutions, long-term care units, nursing homes, residential homes/care units, sheltered accommodation, old people’s homes. Partly this increased number of terms is due to the political pressure to abandon institutional care and change the image of elderly care to be more homelike (see more in Næss et al. in this book). In this book we use the terms care home or nursing home although there is no precise definition for these even in the Nordic countries. Here they are mainly used to refer to units where elderly people with various care needs are living with 24-hour care staff available.

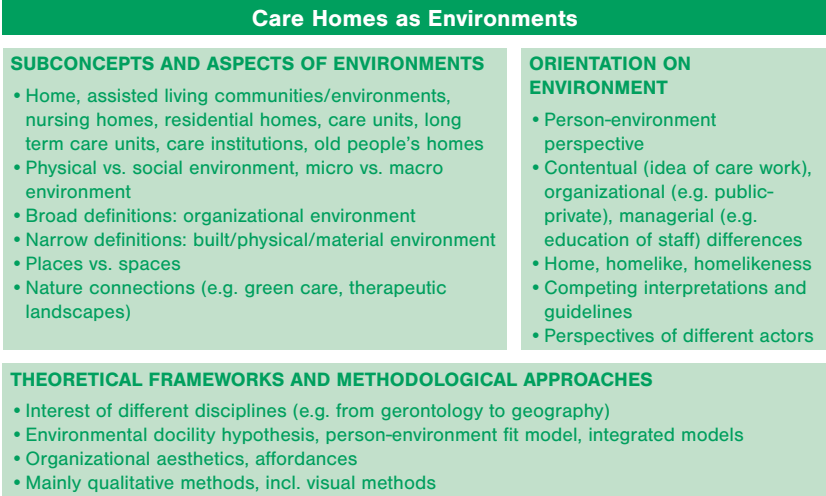


Figure 2. Care homes as environments

The composition of different care homes is affected by many factors. For instance, our research visits to care homes in Denmark, England, Finland and Norway on the CoWell project revealed the basic differences regarding the care homes: are they mainly institutions, care and working units or homes for elderly people. For us it appeared that some of the contentual, organizational or managerial differences were country specific, but many unit-specific differences were also apparent.

Currently it seems that the governance and privatization of care have extensively modified care in England, but lately also in the Nordic countries (e.g. Stolt & Winblad 2009; Vabø 2009; Rissanen et al. 2010). One implication of this is that organizational studies have also focused on structures, provision and finance systems or the organization cultures of care homes. These questions have been studied, for instance, in the research tradition concentrating on comparisons between private and public care homes, such as their quality (e.g. Amirkhanyan et al. 2008; Komu et al. 2011). For this book it is interesting to note as a detail that very unclear, sociology oriented concepts such as private or public are used on organizational level but also on unit level to describe private, semi-public or public environments inside care homes.

The concepts home and homelike have raised much discussion in our research process (e.g. Vihma 2012 and in this book; Kälviäinen in this book, see also Wahl 2001; Rowles & Chaudhury 2005; Ronch 2011). What makes a home, what constitutes homelike, or should homelike even be the target of care homes? Or are such attributes something beyond the personalization of rooms, with residents' own belongings, photographs or furniture from their previous homes. Recent Danish research on homelikeness (Aasgaard et al. 2012) in nursing settings has identified two characteristics of homelike: 1) the caregiver being near and offering safety and 2) a living room and kitchen as a common social arena. The study also showed that people with dementia seek safety and fellowship in common living rooms and do not spend much time alone in private rooms.

Besides the term used for care homes and the identity of home, other definitional problems concern the definitions of environments, places and spaces, concepts with roots quite often in the discipline of geography. There may have been a surface split between physical environment and social environment (see more in Wahl & Lang 2004) or in organizational sciences the environment concept has been used very broadly to refer to all issues around the organization, but it can also be seen more narrowly concerning built, physical, material environments. Concepts like micro and macro environment have also been used in discussions. The same confusion surrounds other concepts, for instance, Janine Wiles (2005, 101) has stated there are many ways that geographers conceptualize space and there is by no means a universal consensus on the best way to think about space or place.

In fact Malcolm Cutchin (2005, 121) has emphasized that the concept of place has undergone a spectacular renaissance across the humanities as well as the social, behavioural and health sciences during the last two decades. In his view a once moribund concept even in its home discipline of geography, place has become a valued focus for research in many disciplines. Place, as a concept referring to the ensemble of social, cultural, historic, political, economic and physical features that make up the meaningful context of human life, is increasingly recognized as an important element in research, education and practice relating to older people.

In this book we have selected most often environment as a concept to refer to the main focuses of this publication, the physical, mainly built environments and social environments of various care homes. However, it is important to remember the message of Hans-Werner Wahl and Frieder Lang (2004, 3-4) of striking structural similarities between the physical and social environments from the perspective of elderly people. They have stated that physical and social environments are major resources or constraints for the individual's action potential and quality of life. Similarly individuals appear to actively regulate the quality, structure and function of their physical and social environments and thereby enhance their physical and social resources. Hence

some chapters also address the connections of physical and social environments to wellbeing.

It is also significant to note the attempts to connect not only built environment but also nature to wellbeing. As Erik Allardt (1998, 39-45) has emphasized later in his wellbeing concept, the natural surroundings of the accommodation and aesthetic experiences are important parts of wellbeing. The concepts Green Care (e.g. Vik & Farstad 2009) or therapeutic landscape (e.g. Williams 1999) can be interpreted as examples of how this kind of newer conception of nature has assumed a more significant role in health and social care systems and practices. In practice, for instance, the study by Martha Raske (2010) suggests that the garden had positive effects on residents' quality of life, particularly in terms of meaningful daily activities, enjoyment of daily life, resident relationships, and functional competency. In the same way the significant role of pets has historically been recognized in care processes (e.g. Smith et al. 2011).

Various researchers (e.g. Rioux 2005; Wiles 2005) have raised very relevant discussion on the competing interpretations of the same environments, constant renegotiations concerning the environments or control of environments connected to elderly people's wellbeing. The recent study by Popham & Orrell (2012) in the UK context has shown that for people with dementia the most important factors in the care home environment were not the layout or design of buildings but the ability to make choices, engage in activities, and the staff's approaches to care. However, the same study showed that the managers felt that comfort and homelikeness (for instance the personalization of rooms) were the most important features in care home environments, while staff rated health and safety highest. These results show that the different actors may have quite different interpretations of environments and the question is whose voice is heard in care and design processes (see also Oswald et al. 2007 on home settings). One of these voices is also that of the architects (see more in Viinisalo-Heiskanen & Hujala in this book) and the design or care guidelines (see more in Kälviäinen and Komu et al. in this book).

Popham and Orrell (2012) once again demonstrated in reality how well-meant efforts to increase residents' activity may be forbidden in safety guidelines. Although all homes had safe enclosed gardens, residents' access was heavily restricted because of the safety concerns of staff and managers. This emphasizes that health and safety issues may influence how an environment will be used (whatever its design features) and this can have a marked effect on elderly people's wellbeing. Likewise the study by Kathleen Benjamin and co-workers (2011) states that physical environment can act as a barrier to physical activity in care homes. This study showed that these barriers involved the intersection of both permanent structures in the built environment – such as ramps, heavy doors, and narrow hallways – and the increased use of large pieces of equipment such as patient hoists.

To summarize, it seems that the wellbeing of elderly people is related to combinations of person-environment-activity which could be concretely described as an agency of both physical and social environment. In the care home context an important question is how this kind of agency of people in environments can be guaranteed and what forms such agency should actually assume. Critically, one might ask if physical activity is always a good target or what, for instance, is entailed in passive activity, when the frail bodily is a reality (see more in Thomassen in this book). Research has previously shown that even small involvements can have extensive effects on the wellbeing of the elderly (e.g. Barnes 2006, Falk et al. 2009).

In addition, it is important to remember that besides the elderly people and different kinds of staff who are located to care homes, other actors such as informal carers, relatives or voluntary actors are partly dependent on the prospects of environments to fulfill their agency in connection with the wellbeing of the elderly. For instance, family members may want more day rooms offering places for quiet visits (Popham & Orrell 2012) or residents' visits by the clergy and specialized recreation groups, which also need different kinds of environments (e.g. Park et al. 2009). Altogether the role of informal care varies between individuals and countries (e.g. Bonsang 2009; Horvath & Mayer 2010), the meaning of relatives and the role of informal care do not vanish in the care home, and in fact there is a research area for identifying models of informal care and factors that predict family involvement (e.g. distance to unit) in residential long-term care (e.g. Gaugler et al. 2003; Lum et al. 2008), but it seems still that the affordance of physical environment for informal care in care homes is little noticed in practice or research.

From the research perspective it seems that there is a greater body of work, albeit somewhat less empirical and theoretical, in the area of environment and ageing than in the area of wellbeing and ageing. However, Hans-Werner Wahl (2001), Wahl and Lang (2004) and Wahl et al. (2012) have aptly summarized the existing research and theoretical approaches as regards the environmental research perspective in aging contexts. For instance, they have discussed the Environmental Docility Hypothesis or Person-Environment fit model (e.g. Lawton & Simon 1968; Kahana 1982) and recently their own integrative model of aging and environment based partly on the work of M. Powell Lawton (Wahl et al. 2012). All these offer tools to better understand the relation between person and environment.

In addition, organizational aesthetics including the experience of materiality serve to expand the relation of environment and wellbeing from an organization studies perspective. Besides the sense of sight and 'the visual', organizational aesthetics is also concerned with other human senses, such as hearing and sound, smell and scent, taste and flavour, as well as touch and physical contact in care homes (e.g. Hujala & Rissanen in this book). The affordance concept (see more Gibson 1979) used for instance in design sciences can likewise be seen as one tool to

connect environment and wellbeing. Päivi Topo and Helinä Kotilainen (2009, 45) argue that a living environment at its best is enabling: it provides opportunities for action and self-expression. But sometimes at its worst it limits or stops action and provides only very limited opportunities. They claim that such enabling and restrictive qualities of living environments have been described as affordances. All these newer theoretical concepts in particular have also served to extend the methodological approaches of environment and wellbeing research to some novel orientations such as visual methods.

Concluding remarks

Figures 1 and 2 summarize some sub-concepts, orientations, theoretical frameworks and methodological orientations for wellbeing and environment which have been recognized during this research journey. However, it must be stated that firstly, the split between concepts and theoretical frameworks is not easy to define; concept definition and theory building may be quite near each other. Secondly, many concepts and theoretical frameworks mentioned here are parts of wider theoretical approaches. Thirdly, all items mentioned or their interpretation are mostly the subjective emphasis of the author based on her readings and research experience, other options could be available.

Further, it is significant to note that the huge expansion of practical and scientific knowledge of wellbeing or environment has made it possible to collect and integrate knowledge in more systematic ways, like reviews, but their chances of resulting in evidence-based guidelines for wellbeing or environment practices or research at the best connected to them to each others' are still somewhat remote. For instance Karin Dijkstran (2006) and co-workers still believe that based on the research available, it would be premature to formulate evidence-based guidelines for designing healthcare environments. However, the most important issue is perhaps not strict guidelines but to recognize and discuss research and practical knowledge and their relations to wellbeing and environment connected to elderly, when care, design or management processes are planned or reformulated.

Figures 1 and 2 show that there are indeed many different ways to approach the relation of wellbeing and environment connected to elderly people in care homes. Maybe what is significant for future research is to make reasonable and out written choices of concepts, relations and theories besides perspectives of the philosophy of sciences which were not discussed here at all. This preliminary framework in this very complicated research area should be enhanced through design and design approaches like design for all and management concepts and theories, which were the other starting points for the CoWell project. The afterwords forming the last chapter of this book will raise some mainly empirical lessons to learn for managing elderly care found during the research journey of this project, but the elderly care management

area would also need more concept and theory oriented discourse in the future (see e.g. Kokkonen et al. 2012).

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1 The titles of works published in languages other than English have been glossed for readers’ convenience.

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Homelike Design in Care Residences for Elderly People

Susann Vihma

In this chapter, the concept of home in elderly care is examined through the literature and visits to facilities. One of the key issues is the nature of these residential milieus when they are also workplaces. The main question is therefore how homelike qualities can be implemented in such places. The matter is increasingly important because in many countries a home has been the primary aim in the planning of elderly care and residential units. There are many possible ways to try to satisfy this requirement, but there has been very little discussion on the subject. Another important aspect of homelikeness is that, while architecture and design can contribute to its realization, their full potential has not been exploited. Since my perspective on the topic is design, I will start by introducing readers to some current ideas in design research.

Design research and design semantics

Design research as a discipline has emerged in the last fifty years to parallel the much longer established discipline of design practice. Today design research comprises many different approaches and methods, and its theoretical assumptions also cover a range of approaches. It is closely linked to a number of neighbouring fields, such as technology, business economy, sociology, media studies, and so on. All these fields provide design with conceptions based on their respective traditions. Neither design nor design research are limited to the planning of individual objects or places; they have today broadened their scope to include activities, functions, concepts and strategies. As a professional activity within industrial production, design has always been a team effort, but today, more than ever before, it is driven to include users and other stakeholders in the planning process. Approaches such as usability design, co-design and participatory design are favoured today.

One relevant theoretical branch of the discipline is design semantics, the study of representational and communicative features of the built environment. Design semantics exploits a variety of basic assumptions and concepts that have been adapted from such areas as the psychology of perception, cognitive science, semiotics, aesthetics and design history. This book chapter belongs to the tradition of design semantics, and examines the qualities of space and objects as they can be interpreted by their users. In design semantics, people are seen as interacting with the physical form of objects and with space, which refers to ideas, styles, cultures, activities, or symbolic content, and also affects the emotions, thinking and behaviour of their users. The physical environment and its design signify and communicate with a person who acts and lives in this environment. This process and quality of signification can be described, thematized and discussed, and constitutes the subject of design semantics proper. The environment can convey qualities that can be felt and interpreted, a case in point being the homelike quality in elderly care centres.

When the homelike quality is set as the main goal for organization and design, it needs to be looked at carefully, otherwise the goal remains unreachable, as is known to have happened. Because residences for elderly care (often called care homes or nursing homes) are seldom examined as specific milieus of habitation, their institutional features seem difficult to identify and address. One extensive interview study was conducted in the Netherlands, investigating the “feeling at home” experiences of 686 inhabitants (de Veer & Kerkstra 2001). The approach was that of nursing, and hardly any attention was paid to the residence as a milieu. Homelike instead of an institutional milieu – conveyed by the expression “a home experience” used by the Danish, or “a sense of home” by the Dutch – is currently presented as a general objective in reports and national design guidelines (de Veer & Kerkstra 2001, 1; Aasgaard et al. 2012). Yet no clear idea exists as to how homelike features can be implemented in practice. We may, therefore, with good reason ask: What

are the foundations of good institutional habitation from the inhabitants' point of view? What are its desirable properties? What are the things that should be avoided? In the 1970s, literature on habitation of the elderly focused on such concepts as supportive housing and universal design. Then the emphasis shifted to the efficiency of housing, whereas today the focus is on the quality of the living environment (Caouette 2005, 251).

Although we have knowledge and experience of the changes brought on by ageing, the practical application of such knowledge in the design of elderly care residences can be difficult, because there has been very little discussion about the qualities of homelike milieus, or they have received only superficial attention. Moreover, demands on habitation often appear to be mutually conflicting when considered from the perspectives of the residents, staff, administration and others. Needs for changes are difficult to implement because of the complexity of the residence and the considerable demands placed on institutional living and care. Although there is a need to address homelike living as opposed to institutional habitation, the subject has been little studied and under-theorized, as pointed out by Twigg (1999, 382), Sundell (2011, 52), Gillsjö, Schwartz-Barcott and von Post (2011, 2).

This chapter discusses the concept of homelikeness as a key design-semantic theme in care residences. I will point out certain factors that persistently seem to perpetuate institutional features in residences for the elderly. The analysis of the research literature and discussions during visits to facilities show that reducing their institutional character is internationally a general goal. My data comprises the studies and visits conducted within the CoWell project in Finland, Denmark, Norway and Sweden, together with accompanying notes and photographs (see also the fairly extensive survey by Ryhänen et al. 2007).

“The home”

The home has nevertheless interested researchers in different fields for decades. The study of the social and cultural meanings of space, place and landscape along with various other concepts is known as cultural geography. Accordingly, the home can be conceived of very broadly, such as the Earth being the home of humanity, for example. In discussing the concept of place, Cresswell (2004) makes the observation that the most familiar example of a place is none other than the home. The element common to all experiences of the home is that people feel attached and rooted to it as a place; the home is something special and unique. More than any other place, the home is associated with certain key meanings in life; home is the sphere of nurture and care. The home is also seen as a private place of rest where one can withdraw from the world and, at least to some extent, control what happens in the limited space. At home, we can both be and express ourselves. Cresswell (2004, 24-25) refers to Heidegger's concept of dwelling as an ideal way of being and to Bachelard's notions of the house or home as a primal space. The home has also been discussed in sociology, yet for some reason all these

discussions and concerns are scarcely discernible in reports on elderly care and unknown among planners. Furthermore, it seems that the home as a research subject has been approached from the vantage point of separate disciplines, and multidisciplinary reviews of the literature have only been conducted recently. It is probably also the case that the home has mostly been studied as an experiential phenomenon, with scant attention being paid to the quality of the physical environment and its homelike aspects, such as in an institutional residence.

Oswald and Wahl (2005, 6) have shown in detail, from the perspective of gerontology, that the significance of the home increases with ageing, because elderly people spend a lot of time at home due to decreasing levels of activity. For old people in particular, a homelike atmosphere is important, because it is an expression of personal values and lifestyle (also Gillsjö et al. 2011, 7). Ideas of the home may nevertheless be excessively biased, and can easily conceal power relations within a home. Feminist theorists, among others, have criticized such ideas because the home has also entailed hard work, submission and even danger. Even when different types of homes are identified, many researchers nevertheless share the view of the home as a warm, caring place. This one-sided idealization of the home has been criticized because the home does not always represent such a rosy picture. A closer look at the home reveals its political nature as a space (see also Twigg 1999, 384).

Whenever we speak about the home, we should remember that such talk always involves a distinction between the private sphere and the external, public world. Moreover, the home embodies both material and ideological aspects, which means that it also materializes and structures social reality (Twigg 1999, 393). That is why the design of the home and homelike qualities are important issues. It is also important to remember the close connection between the home and memory, particularly in the context of the living conditions of the elderly. Objects in the home establish links to the past. Ordering them is one way of expressing one's identity, in addition to which the objects also define one's social status. The phrase "feeling at home" expresses a relationship between a certain place, the objects and a person, a relationship that evolves and develops over time.

In research, the home is often conceived of as a place, but above all as a relationship and an experience. As an experience – a sense of "being at home" – the home constitutes an insider's unique experiences arising from activities of all kinds undertaken at home. It is therefore difficult to determine the point at which the home as a place becomes a mode of being. For research, the home remains a shadowy area. One reason is probably that it is a private place to which it is difficult for researchers to gain entry. The nebulous meaning of the home as a spatial and social entity – home as a house, neighbourhood, landscape, city or nation – makes it an endless philosophical quagmire where no simple answers can be found (Dovey 2005, 362).

The concept of homelike in all its complexity has not been articulated in the design and organization of institutional residences. For instance, the Danish researchers Aasgaard and co-workers (2012, 24) observe that there is little research on the quality of homelike, in spite of the fact that since the 1990s it has been deemed an ideal in the care of the elderly. This in turn may have led to vulgarization, a perception of the home as a kind of idyll, which in turn leads to an excessively narrow conception of the qualities of the home. The Swedish researcher Eva Lundgren (2000, 116) claims that elderly care habitats are created by the staff, and the result can be described as over-decorated and 'cheap'. Actually, in Lundgren's opinion, homelikeness is cosmetic; it is ideological make-up.



When we want to retain old things in an institutional milieu because they carry memories, we may ask *whose* memories they ought to be, particularly if the items are not chosen by the residents themselves (Figure 1).

Decorative antiques and bric-a-brac may not create a more homelike environment.

Decorative objects in the semi-public spaces of care milieus are often chosen by non-residents and reflect an idealized rather than an experienced past.

Figure 1. The interiors show various collections of items which seem to belong to nobody.

The concept of the home in institutional residences

A sense of home in a residence cannot be established through care practices alone, not even when the workplace of the staff is understood to be the home for the residents. The concept of home is easily a kind of an unreflected given for most people. Members of the staff have homes of their own, and the idea of home is conveyed from their personal experiences to the workplace and into the residence and its living conditions. The actual proprietors of the space are the staff, not the residents. Responsibility for the space belongs to the staff and the organization, and it is they who make the rules, which are largely determined by the prevalent practices and culture of care.

People generally have a very specific idea of this familiar subject and its associated atmosphere of the home, an idea based on their personal experiences of their own home and those of their nearest and

dearest. This concept of the homelike will inevitably manifest itself in some way when requirements for something homelike are applied to institutional habitation (see also Aasgaard et al. 2012, 27–31). However, in administrative reports homelike qualities are often reduced to some basic, tangible requirements, such as the need for a private room or some other, in itself quite appropriate, quantitative spatial dimension. Or then, as Verma (2009, 10) writes: “[T]he size of the dwelling unit affects homelikeness and pleasantness, and the significance of this is even greater in the design of living environments for people suffering from dementia. A homelike atmosphere of a family dwelling can only be created in a unit designed at most for 5–8 inhabitants.” Similar observations have been made in Finland by Maria Klemez (2012) in a study of general problems in buildings for the elderly: the rooms are undersized, the buildings are not integrated into the urban fabric, everyday routines and functions all require permission. The commonplace need for “a room of one’s own” with personal furniture tends to be emphasized in objectives and goals. This is not enough, however, because institutional features manifest themselves particularly in public and semi-public spaces such as lobbies, dining rooms and living rooms as well as entrances, their furniture and fixtures.

On the other hand, it has been suggested that institutional residences should not be made subject to some generalized requirements concerning homelike features, because the elderly should not be treated as a homogeneous group; their backgrounds may differ considerably. It follows that there should be several different concepts of the home on offer, to be applied as required. It further follows that the concept of the home cannot be regarded as uniform and fixed; it is flexible and can be changed by inhabitants and staff. Modifiability has been the main goal in the design of the recent assisted housing project in Viikki in Helsinki, for example (see Hynynen 2010). It should be evident at this point that the homelike goal is closely linked to the organization and management of the residential centre, and thereby also to funding and care ideology. The conception of homelike thus begins to represent the culture of a society at large.

Some homelike features are apparent in Patricia Yancey Martin’s sociological study of 2002 in which she compares them to institutional factors. In an earlier study conducted in 1984 Martin wanted to find out whether conditions in small institutional care residences meet the criteria of what Goffman calls a “total institution”. Martin’s data in 1984 covered a variety of institutions, such as “old people’s homes, children’s homes, and probation hostels” (the appellations reflect the time of her research). In the later study, she continues to research with a different approach, positioning herself inside the narrative, inside the method, registering also her own experiences as observer and interlocutor (2002, 879). Thanks to this approach, we can see that her field of organizational studies comes close to the research themes of design semantics, meriting a closer look at what organizational studies produce that can be useful in

design (Figure 2). Highlighting this fact – the link between organizational research and design research – is one of the main purposes of the CoWell project.



Figure 2. Institutional features are often highlighted by decoration and unintentional markings as, for example, bulletin boards.

Martin uses the design semantic concept of “spirit of place”, familiar from architecture, which embodies “the corpus of sensory perceptions in and reactions to residential organizations”. However, she does not make direct reference to design writing or to *genius loci*, such as the well-known book by Norberg-Schulz (1979). Martin suggests that the spirit of place is actively created and that even small changes in practices can have a positive impact on it. She also considers it a paradox to call residential organizations ‘homes’, because the residents are unable to control their own bodies in relation to place, time or activity (see also Dovey 2005). In other words, they are unable to do the things they used to do in their own homes, such as make a cup of tea at two in the afternoon, or take a walk at sunset. They must submit to the authority and discipline of the formal organization that controls their space, social relations and bodily functions. Residences may be somewhat homelike, but, as has often been noted, they are not homes in the ordinary sense of the word (Martin 2002, 867). When management and staff speak of home, there is always a paradox involved. There is an underlying assumption that the residents have the same rights and privileges as they would have at home, but this is not the case. Personal functions, such as washing, dressing, eating, are all publicly administered, and sex is often taboo. Because care centres are workplaces for the staff, they involve certain working hours, responsibilities, routines and free time, which influence the activities and the atmosphere of the habitation.

The spatial design can restrict the residents' field of vision to some extent, but not the smells and sounds of others, which permeate the entire building. For example, a high ideal of hygiene may require the use of powerful detergents, with the consequence that their acrid smell is everywhere. Other possible sources of powerful odours in these residences include cooking, laundry and urine.

Although Klemes (2012) for one lists residents' needs and general services, her study offers no view of how the functions could be implemented in actual interiors and in furniture design. She only mentions that windows and window frames contribute to the homelike ambience of a room. Elsewhere she discusses dimensioning and the lighting of spaces. Lighting is also mentioned in many other reports on architecture and spatial design as a factor that creates atmosphere and even enhances the sense of homelike (e.g. Maila 2012, 26). Architects even pay attention to floor materials.

All institutional residences involve things that are difficult to manage, such as meagre financial resources and the power disparity between staff and inhabitants. Death and dying and the general deterioration of health are central and particularly important issues in care institutions of the elderly. Martin's study (2002, 865) reminds us that old people's residences deal with the loss of bodily functions and death in different ways. Because the presence of death may dampen the atmosphere in the habitat, it is kept out of sight. In order to avoid upsetting the residents and decreasing their wellbeing, an atmosphere of calm and quiet is fostered.

Martin's study of different types of care residences (2002) suggested that the most important homelike factor was a friendly and welcoming atmosphere. The homelike impression was enhanced by warm, soft colours in the shared spaces as well as by decorative objects such as table napkins. Moreover, personal belongings, such as spectacles, books, cardigans, slippers and so on, were left lying around. In such spaces, the residents could be observed chatting among themselves, maybe playing cards or listening to music. They made plans for future activities together. Visitors were greeted. Such behaviours were seen as being contrary to the usual ambience in institutional facilities, which were dominated by a quiet and passive atmosphere. In institutions, activities were highly regulated, with residents tending to stay in their rooms or sit in the corridors with a nap blanket around their knees. The staff were dressed in work uniforms. In some institutions, the dress was used to indicate the person's responsibilities and position. Institutional residences appeared and felt formal, orderly, and distant rather than casual, cluttered and emotionally close.

Thanks to her participatory research approach, Martin was also able to study the aesthetic experience of these residences. The aesthetic dimension had previously been beyond research because of the researcher's position as a neutral, external observer. Martin concluded that few organizations can produce quite as many intense aesthetic

experiences as an elderly care residence. It is therefore important to consider aesthetic values when planning and running these residential organizations. Aesthetic experiences affect the way the semi-public spaces are used and how they are organized. Moreover, they also reflect the power relations in the organization (see also Vihma 2012). Martin's research suggests that the independence and rights of the residents are best promoted by empathetic control and benign use of power, not by some disciplinary and strict arrangements. Her research thus illustrates the close ties between organizational aesthetics and design semantics.

It is interesting to note that another study, quite different from Martin's, also ends up stressing the importance of the attitudes and preferences of residents and staff for the organization and design of the residence (see Andersson et al. 2011). Investigating the use and usability of institutional residences in the Gothenburg area, the main focus was originally on functionality, efficiency and accessibility. Nonetheless, systematic observation of these features revealed interesting information about the character of the spaces, such as the kitchen, the dining room, the living room and the corridors. It was observed, for example, that the shared spaces were used to store packages, trays and other items, thus restricting their use for other purposes. Although the study did not specifically examine homelike issues, it was observed that a repetitive and fixed day schedule is incommensurate with a homelike milieu and the kind of activities that take place there (see also Martin 2002, 389; SOU 2008). The study included a discussion on the reasons



why some spaces were underused or led to conflicts between the activities of the residents and those of the staff.

On the other hand, it has also been claimed that the quality of living is *not* affected by the spaces of the staff (Aalto et al. 2011, 2). On my visits to facilities, however, I noted that the residence actually comprises a spatial whole in which it is difficult to separate the office or other spaces reserved for the staff from the activities in and the interior design of the space for residential use (Figure 3).

Figure 3. The residence as a spatial whole. A living room with a window to the staff office.

A look into the design of institutional care residences

In the above, I have discussed the research literature on homelikeness and visits to institutions from organizational and design semantic

perspectives. A deficiency shared by nearly all the research literature gathered for this study is that it does not show how homelike qualities can be implemented, that is, what homelike habitats can actually look like. One exception is the report of the inventory of services for the elderly in Finland, which is illustrated with photographs furnished with short captions (Aalto et al. 2011). As noted in the CoWell project, photographs have an important methodological function when studying connections and impacts in organizational and environmental design. Photographs are not only documents and illustrations of things observed; they also serve as tools for analysis, although their methodological restrictions have to be taken into account, such as framing or cropping, and the fact that photographs record the perceived environment only partially.

Of course, the implementation of homelike qualities is subject to many restrictions, particularly the limits set by financial considerations. Some ideas that would enhance homelike features will thus probably remain unrealized. Spaces must be designed to be cost-effective. However, the purpose here is not to provide concrete instructions for design practice, but to reflect, as in the above, more generally on the requirements for design, and to clarify its basic assumptions, especially the semantic qualities of the milieu. The objective is to examine conceptions, such as homelike, which are conveyed by the physical environment. The interpretation of homelike requires that we interact with the actual settings. Furthermore, the examination of semantic qualities of the environment comes close to so-called concept design, the study of alternative spatial and furniture design as part of organizational strategy.

Studies of the experiences of residents show that the most important factor contributing to the homelike quality of institutional living is the attitude of the staff, which is not surprising (especially when the study is carried out from a nursing perspective, as in De Veer and Kerkstra 2001, 6). However, social scientists have increasingly begun to emphasize that the determinants of wellbeing must be extended to include the design of the physical environment, and have begun to study places and spatial arrangements as places of interaction. The physical setting has nevertheless attracted less attention than most other problems. Hence, there is very little literature on the subject to help designers in their work.

Recently, though, a Norwegian designer has searched for new approaches starting out from very basic questions about the physical environment in elderly institutional living (Bleken 2011). Another comprehensive account of the subject is a report for designers written as a textbook. The book was written by the American designer and design teacher Joseph A. Koncelik in 1982. I have taken it as the reference point for my discussion and I hereby invite the reader to make comparisons to the situation today, in 2012. Although 30 years have passed since its publication, it presents general viewpoints on design that remain

valid to this day. Unlike the 1980s, however, more efforts are made today to consider the views and experiences of users in the design process. Koncelik's book begins with a relatively extensive introduction to the changes that take place in ageing, particularly when people move to live in an institutional facility. The writer's attitude is openly sympathetic. He claims (1982, 22) that the objective of homelikeness is misleading, although it is very popular. Residences for the elderly are usually designed with health-care spaces as the underlying template, which means that the space is overshadowed by hospital-like features, although these may be quite laudable as such. Koncelik is even sceptical as to whether there actually are any products designed for the elderly, because the things they use are so deficient physiologically as well as psychologically, and satisfy only very poorly the usability criteria put forward in the literature.

After the initial articulation of the subject, however, Koncelik's book loses sight of the plurality of viewpoints inherent in the residence as he begins to present instructions and examples of solutions for spatial division, dimensioning, lay-out, furniture etc. The reader and the eventual designer are left with nothing but narrow technical and ergonomic information. Institutional aims of efficiency, economy and hygiene take precedence. No solutions employing an alternative style of design are presented, only abstracted models or prototypical constructions. It is my contention that it is precisely such simplified examples of products and spaces that easily pervade actual design ideals and manufacture, and thereby appear unmodified in actual interiors (compare, e.g. to Hynynen 2010). The result is consolidation of institutional characteristics; alternative designs for different types of spaces are not considered at all.

Furthermore, Koncelik argues that spatial design usually tends to proceed from the top down and is managed from an overall planning standpoint. The design of semi-public milieus and "micro-environments" and the selection of furniture and equipment are relegated to the management or staff of the institution, who have no actual design competence (Koncelik 1982, 28). Staff have recently been included in the design process in Finland, but the result was nevertheless quite institutional (see Aalto et al. 2011, 56-58). It is clear that the design of residences for the elderly must take into consideration changes that take place in ageing, such as those involving sensory functions. There is a great deal of information available on such matters, but it would be important to *show* how it can be applied in spatial and furniture design. It is also important to have an understanding of the various ailments brought on by ageing, so that they do not unnecessarily become factors that dominate the milieu.

The micro-environment comprises seats, tables, light fittings, equipment and so on. Koncelik and Kropat conducted a survey earlier, in 1978, to determine which features manufacturers, architects and designers focus on when they design products for the elderly, and

which of those ended up in institutions (Koncelik 1982, 28-30). Interior design received less attention than other factors, although it is the most important one for the residents' wellbeing. The micro-environment was not taken into consideration in architectural design, which focused instead on the structure and layout of the building, on lifts, bathroom sizing and lighting systems. In addition to these aspects of the residence, however, architects did seem to have a special interest in chairs, the properties of which were often specified. Product designers, on the other hand, did not involve themselves in the design or the properties of floors, walls or ceilings. The study further noted that some manufacturers had placed the furniture and fixtures intended for the elderly in a special category of *products for the disabled*, which aptly summarizes the nature of these products.

The integration of furniture and space is crucial. If furniture and fittings are not designed with the milieu in mind, the interior in point of fact remains without architectural and design semantic articulation, resulting in randomness and confusion (often unused spaces as well, as when furniture cannot be conveniently placed in the corners of a room, for example). There is little discussion in the literature of the effects of style on the milieu of these institutions. Thus the use of some specific style easily results in an inadvertent emphasis on institutional features, even when the aim is to increase homelike ones. If functionality is stressed, the result is a reduced or sterile style. On the other hand, if stylistic ideals are sought from periods past, such as the rococo, which is quite common, a conflict may arise between the objects and the residents' lifestyle. In a report, for example, a photograph of period furniture carries the caption "beautiful furniture" (Aalto et al. 2011, 15), but it is not indicated whose preference is reflected by this. Elsewhere it is stated that shared spaces should be designed in the same way as hotel lobbies (Ryhänen et al. 2007). Although we may assume that researchers and designers are aware that there are different types of lobbies, the writers do not indicate what kind of lobby they are referring to.

Designers are generally employed in the building process at two stages: in the initial phase, and in renovation. Koncelik (1982) suggests that design should be seen instead as a continuous process, although the management and funding bodies of projects would like to see them complete when the institution is opened. Do they hope that the institution would remain unchanged throughout its planned lifespan? All environments are dynamic, however, and should therefore be modifiable according to need. Koncelik wonders why there are still so few actual outcomes reflecting this idea, although research knowledge is available and design methods are better than before. What would provide an impetus for change? While necessary, it is not enough that we produce more information for designers, management or staff, because the real obstacle to change is inadequate budgeting for the construction needs of institutional residences. This, in turn, is a reflection of the broader cultural situation in which quality and design tend to be actively

undervalued. Ageing is unattractive, and according to Koncelik in the United States, at least, reform can also be impeded by the professional attitude of personnel and by care practices, because ingrained practices are difficult to change. The situation may be familiar and topical elsewhere as well, although the context of the claim was American and it is now 30 years since Koncelik presented his view. According to a recent report on services for the elderly in Finland, some municipalities have no plans for such services (Kuikka 2012, 9).

In conclusion

The other chapters in this book discuss the wellbeing of elderly people as a complex subject, and I have therefore not addressed the issue of organization and management in any detail. However, studies clearly show the connections that exist between the organization and environmental design, and the process-like nature of both. Both the organization and the environment have an impact on people's conceptions, practices and the division of labour among stakeholders. The unity formed by the organization, management and the physical environment influences all relations, personal relations included, particularly those between residents and staff. It also defines the quality of activities and spatial organization, interior design, choice of furniture, and many other things in the residential facility (Figure 4). It follows that the goal of the design of institutional residences cannot be a single, fixed end result. Instead, what is needed are different possible frameworks to support the ever-changing organization and design. Also needed is continuous assessment of the relationship between organization and the spaces, which design can offer. As one solution, I would recommend that the design of institutional residences should aim at modifiability and flexibility as their basic feature (see Vihma 2012, and also architect Markku Sievänen's statement in 2012 on the design of the Wellness Centre Onni in Pukkila, and the views of the American researcher Victor Regnier on the concept of age in place, 2002).



Figure 4. Quiescent arrangement and austerity in a dining area.

Homelike features would then not represent a past period or permanence, but would instead constitute an active and vibrant relationship to the product environment that would be receptive to changes that can be implemented in everyday activities. The implementation of homelike qualities in the physical environment of care residences could then begin to manifest itself starting from the design and planning phase and continuing as an on-going process that is able to accommodate on a daily basis any changes involving residents and staff. The task of the designer is to provide valid alternative models that are worth discussing, models which can be used in encountering new situations.

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Architects' Talk about People with Dementia

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The way we habitually talk about elderly people affects their position and the treatment they receive from society. In this chapter we examine architects' talk about elderly people with dementia. Architects play an important part in designing for the wellbeing of elderly people, although they usually do not have any direct relation to elderly people at all, making their role quite demanding. Here we examine what meanings and what kind of social reality and agency the architects construct in their talk about these old people and about the process of designing care environments for them. The research data comprise interviews conducted in 2006 with four Finnish architects. The architects' talk defines the old people as passive objects and external actors. The way the architects talked about dementia reflects and resembles the way this subject is discussed in society.

Architectural design for elderly people

Designing care settings for old people suffering from dementia has become a subject of discussion and of research particularly in the 2000s. Cognitive problems and various types of dementia have increased as the population ages. These conditions make it more difficult for elderly people to cope in their own homes and in residential care. This also creates new demands for architects designing housing for elderly people. The architecture of elderly care homes can be deemed a socially significant phenomenon as it is considered to be an expression of the general appreciation and care of the elderly in society (Regnier 1994).

When the living arrangements of elderly people suffering from dementia are discussed in public and in research, the perspective is generally that of the party arranging such services. The views of those who design such facilities, the architects, generally receive less attention. This is interesting, given that, alongside those planning the care, the architects are considered key actors. Jonas Andersson, who has researched architecture “for the silver generation”, stresses the significance of architecture as a field of research adjacent to gerontology (2011b, 572).

Recently some researchers have addressed the challenges of creating architecture for elderly people (see e.g. Andersson 2011a; Knudstrup 2011). However, in the design of housing for the elderly and also in research thereon, the focus has mainly been restricted to interior design. Care environments for elderly people with dementia have been studied especially from the perspectives of functionality and safety (see e.g. Day et al. 2000; Topo & Kotilainen 2009). Since the turn of the millennium increased attention has also been paid to exterior design, such as grounds and gardens (Regnier 2002; Brawley 2006). Lately research on ‘aging in place’ addressing the value of familiar surroundings has also attracted attention (Rosel 2003; Verma 2009).

In developing living arrangements for old people and in the design of care environments the talk is frequently of physical, mental or social ability to function. Ability to function focuses on the potential abilities of the elderly, but it does not necessarily reveal much about their actual functioning ability nor yet about their opportunities for functioning (Jyrkämä 2008). Regarding the design of care environments another fundamental question concerns how old people position themselves in design processes for living arrangements. The agency of the old people themselves has frequently been neglected in design processes and studies on design.

In sociology the term agency has frequently been associated with Anthony Giddens (1984; see also Ahponen 2001; Jyrkämä 2008). Giddens links agency to the relation between human action and structures. Structures are produced through individual action, but they also affect individual action. This kind of duality of structures means that from the perspective of the actor social structures are both the outcomes of action and the tools by which action is produced.

For elderly people with dementia the construction of agency could be contemplated as follows: On the one hand how these people are constructed as actors determines the attitudes taken towards them and what kinds of care environments are designed for them. On the other hand the types of care environments designed for them serve to construct the conception of these old people and their agency.

Here we consider the agency of old people with dementia with loose reference to the modelling of agency presented by Jyrki Jyrkämä (2008). According to Jyrkämä, the dimensions or so-called modalities of agency are *knowledge and skills*, *will*, *feelings*, *ability*, *obligations* and *opportunities*. In the context of living environments of elderly people, *knowledge and skills* refer to how elderly people can use the skills they have acquired in the course of their lives and whether these skills are adequate for accomplishing everyday routines. *Will* has to do with wishes, volition, motivation and objectives, e.g. what elderly want to do in their homes. *Feelings* are connected to experiencing and assessing the characteristics of living environments and attaching feelings to these. The *ability* dimension is concerned with physical and mental functioning ability; e.g. how physical spaces and technological devices enable or restrict elderly's activities. *Obligations* have to do with some specific physical, social, normative or moral obstacles, necessities and restrictions; with regard to dementia it means, in particular, that some concrete restrictions in physical environments are unavoidable. *Opportunities* refer to how the place where one lives affords diverse opportunities for action and enables one's own choices. Agency comes into being, takes shape and renews itself as a process interwoven within these modal dimensions. Agency and its modalities can also be comprehended as being the subject of one's own life, in other words, as participation in one's own life and the chance to exert influence over it (Jyrkämä 2008; see also Honkasalo 2004).

Thus in this chapter we scrutinize architects' talk about elderly people with dementia. We examine how the social reality of elderly people with dementia is constructed when the architects speak about designing care environments for elderly people and what kind of agency of elderly people is embedded in the discourses related to dementia.

Discourse analysis of interviews with architects

Our interest in interviewing architects was kindled by the observation that architects were seldom mentioned in Finnish studies in the field of social and health care. Architects themselves have seldom as authors addressed the design of dwellings for elderly people suffering from dementia. Only a few concrete construction guides to the subject could be found in Finland from the mid 2000s (e.g. Kotilainen et al. 2003; Kaipainen 2005).

Four interviews with architects were conducted by the first author in August-September 2006 in Eastern Finland. The interviewees were randomly selected from the local telephone directory; all those selected

happened to be male. The interviews can be described as a hybrid of the semi-structured interview and the theme interview. The interviews proceeded largely according to the question framework prepared in advance. The questions concerned the length of the architects' professional experience, what types of buildings they had designed and the design of dwellings for people with dementia (for example: where an architect could find information on the requirements for designing dwellings for the elderly and what the future prospects were).

The architects interviewed had long professional experience from 20 years up to 35 years. During these years they had accumulated experience of very different design tasks both in Finland and also abroad. Their design experience included among others residential, business and industrial buildings, schools, hospitals, old people's homes, special accommodation for handicapped people, churches and prisons. The design of dwellings for elderly people suffering from dementia was new to all of them. Three of them were currently working on their first such building, the design and implementation of a development owned either by a municipality or privately. The fourth interviewee reported having considered the requirements for such living in connection with the design of dwellings for handicapped people and old people's homes.

The recorded interviews were transcribed almost verbatim by the first author immediately after their completion. The transcribed interviews amounted to some 42 pages of text. In spring 2011 the recordings were listened to several times and the transcriptions were reread. Thus it was possible some years later to use originally spoken data to review the interview situation. The architects demanded absolute anonymity. In order to ensure this and to protect the identities of individuals mentioned in the interviews all names of people and places were changed.

We analysed the architects' interviews through discourse analysis based on the approach of social constructionism. According to Kenneth Gergen (1999) and John Shotter (1983), social reality is constructed in interaction between individuals through talk and use of language. Our aim was to analyse how the architects in their talk produce social reality about old people with dementia. We were interested in how the architects talked about old people with dementia, not in the architects as individuals, nor in their subjective experiences of these old people. The object of interest was the architects' talk and the linguistic variation relating to various social situations and connections. We also examined the consequences, intended or unnoticed, enabled by this linguistic variation (see Jokinen et al. 2006). The linguistic variation emerged in the architects' interviews at many controversial points producing totally different definitions of old people with dementia.

After going meticulously through the data several times we were able to identify four discourses through which the interviewed architects made dementia and related issues understandable to themselves and others. By discourse we refer to "a connected set of statements, concepts,

terms and expressions which constitutes a way of talking and writing about a particular issue, this framing the way people understand and act with respect to that issue” (Alvesson 2004, orig. Watson 1994, 113). The discourses identified were problem orientation, alienating objectification, stigmatizing categorization and restricted freedom.

Problem orientation

The problem-oriented discourse produces old people as a problem at a societal level as well as at an individual level. The discourse produces concern about the increase in dementia sufferers and the chances of society to provide accommodation for these old people. The old people are perceived as an extensive and growing problem at a societal level.

... just now this is *an accelerating problem* in Finland... (A4)

This “jackpot” will be here after the period 2010–2015, this will be on our hands, big age groups starting to get there, well. Regarding that *mass* which it will be in ten to fifteen years, it’ll be here in ten years, all you can say is that *we won’t have time, we’ll be late...* (A2)

In the second excerpt the architect refers to the number of old people as a “*jackpot*”, using this generally positive word for something which is in point of fact negative in this context. This expression makes the population group referred to problematic. Both excerpts mention the future old people as a threatening mass of people coming as it were from outside society and the problem they constitute is difficult to respond to.

In the problem-oriented discourse old people with dementia are also categorized as a problem and threat at the individual level.

... a demented person has like these *aggressions* and all sorts of these *rages* and you have to be prepared for them... (A2)

The excerpt above defines as a problem the unpredictable, even dangerous behaviour of an old person. The expression constructs the old person as one to be treated with caution and even fear, which precludes equality with others, those without dementia.

The problem-oriented discourse determines the design of housing by the requirement for safety, which emerges in the talk of various risk situations. Risk situations, for example, are determined through the use of the devices in the dwellings, such as leaving the oven on. This discourse thus defines the threat as also being posed to the individual him/herself as in the following extract:

With the demented person there are these *matters of safety*, that she or he might *cause risks by leaving the oven on* or... (A4)

... and doesn’t go anywhere from those premises so that nobody knows that s/he is going. (A2)

In this last extract the old person is defined as one under surveillance, who has lost the status of a person with independence regarding comings and goings. This person must either report that s/he is going somewhere,

perhaps to a member of the staff or then should not go out of sight. From the agency perspective the emphasis in the problem oriented discourse is on mental functioning ability.

Frequently in this discourse the old person is contemplated through other people's experiences. An exception to this is the following comment by architect A1:

It must be really difficult to cope... s/he can't remember to switch the hotplate off or remember to shut the fridge door... (A1)

Here the architect presents a problem for the old person but does not consider the old person her/himself a problem. The architect endeavours to open up the problem from the perspective of old person and makes a reference fairly rare in this data to the old person's own opportunities for agency. The problem-oriented talk here becomes empathetic and understanding talk.

Alienating objectification

In the discourse of alienating objectification old people are positioned as a remote, anonymous mass and as passive objects. The discourse produces distance between the designer and the old people.

Demented old people are presented as an unknown nameless mass felt to be remote, to which the architect has no personal or close relation. The old people are spoken of in the generalizing plural, references are made to "them", "the ones I've seen", but with whom there has been no contact.

... oh yes, I've seen them, but I've had nothing to do with them... (A2)

Well *those demented cases, they've been visible...* (A1)

... *they put them anywhere* at all, those demented cases nowadays... (A3)

The talk about an unknown mass is also objectifying and passivizing talk. Old people with dementia are presented as targets of other people's actions, not as independent agents.

... to obtain... general information about how *one should live and be with* a demented person. (A4)

... the literature that I've got hold of, well it describes this nature, what a demented person is like *and how* in general *to deal with him or her*. (A4)

In these extracts the demented person is defined from another person's perspective, as something 'to be dealt with'. This expression excludes the possibility of equal treatment: in dealing with a person one is the actor and the other is the object of the action. The everyday routine of a demented care home resident is also rendered comprehensible in the passive voice. It is essential here that as old people are discussed in the passive, they are constituted as passive objects and passive actors, which creates an image of an anonymous mass.

... the grandmas *are put* in rocking chairs and *they're fed* with a spoon and we have nice curtains here and *there's the telly to gape at* and a bit of handwork and that's that. (A2)

Architect A4 describes the “sameness” of the mass by comparing the situation in the care unit to his own experiences of visiting a mental health facility:

... now when *they're all a bit the same sort...* and they have a passivizing effect when they lie about where the others can see them there on the sofas in the common spaces... (A4)

The conception of a mass thus produces the fact that the “same sort of people” are put together, in the eyes of an external visitor the individual loses his/her individuality actually leading to a loss of individual agency, as the same architect continues:

If old people are in the same place it's likely to start looking the same. That is if old people of just about the same age are almost all walking on a stick tapping along, well then *the whole thing looks a bit the same, it puts a stamp on it.* And it may be that in the beginning it is inspiring and there's peer support, *but it, too has a passivizing effect.* (A4)

A fairly atypical comment in the data from architect A3 describes the distinction between passivizing mass and object discourse and active individual subject discourse:

If they come from some *grandma's cottage*, well *they'd like to have a rocking chair in there and something like that...* (A3)

In this extract the architect contextualizes and familiarizes the demented people's former living environment and above all – very unusual in this data – refers to their own will, their own agency. It is in the interview from this architect that the only direct reference in the data is found to the emotional states of demented people, that is, the dimension of feelings.

I can't say about how *happy and well* they can live there in those one-room dwellings as I've had no experience of it at all. (A3)

Thus in contrast to the alienating objectification discourse these two last examples create an image of the demented person as an individual: the subject of his/her own life, with a past and with hopes of his/her own. But such talk is exceptional in these interviews.

The discourse of alienating objectification creates between the designer and the demented elderly resident an indirect, externalized relation. At the same time as the old person is positioned as remote and unknown, the architect creates his own position as an external actor who is in no direct relation to the end user of a dwelling, the design of which is not driven by the needs of the individual. Conceiving of the demented old people as a passive mass devoid of their own agency can produce standard housing solutions which meet the needs of safety and

functionality, but which do not meet the mental, social and aesthetic needs of the target group.

Stigmatizing categorization

As noted in connection with the preceding discourse, it was found that the architects felt that dementia was a largely strange and unknown phenomenon. The social representation approach of Sergei Moscovici (see e.g. Wagner et al. 1999) considers how a person is inclined to render the unfamiliar familiar by comparing it through metaphors to something that is already known. In addition to the discourse of alienating objectification, we identified the discourse of stigmatizing categorization. People suffering from dementia were equated in the architects' talk with other, more familiar marginal groups: those deviating from the "normal" in different ways, such as invalids, handicapped people, patients, even stupid people. Such equating produces stigmatization.

The demented person *is not stupid*, so I would like assume, s/he can get along, s/he has only got a memory disorder or a gap or such. (A2)

If it's a really *clearheaded* demented person... (A1)

... in a certain way is capable of doing things like a *normal* person...

demented people function normally... (A4)

But to a large extent the needs come *in all handicaps* from the handicapped him/herself, that is, *from the limitations themselves*... (A4)

... there are those with *mobility impairments*, then there are the demented and older people in other ways. (A2)

Thus already familiar special groups are used to categorize demented people as "deviant" from other "normal" people into their own special group. What typifies this categorization is that it is used to distinguish the group as an entity of its own, but on the other hand, as in the preceding discourse, the assumption is made that all within this group are the same.

What is crucial to this discourse is what metaphors and similes are invoked, even if inconspicuously and unconsciously. For example, comparing a demented person to a stupid person, even if achieved through negation (see above "*and the demented one is not stupid, so I would like assume*") nevertheless creates an image equating the stupid and the demented. At the end of the extract "assume" serves to confirm the equating.

The categorization talk is rendered stigmatizing by the fact that equated groups are produced as problematic, groups deviating from the norm. Dementia and old age are equated, for example, with the problems of those with impaired mobility, invalidity, aggression and complaints.

... I'm involved in that and in work with the aged, so that way, involved a bit in *all sorts of those troubles*. (A4)

Stigmatizing categorization is in a way a corollary to the alienating objectification discourse in that the "unknown" is rendered known

through equative categorization (Wagner et al. 1999). The discourses are also overlapping in that both produce similarity, one of them through generalization and mass-thinking, and the other through emphasizing internal similarity within the group members. Both these discourses work against the demented old person being constructed as significant, as an individual in his/her own right whose individual wishes or needs the architect should endeavour to fulfill. The stigmatizing dimension of the categorizing discourse relates to the problem-oriented discourse first presented and both these discourses in a way justify the talk about incarceration and restriction in the following discourse.

Restricted freedom

The discourse of restricted freedom approaches old people suffering from dementia on the one hand through the theme of freedom and on the other through the theme of incarceration. Like the alienating objectification discourse, the discourse of restricted freedom positions the residents partly as an anonymous mass and partly as passive objects. We found that the alienating objectification discourse produced distance between the designer and old people. The restricted freedom discourse is based in part on talk of problems, but also brings to the fore the ethical aspects of architectural design. The discourse at times brings the architect closer to old people.

Freedom is determined by the expressions referring to the spaciousness of the living environment. On the one hand freedom is presented as the freedom to move freely in a closed area which is under surveillance. Thus freedom is restricted. The theme of incarceration and freedom are frequently present simultaneously in the talk. This can be seen, for example, in the following extracts in which architect A1 describes the ideal living environment for a person with dementia:

All of a sudden something *open and spacious* comes to mind... *good access to the outside, no need to be indoors, then it requires a fence around it and surveillance*. Nevertheless that it would be there, that *one could get out to go about in nature*, what does it matter if there is no problem there and this demented case is walking about outside.
(A1)

... if I were demented myself, it would be really good and *there would be nobody pushing their nose in* and it would be a safe option. It's a bit like one of those *concentration camps*, if we say (laughter) *a large fenced area*. In that sense I don't mean but some sort of a solution, *a wide spacious area* and all good services... *spacious facilities and open doors so that there's not somebody straight away on your tail like when you open that one door* (laughter). (A1)

At the beginning of the latter extract architect A1 momentarily assumes the role of an old person imagining the need for freedom and excluding the idea of close continuous surveillance. At the same time he comes

closer to the resident. This only occurs momentarily as the talk continues with a reference to a concentration camp, which is at odds with the resident's perspective and the notion of unrestricted dwelling. In spite of the speaker's laughter when explaining the expression by using the heavily charged *concentration camp* he unwittingly casts a dark shadow over the otherwise relatively free image of dwelling. At the end of the extract by using a metaphor ("*that there's not somebody straight away on your tail*") he again brings his vision closer to the old person's longing for freedom.

In the next example architect A3 compares the square metres of living space in the old people's dwellings to his own experience of the floorspace of prison cells:

When the talk is constantly about the numbers of square metres... There's no way you can get to the number that would be desired for those rooms, that is they are likely to remain smaller than *well they're bigger than prisoners' cells, but you should make spaciousness for them, too* and room so that they don't feel cramped. (A3)

The words space and spaciousness in this extract refer to the theme of freedom. Incarceration is introduced in the comparison to prisoners' cells and a reference to the cramped spaces. This architect reported having previously designed prisons, thus the preceding comparisons can be explained in part by his earlier design experiences. On learning about this experience and the aforementioned comparison to a *prisoner's cell* the interviewer sought further questions about similarities between the dwellings of old people and prisoners. The prison effect becomes concrete in the talk in the following extracts about the number of square metres.

... they should be about 16 to 18 square metres and *here they're 12 square metres*. The prison dimensions at the end of the 1980s were *seven square metres per prisoner, now it's ten for prisoners* and so it's after all *a couple more square metres* for the grandmas and grandpas here... (A3)

The architect does not use the word "punishment" but the comparison of the size of the "cells" creates an image of those in penal servitude: some for their crimes and others for their dementia and old age. Other terms used by the architects referring to closed spaces and those restricting freedom were "*institution*", "*closed ward*" and "*institutional facility reminiscent of a hospital*".

In the next example talk about restricted freedom is connected to the stigmatizing categorization talk:

... there are those with impaired mobility, then there are the demented and older people in another way and them... terminal care, which is also connected to this, *that they are moved to these premises* in which there are *dementia cases, those with mobility impairments and those*

like on their way out... or then those that are very seriously ill with nothing more to do but wait. (A2)

The groups equated are produced here as problematic groups and thereby the building also appears as a hopeless place of closed life. Here and also in the “cage” talk it is essential that the comparison, which is made possibly in an unnoticed and unconscious way, imparts an impression of paralleling elderly with e.g. prisoners or even caged animals.

... put into an enclosure. But that’s not very nice either, that’s you might be like in an animal’s cage. Since those people do not need external services, those who as they say are put in a cage, they don’t need external services. They only need a feeling for the environment. (A2)

The imprisonment discourse is the countertalk to the security talk, of which there is a great deal and which is like a factual source and basis for design. In a way the imprisonment talk is also largely ethical talk as in the following extracts.

... so we come to this extremely difficult subject as imprisonment in one’s own home. Do we have the right to imprison him/her behind the door which restrains him/her so that s/he cannot get out. (A4)

... the main values of operations, that how can movement be restricted or extended in like an ethical sense...(A3)

In both extracts the architects call into question the right of other people to intervene in the personal freedom and integrity of an old person with memory disorder. With such talk the architects bring old people closer to themselves and other ‘ordinary’ people. The ethical talk continues in the following example in which architect A4 refers to the Finnish legislation:

Because s/he has a certain human right to freedom of movement. According to Finnish law a person may not be forcibly restrained without sufficient grounds. Such sufficient grounds should be medical certification or under some other special legislation. (A4)

As noted above, the discourse of alienating objectification can produce standard solutions which correspond to the needs of security and functionality and thus the modality of ability and obligations, but not to the mental, social and ethical needs of the target group. The discourse of restricted freedom, instead, also defines agency by bypassing the will and opportunity dimensions. Paying attention to old people’s own needs and ethical contemplation differ from the negative and problem oriented tone of the other discourses.

Limited agency, exclusion and otherness

The aim of the study presented in this chapter was to examine how the social reality of elderly people with dementia is constructed in the talk of architects and what kind of agency of elderly people is embedded in the discourses related to dementia. In light of the analyses of interviews with four Finnish architects in 2006, four discourses were identified; problem

orientation, alienating objectification, stigmatizing categorization and restricted freedom.

From the agency perspective, elderly people as actors remained distinctly on the outside: in the architects' talk they were produced as passive objects of design and as an anonymous mass about which the architects themselves knew very little and of whom they had no experience. Of the modalities of agency the emphasis was mostly limited to what the old people were able or unable to do and what they were capable of. Problem orientation was apparent and a positive individual-centred approach considering the modalities of what the old people could (possibly) do and what they might want was little in evidence, likewise the dimension of feelings.

The dementia talk of the architects reflects and concurs with the discussions held on this issue in society and according to social constructionism also has an effect on these discussions. The discourses constructed as the findings of this study can also be discerned in the talk of other actors about dementia and old age more generally. For example, relating to problem orientation Sinikka Vakimo (2001) has noted that in modern western society old age is contemplated as a problem of either medical science, social policy or society to which a solution is sought. In the documents governing services for the aged, such as quality recommendations and surveillance instructions, features of objectification are perceptible: in guidelines emphasizing the security and functionality of the caring environment old people themselves are easily defined as object and not as active actors whose voices should be heard. Öhlander (1999) has stated that people may be stigmatized through the physical and social environment and that demented people are among those who are subjected to being segregated and passivized by institutions. Katsuno (2005) also obtained similar findings when studying the assessments made by old people in early-age dementia of their own quality of life.

On a theoretical level the externality and passive agency image of old people with dementia emerging from our research can be connected with otherness (Pietilä et al. 2010). Otherness refers to the exclusion from the community or society. Otherness defines a certain group of people as deviant from the rest and puts them in an inferior position *vis-à-vis* the "average" person. Usually such use of power and exclusion are not perceptible and intended or they may even be a consequence of well-meaning paternalism. Minna Pietilä and co-workers (2010) state that such dynamics of othering, which at worst no longer respect the common rules of humanity, exist, for example, in the long-term care of those with dementia. In the context of our own study otherness manifests as exclusion from the design of living environments, but is also reflected more extensively in the "secondary" position of old people in our society.

Further, the concept of homelike, which can be considered part of the dominant discourse related to the welfare state, did not emerge from these interviews. Generally the desirability of homelike sheltered

accommodation is mentioned as a significant factor in the wellbeing of old people although the use of the concept and its consequences have also been criticized. For example, Eva Lundgren (2000) has noted that homelike can be perceived as an important part of political rhetoric. In this connection what is essential is that the aesthetics of homelike and the content of the concept are models of the “normal” home (Lundgren 2000). The homelike characteristic as the “perspective of normality” did thus not emerge in these interviews. Instead, the talk about stigmatizing categorization and restricted freedom represented the talk about non-normality, which in these interviews acquired a stronger position than normality.

The research data was limited and the findings cannot be generalized because the interviews included only four architects. Moreover, the interviews were conducted at a time (2006) when less construction of accommodation for old people was under way than is currently the case in Finland. The frame for the interviews constructed by the first author and her own orientation affected what concrete subjects were included in the interviews. Nevertheless the data in a way might describe a situation in which many architects are at this very time embarking on their first dwellings for old people. In addition to this, the detailed analysis of the interviews brings to the fore essential themes which might serve as concrete examples of a more extensive cultural discourse and provoke discussion on a more general societal level in the decision-making discussion in society regarding old people and dementia. In light of our research we can conclude that there is indeed a need for more research on the architectural design for elderly people.

It is nevertheless good to note that, in spite of an effort to achieve architecturally good solutions, there are many considerations affecting the realization of designs during construction of care homes, for example. The power of money in the design process also emerged from these interviews with the architects. Regrettably good details conducive to the wellbeing of old people are often removed from the designs by other actors. There is a need for research on design professionals and other central actors such as officials, care professionals, property developers, builders and financiers specifically as a basis for improving the collaboration between them. And from this group the future occupants, the frail elderly residents should not be forgotten.

On our CoWell research project we monitored in 2010–2012 the design and construction process of a publicly owned care home. This demonstrated that at its best collaboration between various actors starts from very early in the planning stage and that co-operation can be sustained at all stages of the process. This example was a really ideal case in the sense that the multi-professional ideation and planning process for the “ideal perfect care home for the elderly” was originally made possible through the EU-funded project. In practice such investment for designing care environments is seldom available. Therefore it is indeed

important to draw attention to successful planning processes and proven solutions and also to the perspectives of various actors.

The design of dwelling environments for old people is one important part of the management of services for the elderly. Increasing co-operation and a shared understanding among all those involved in the management of services for the elderly is important so that every old person suffering from dementia can be guaranteed a good life in the future, too. "By understanding the hidden meanings and the emotional content of the space we can create buildings which awake us to better comprehend our own existence and to attach a more profound importance to it" (Leppänen 2006, 83).

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Contested Spaces – the Perpetual Quest for Change in Norwegian Nursing Homes

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In Norway, long-term care for older people in need of comprehensive care is high on the political and social agenda and is ranked as one of the most decisive issues shaping the voting behaviours of Norwegian voters. In political and public debates, the notion of a crisis is used to advance a constant quest for improvement. Hence, the question of what role and function nursing homes ought to have in the care of the elderly segments of the citizens never seems to be entirely settled. Looking back on the history of elderly care, the chapter demonstrates how nursing homes have always been controversial, both in their conceptual forms and as materialized structures intended to embody the instrumentalities of a particular ideology.

Nursing homes: A principal but contested care alternative

The Nordic welfare states resemble each other on several counts in their histories. Yet on a detailed level, for instance in the respective countries' public care sectors, developments have been non-synchronous and along different pathways. Until the 1950s, elderly care was commonly associated with *gamlehjem* (old people's homes) – an institutional remnant of the poor law period – in all the Nordic countries (Armstrong 2009). However, beyond this point, each country has a unique history in terms of ideology and policy directions, something which is reflected in the countries' particular patterns of prioritization, conceptualization, and organization of different public care solutions. Given these differences, we concentrate our attention on the particular case of Norway, elucidating why nursing homes have retained a more prominent position in contemporary Norway than in the other Nordic countries (Armstrong 2009).

In Norway, elderly care forms a part of a comprehensive infrastructure of statutory services provided through local authorities. The multi-level government model, which is typical of all the Nordic countries, is characterized by a combination of local autonomy and extensive integration between central and local levels (Baldersheim 2003). Local service provision is influenced by central government through judicial acts, monitoring and substantial block-grant funding. Nevertheless, service provision is strongly influenced by what occurs at the local level. In long-term care, the endemic diversity in the municipalities' demographic, geographic and economic character has resulted in diverse fusions of traditional institutional care facilities, home-based care and intermediate solutions (Huseby & Paulsen 2009; Gautun & Hermansen 2011; Hjelmbrekke et al. 2011; Vabo & Burau 2011).

Despite a diverse mix of service profiles across municipal borders, the overall trend in long term care is a shift of focus from institution based care toward home based care and more “home like” residential facilities. Yet nursing homes still constitute a principal public care alternative, and even though they are rarely a first choice of residence for any individual, they are considered to be of vital importance for families facing a heavy care burden as their old family members become severely impaired or terminally ill.¹ In public debates concerns about the accessibility and quality of nursing homes are significant parts of the political battle over the welfare state. Governments are continuously pressured by opposition parties and advocate stakeholders to find new and better ways to ensure that the most vulnerable old are treated with dignity and respect. There is a call for improvements in medical treatment and care, but also for innovation in the physical design of institutions and in the organization of service provision, which can improve the quality of life

1 In Norway, about 40 percent of all deaths occur in nursing homes (Statistics Norway 2012).

of residents in nursing homes. Hence, those planning, working and living in contemporary nursing homes face the challenge of how to navigate the tensions between medical treatment and care.

Like most human service organizations, care homes are an archetypal example of institutionalized organization, i.e. they are heavily dependent on their institutional environment for their legitimacy (Hasenfeld 2010). They adopt and uphold moral systems and cultural frames that resonate well with their significant audience, such as legislative bodies, local governments, regulatory agencies, professional associations, mass media and clients. Yet institutional environments are both heterogeneous and turbulent, as stakeholders represent diverse interests and competing ideologies, which again causes instability and change (Hasenfeld 2010, 15). As noted by Newman (2001), institutional changes seldom occur through organic and evolutionary processes by which one regime is steadily usurped by another. More typically, old and emergent regimes interact in a way that causes different elements of the new and the old to be reframed and repackaged.

In this chapter we aim to provide an historical analysis of how the role and function of nursing homes have been temporally shaped by competing strands of thought ever since the term “nursing home” was formally introduced in Norway in the 1950s. Our focus is particularly intended to portray how discursive elements, as emanating in politics and public debates, have become manifest in practice. How have ideological discontinuities worked to shape the functional, organizational and physical structure of nursing homes? For instance: Who are nursing homes for? Should they be operated as treatment or residential facilities? If they are to retain both these functions, can the particular qualities of a treatment facility be combined and balanced with ideals of what is deemed homelike? How are these questions, regarding the role and function of nursing homes, intertwined with investments and interests in other forms of care alternatives targeting the elderly?

The historical roots of Norwegian nursing homes

Until the latter half of the 1800s, the extended family was the principal source of help and security in old age in Norway (Ministry of Health and Care Services 1955; Hauge 2005).² Yet, one should be wary of attributing a mythical dimension to its care capacity, since material circumstances

2 Since 2005, care services and living solutions for elderly have been the political responsibility of Helse- og omsorgsdepartementet (Ministry of Health and Care Services). However, from 1913 to 1993, this responsibility was held by Sosialdepartementet (Ministry of Social Affairs), between 1993 and 2001, by Sosial- og helsedepartementet (Ministry of Health and Social Affairs), and between 2002 and 2004, social- and health matters were split between Helsedepartementet (Ministry of Health) and the Sosialdepartement (Ministry of Social Affairs).

tended to dictate its form and structure. Hence, as Tornstam (1983) has noted regarding the role of the extended family in Sweden, it was often riddled with generational conflicts and pecuniary dilemmas, sometimes leading senescent bodies to be auctioned off or abandoned in the woods. However, for elderly dependents without a family in Norway, an arrangement termed the *legd* system entitled people to stay on designated farms for limited periods, according to certain rules (Daatland 1997). As the economy and the character of many farms were beginning to change, as a consequence of industrial developments, the need for institutional care arose both in rural and more densely populated areas.

Most of the first institutions were operated municipally and were commonly named *fattighus* (“houses for the poor”), and as the term reflects, they catered, although modestly, to everyone in need, regardless of age or health condition (Ministry of Health and Care Services 1955; Hauge 2005).³ In other words, they catered to an entirely different clientele from what we find in contemporary Norwegian geriatric institutions, and in no way could they be considered institutions for the elderly (Bache & Østvedt 2005; Selbæk, Kirkevold & Engedal 2007). At the beginning of the 20th century, many of these arrangements were being replaced, as investments were made in residential facilities exclusively for older people.

The relatively swift changes stemming from the industrial advancements and urbanizing tendencies of the 1800s were accompanied by significant changes when it came to the classification of people. While the first, poverty-oriented institutions identified and targeted general dependency, the public was simultaneously beginning to realize that elderly people, in light of their diacritical traits, ought to be identified as a distinct category. Dignified treatment was to equate separate elderly-oriented facilities. The construction of the first institutions intended “exclusively” for the elderly, was therefore a manifestation of a significant shift in terms of the classification of elderly people in the Norwegian context. Despite this turn, it took considerable time before these nascent institutions were inhabited predominately by elderly people (Ministry of Health and Care Services 1955). This did not happen until after the conclusion of World War II, when the particular needs and human qualities of other “categories of people,” such as people with various mental disorders or disabilities, began to be properly recognized and responded to.

Throughout the inter-war years, the demand for public care was on the rise, particularly in urban areas, and questions concerning the distribution of responsibility, institutional capacity and institutional quality aroused interest. On the political level, a particularly controversial issue concerned how the engagement of public and private actors ought to be balanced. Whereas the social democratic

3 This was the structural origin of the first care institutions in all the Nordic countries (see for instance Daatland & Sundström 1985; Antman 1996).

Arbeiderpartiet (Labour Party) identified all types of care provision beyond the family as a public responsibility, the bourgeois *Høire* (Right Party) reasoned on the basis of costs, a concern for the interests of private actors, and for the elderly, that semi-public arrangements would be the optimal solution (Seip 1994, 85-87). Due to the precarious capacity situation, however, the Labour Party's view was compromised, thus opening up for a shared responsibility between municipalities and church communities, since the church saw elderly care as strictly linked to their traditional domain of social engagement.

A series of developments can be linked to this distribution of responsibility in the inter-war years. An important element featuring on the agenda of the church was to promote recognition for the fact that institutional elderly care was not just a matter of concern for people with limited pecuniary means, but also for the well-off. According to Seip (1994), the bourgeois' channelling of demands through the church parishes had a decisive effect on the direction taken in the elderly care sector, eventually contributing to its inauguration as a universal right and public obligation.

Other ideas, of which we see the remnants of today, were also set in motion in the inter-war years. A decade into the 1900s, an influential pastor, Eugène Hanssen, promoted not only the contributory nature of the church, but also voiced his engagement in terms of both the symbolic and pragmatic qualities of the institutional facilities. One of Hanssen's focal points in this respect was the question of what could improve or impair the wellbeing of the institutionalized elderly. While the municipality of Oslo's plan to erect an institution with a housing capacity for 500 people was met with general public scepticism in 1910, Hanssen came to respond in an alternate and extended fashion (Seip 1994). The municipality, fearing that such a huge structure would have a repellent outward appearance and be of an unmanageable size, consequently altered its plans and constructed five smaller institutions instead. Hanssen's response was to be more philanthropic and person-centred, as he initiated the establishment of two Dutch-inspired institutional alternatives in Oslo. The idea was that the elderly were to live in "smaller units" or apartments with separate service areas, thereby recognizing the individual. This focus was on the homelike and on wellbeing was the start of a lasting appraisal of independent living solutions, much like those favoured in the contemporary Norwegian context.

Although elderly care was promulgated as an important part of the municipalities' mission at the turn of the 19th century, the shared engagement of both private and public actors was not entirely positive in its outcomes. Both the intended care-giving functions and the homelike features of the institutions were compromised by financial constraints and by a publicly sustained association with the former houses for poor people. The pre-war institutions for the aged have generally been labelled as "holding places". Yet, it is important to point out that these institutions

were central in making elderly care a public concern, as they symbolized the nation in that they were a materialized form of public solidarity.

1945–1975: Decades of service expansion and great expectations

In the 1950s, when the wounds of World War II had begun to heal, the institutional facilities intended for the elderly were considered to be of such a poor standard that they were considered an undignified accommodation option. In a report from the Norwegian Ministry of Health and Care Services (1955) evaluating the housing and care situation of the elderly segments of the citizenry, it was suggested that the proportion of long-term residents in institutions ought to be kept as low as possible. Instead of improving the infrastructural base of the existing institutions, making them more appropriate for residential purposes, the new policy strategy stressed that older people, instead of being referred to passive “holding places”, should be offered active treatment in suitable treatment facilities (Nasjonalforeningen 1955; Hauge 2005).

A core aim of the post-war elderly care policy was to avoid segregation among older people. People were instead to be enabled to participate and take an active part in society in spite of infirmity and old age. On the political level it was established that old age was no longer to be regarded as a passive phase of life; older people should be as active as possible both physically and mentally. From this idea, a range of preventive actions were proposed, including improvements to the pension system, better housing standards and generous provision of home care. It was argued that home care was good for the elderly because it would both prevent and postpone institutionalization. The old-fashioned residential institutions, according to the new ideology, were to be replaced by two different kinds of institutions – on the one hand *gamlehjem* (old people’s homes), intended for ambulatory, self-reliant individuals, and on the other hand, *sykehjem* (nursing homes), which stressed treatment and subsequent self-reliance (Hauge 2005).

The shift was marked by an attempt to terminologically redefine the purpose and potential of the institutional sector. As the term *sykehjem*, which literally translates as “sick people’s homes”, implies, the clientele was no longer referred to as retirees who were in need of care. In the name of treatment and intervention, the clientele of nursing homes were to be identified as “patients,” implying that elderly people had an inherent potential for improvement. The shift also influenced the nursing homes as architectural, functional and symbolic objects. When new nursing homes were being constructed across the country from the 1960s, the infrastructural aesthetics were imbued with the treatment ideology, giving the new facilities more of a hospital-like character and no homelike feel. This was an ideological shift which came to have longstanding consequences for the direction forward in the institutional

sector, as it identified both old age and needs in a purely medical perspective.

The shift in ideology was well meant, as it aimed at transforming institutions operated as “holding places” into to “active facilities” offering older people treatment and rehabilitation. There was, however, an economic dimension to the shift. On the one hand, there was money to be saved by limiting the number of single rooms. On the other hand, through the treatment function, the nursing homes were intended to have an overlapping connection to the hospitals. Patients with less critical conditions could receive basic treatment in nursing homes, thereby freeing up capacity in the hospitals. The nursing homes were in this sense intended to function as “B-hospitals,” as secondary or supplementary hospitals, not as long-term domiciliary facilities or “passive institutions” (Nasjonalforeningen 1955; Ministry of Health and Care Services 1955).

Throughout the following decades, it became all the more apparent that the focus on treatment had been somewhat exaggerated. The rehabilitative vision and the conceptually innovative nursing homes did not achieve their intended functions; instead they largely became institutions where people lived on a permanent basis, as residents, not patients (Daatland 1999). Nevertheless, the fact that the physical infrastructure had favoured a clinical environment probably served as a driving force for additional steps to be taken to put the treatment ideal back on track. Through a legal proposition from the government (Ot. prop. No. 36, 1967–68) it was reaffirmed that nursing homes were mainly regarded as facilities for elderly people in need of medical care and attention. Based on the idea that nursing homes were to relieve the burden of caring for people in hospitals, it was proposed that the organizational structure of the apparatus be reworked through the new Hospital Law of 1969. According to this law, the administrative responsibility for the nursing home sector was transferred from the municipalities to the county level, where funding was to be supplied by a generous national reimbursement system (NOU 1997:17).⁴ Obviously, this worked as an incentive for municipalities to orient people in need of comprehensive care toward nursing homes.

1975–1995: The era of stagnation and counter-reaction from the “grass-roots”

The 1960s and 70s are often referred to as an era of welfare *expansion*. Public service provision expanded greatly thanks to generous earmarked grants provided through a reimbursement scheme from central government to local municipalities. However, as the infrastructure of services was established in the late 1970s, concerns about economy

4 Norway has a three-tier government structure: central government, counties (N=19) and municipalities (N=429). (Situation in 2012).

began to emerge (Seip 1994). This marked the beginning of an era of *stagnation*.

In the mid 1980s, a comprehensive decentralization reform was implemented. The old funding system, based on earmarked grants, was replaced by a system based on block grants. Hence, local authorities of the three-tier system were stimulated to find cost efficient ways to match needs with services. Along with the changes in the funding system, legislative changes delegated the responsibility for a wide range of services to the local level of the three-tier system. The municipalities were assigned responsibility for primary health care and for various kinds of housing and care services, including nursing homes, which had been under county administration for a decade. Medical treatment, rehabilitation and social care were supposed to be woven into a cohesive continuum of care.

As state subsidies were capped and central authorities no longer reimbursed expenses for care, incentives for expansion stagnated (Vabø 2012). Most municipalities changed their long-term care policy and the number of beds in institutions was reduced as tasks were transferred to the home care system. Whereas home care expanded (first of all home nursing provided around the clock), the institutions were now becoming increasingly reserved for elderly residents with extensive, long-term needs for care and supervision (White Paper No. 25, 2005–06). Hence, the proportion of residents aged 80+ in institutional care facilities increased steadily from 52 per cent in 1960, to 56 per cent in 1970, to 64 per cent in 1980, to 73 per cent in 1997 and to 77 per cent in 2005 (Statistics Norway 2010). Stricter selection criteria for receiving institutional care thus resulted in shorter average duration of stay for residents (Daatland 1997).⁵

In the wake of the decentralization reform, services and care for the aged were concerns increasingly raised in public and political debates. Severe criticism was expressed in the media about the volume and quality of care being decidedly inadequate. Municipalities complained about having excessive responsibilities and inadequate resources. In 1990, a local grass-root uprising in Oslo spread nationwide under the banner of “the elderly revolt” and forced through an extra billion NOK grant (“the elderly billions”) in Parliament (Daatland 1997; Vabø 2011).

5 Similar decentralization reforms were implemented in other Nordic countries around the same time. These reforms were accompanied by radical changes in the respective care sectors. In Sweden for instance, the introduction of the Ädel Reform in 1992, led all forms of care (from home care to nursing homes) to become subject to the same piece of social legislation, namely the Social Services Act (Trygdegård 2003). Administratively, nursing homes were thereby regarded as a form of housing for which the long-term care patients were obliged to pay rent (even if their so-called housing in some cases implied sharing a room with others). Hence, in a legal sense, there is no differentiation between various forms of facilities (e.g. nursing homes, group homes for persons with dementia and service housing).

The Elderly Revolt introduced a sharper tone into the public debates and contributed to the creation of a ‘crisis discourse’ (Lingsom 1997, 56). The revolt simultaneously prefigured the emergence of a more consumerist and demanding orientation among Norwegians (Vabø 2011). It became a recurring argument in public debates that Norway, as one of the world’s richest oil nations, should provide the best elderly care in the world.

In the following years, there was a growing consensus that nursing homes as institutions should be less like hospitals and more like homes (‘care homes’). A range of policy documents stressed that institutional care for the elderly and disabled ought to be downsized and replaced by *home-based or homelike* alternatives (e.g. NOU 1992, 1; White Paper No. 50 1996–1997). As will be further outlined in the next section, this idea became a guiding principle as the government introduced new earmarked subsidies for constructing and refurbishing nursing homes in 1997.

However, the ideological persistence of recent decades had made its mark on the infrastructural side of the nursing homes, something which caused them to lack features associated with a normal living environment. During the decades when the counties bore responsibility for the nursing homes, new investments had mainly been made in the (medical) nursing homes, and not in the residential institutions, *gamlehjem* (care homes) which in the meantime had remained the responsibility of municipalities. A particular problem was that the institutions lacked privacy as the treatment impetus led to the construction of shared rooms and a sterile, hospital-like institutional environment. The treatment ideology was not abandoned altogether, as the nursing homes were intended to maintain their treatment impetus. However, in order to bridge the gap between the two functions, it gradually became common to departmentalize the institutions in line with the hospitals, to some extent segregating residents on the basis of degree of autonomy, medical conditions and care needs.

1995–Today: Modernization and the constant quest for quality

In the wake of the decentralization reform and the subsequent “elderly revolt”, elderly care issues became increasingly politicized. In fact, elderly care has become one of the most decisive issues in shaping Norwegians’ voting behaviour. Accordingly, governments are constantly challenged by the opposition parties to demonstrate that actions are taken to improve the quality of public care provision (Vabø 2011). In the mid-1990s, the elderly care sector was experiencing a “structural lag” (Riley et al. 1994), something which translated into growing discontent and demands for a plan of action. Put simply, a mismatch had occurred between developments in the social structures aimed at the elderly and the number of elderly people in need of care and assistance (White Paper No. 31, 2001–2002). A swift response was consequently in order, and in 1997 the government presented the “Action Plan on Elderly Care” (White Paper No. 50, 1996–97). In order to structurally catch up with the demographic

developments, the plan contained a series of investment grants awarded to local authorities on the municipal level to develop care services and, above all, to facilitate the construction and refurbishment of nursing homes and various other dwellings. Regulations were made to make sure that all inhabitants in nursing homes were guaranteed a single room.

The series of developments following from the plan had significant implications for the role and function of the nursing homes. Through earmarked grants from Husbanken (Norwegian State Housing Bank) many nursing homes were refurbished and made less hospital like, i.e. with single rooms and a more homelike atmosphere. However, in accordance with the prevailing ideology, which stressed independent living and access to care and assistance regardless of living situation, priority was given to the establishment of so-called *omsorgsboliger* [literally care housing] and other living solutions. Care housing units are typically units of 50–55 m², required to provide around-the-clock help, although the label covers a wide range of facilities from specially equipped retirement flats to staffed and shared housing units, some of which are close to nursing homes. Between 1994 and 2008, the number of housing units available to the municipalities for care purposes nearly doubled with the building of 27,000 care housing units, and in 2008 there were 51,500 residents living in municipally administered housings (Otnes 2011). Among people who lived in care housing in 2006, only 1/3 lived in housing with personnel on-site (Otnes 2007), whereas the remaining 2/3 received ordinary home care (i.e. home nursing and home help).

It is commonly assumed that care housing, in combination with home care services to some extent replaced beds in nursing homes. The number of people aged 80–89 living in an institution (nursing home) decreased from 15 per cent in 1994 to 10 per cent in 2008, and in the age segment 90+ there was a decrease from 46 to 36 per cent. Still, an average of 25 per cent of people aged above 80 either lived in an institution (nursing home) or in a municipally administered housing unit during the same period (1994–2008) (Otnes 2011). However, it should be noted that while fewer elderly live in institutions and more elderly receive home care services (particularly home nursing), either in their own homes or in municipal housing alternatives, the characteristics of nursing home residents have also changed. While the total number of nursing home beds has statistically remained at around 41,000 between 2007 and 2010, the number of long term nursing home residents aged 67+ with extensive care needs increased by 9 per cent to an average of 78 per cent (Gabrielsen et al. 2011). Norwegian nursing homes have thus become increasingly reserved for the frailest and most vulnerable elderly, in tandem with the orientation toward homelike living solutions for people with less critical care needs.

Although some care housing units have an accommodation style and services very similar to those of nursing homes, they differ from nursing

homes in that a clear distinction is made between housing and services.⁶ Compared to nursing homes, care housing is based on the assumption that housing is the personal responsibility of citizens, while health and care services are the responsibility of the welfare state. It should also be mentioned that, besides being justified by the ideology of independent living and quality of life, the reorientation toward care housing has been driven by economic incentives (Brevik 2010). For whereas the institutions continued to be an exclusively municipal expense, the state would cover portions of the costs for care housing through rent subsidies, certain services and equipment (White Paper No. 45, 2002–03).

As many municipalities have chosen care housing as a cost-efficient alternative to nursing homes, it has been questioned to what extent they are really adequate alternatives for people in need of extensive care (Hjelmbrekke et al. 2011). As noted by Alvsvåg and Tanche-Nilsen (1999), many of the dependent elderly and their relatives still view nursing homes as a more suitable option given their particular life circumstances. Questions have consequently been raised as to whether the trend of deinstitutionalization has gone too far. For instance, in two separate studies, one focusing on the perspectives of case workers dealing with admissions to nursing homes (Gjevjon & Romøren 2011), and the other on the perspectives of nurses (Gautun & Hermansen 2011), it was found that the majority of participants were of the opinion that the threshold for qualifying for a bed in a nursing home had become too high.

Recently new circumstances have emerged to put new pressure on the nursing home sector. In 2012 the so-called Coordination Reform was put into effect. One of the core aims of the reform is to alleviate pressure on the hospital sector by transferring responsibilities to the municipal level (White Paper No. 47, 2008–2009). In Norway government funding has to some extent been channelled from hospitals to municipalities in the belief that municipal co-funding of hospital services will encourage local service providers to put more emphasis on prevention, early intervention and low-threshold initiatives. There are also high costs to pay for elderly ‘bed blockers’ – people whose hospital treatments are completed, but who occupy a hospital bed because they lack a care alternative in their own municipality. Both of these economic incentives have put pressure on municipalities to be better prepared to provide facilities suited to meet the extensive care needs of the chronically ill and people in need of rehabilitation. A range of intermediate solutions in the making and nursing homes are once again being considered as spaces for treatment and recuperation.

6 This means that Norway has moved in a similar direction as Sweden did in the wake of the Ädel Reform (1992). However, in a Nordic comparative perspective, Norway and Finland still distinguish between institutions and assisted living, whereas this distinction has dissolved in Sweden and Denmark (Armstrong 2009).

Making sense of the present while mindful of the past

It is of course too early to conclude how the most recent reforms will contribute to the constant reshaping of Norwegian nursing homes. However, based on a few snapshots from an on-going ethnographic study of Norwegian nursing homes we can say that the translation of the reform into practice appears problematic. What has been striking in our fieldwork thus far is to see how efforts to create homelike atmospheres in nursing homes are increasingly disrupted by new demands for free beds, occasioned by the fact that people in need of extensive care have to receive this care somewhere other than in the hospitals.

At one of the nursing homes where we conducted fieldwork a typical, modern nursing home, built like a centre with various small departments (both nursing home departments and care housing units) for people with different levels of needs, many efforts were made so that the spatial and organizational arrangements were not reminiscent of traditional hospital-like institutions. The units are decorated and furnished in warm colours, surrounded by semi-public spaces, constructed like a “micro-society” containing a café, hairdresser, chiropodist and a garden with a chicken run. All nursing home departments offer fairly spacious resident rooms with private bathrooms and space for personal furniture and belongings. Moreover, the units have a living room equipped with a TV and a kitchen which serves as a natural rallying point for both staff and residents. Even though dinners are prepared in a catering centre, the kitchen is frequently used for preparing small meals and baking cakes and waffles for afternoon coffee. After the Coordination Reform, however, this bakery-scented ward had been plagued by an urgent need to make beds available for people being discharged from hospitals. Pragmatic arrangements were made, for instance, spacious single bedrooms were temporarily converted into shared bedrooms, and after a period of time, a temporary bed was made room for behind a folding screen in the communal area of the unit. Similar stories and worse are reported in media events. Debates and commentary concern both the need for physical accommodations like ‘mini hospitals’ and ‘intermediate wards’, as well as the need for more qualified medical staff and updated equipment.

Nursing homes are cultural spaces for interpretation (Stafford 2003), socially constructed and reconstructed; on the one hand, incrementally through everyday routines, and on the other, more radically, through various reform steps and measures imposed by governments. In this chapter attention has been drawn to the grand scheme of social processes and to the major changes taking place in the wake of reforms. The above-mentioned snapshots from a Norwegian nursing home exemplify how one particular reform step – the Coordination Reform – destabilized everyday life on the practical level. On a more general level, the Coordination Reform has mobilized actors and stakeholders to strengthen the capacity of local service providers and to provide

recuperative services. Hence, the reform represents a tendency towards a medical model of care. However, the medical turn does not rule out the fact that efforts and numerous projects are made to pull in the opposite direction – towards more homelike environments. For instance, in the municipality of the above-mentioned nursing home a comprehensive realignment project is currently ongoing in an effort to guarantee that residents in nursing homes will have a schedule of activities tailored to correspond with the particular values and interests of the residents.

In a broader historical-institutional context, the current tensions characteristic of nursing homes adds to an on-going struggle about the meaning and definition of these environments. In this chapter we have aimed to demonstrate how tensions between conflicting beliefs and myths about nursing homes have served as drivers of constant changes. The history of Norwegian nursing homes reveals that the developments cannot be characterized as a steady evolutionary process, but rather as a process of contestation between shifting care ideologies and shifting conceptions about the most cost-efficient long-term care solution. Even though political and ideological struggles over contemporary nursing homes reflect the high level of expectation within this wealthy oil nation, the struggles also reflect that there are inherent tensions in the very idea of a nursing home. As described by Stafford (2003, 18): “In the cultural order, the hospital figure is a clear domain. The home exists as a clear domain. The nursing home, caught in the middle, dwells in an unending no-man’s land, a grey area in our society.”

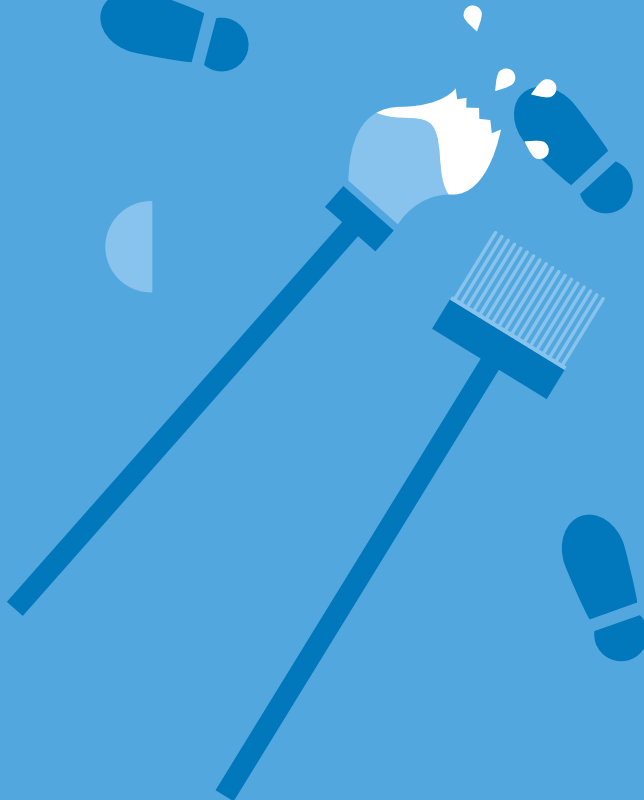
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Living in Care: *Questioning Conventions*



Becoming “A Good Nursing Home Resident”

Jens Kofod

Aspects of the neo-liberal styles of thought are traceable in Danish government policy objectives. In general these objectives identify how the care of elderly people must maintain these citizens' abilities as autonomous agents. Therefore care for the Danish nursing home residents is provided them as assistance that supplements their own efforts. A new type of nursing home – the Staying and Living Environments – forms part of these objectives as residents are encouraged to take part in the social activities in the nursing homes. Taking part in these activities should enable the residents to maintain their mental and physical abilities. However, for the residents it is important to establish a positive mutual relation with the staff members. I apply Goffman and Carsten to argue that it is more important for residents to gain staff's attention and influence the care than maintaining mental and physical abilities.

Staying and living environments as part of the Danish care ideology

The goal of establishing the elderly as autonomous, resourceful agents¹ appears in a new type of Danish care home called ‘Staying and Living Environments’ (SLE) (‘Leve- og bomiljøer’). Both the architecture and the organization of these institutions reflect the empowering intentions of encouraging residents to become active participants in daily unit life (Kofod & Birkemose 2004). SLEs have gradually been replacing the traditional nursing homes since the early 1990s in an attempt to improve the physical surroundings for both residents and staff (Høeg & Nielsen 2005). One overall intention was to establish more homelike settings, with more room for the individual layout of the flat for the elderly person in the SLE, compared to the institutional layout of traditional nursing homes (Andersen 1998; Wagner 1998; Næss et al. in this book). There are notable architectural differences between the two types of nursing home. The SLEs were designed in new buildings, the traditional nursing homes in buildings from the early 1970s. These provide the residents with small one-room flats situated along a corridor hosting approximately thirty residents. According to Hjorth-Hansen and Nielsen (2002), it is the privacy of the residents that guides the layout of the latter. They further argue that it is the rationality of hospitals in which a focus on illness, hygiene, care and rehabilitation guides layout and daily activities. The SLEs accommodate residents in small groups of approximately ten residents, and each resident lives in a two-room flat. Their individual flats lead into a communal kitchen. Contrary to the traditional nursing homes, it is a basic requirement for new residents at the SLE to remain actively involved with other residents and, if possible, to take an active part in preparing the meals or other communal activities (Hjorth-Hansen & Nielsen 2002). According to Hjort-Hansen and Nielsen, the daily activities, with their focus on food preparation and social life, are the core elements of everyday activities, and other activities should derive from the varying needs of the residents.

The architecture provides the opportunities for different aspects of the social life. However, for the new residents at these institutions the relation to staff is by far the most important aspect of their daily lives as residents. Daily living includes different kind of mutual obligations for residents and staff. Part of this is the battles among residents to gain attention for themselves. In the following I will describe how the new residents become aware of this situation and accept it and adapt to the care home practice.

1 The Consolidation Act on Social Services (‘Serviceloven’) describes the policy objectives of elderly care in Denmark.

Talking to and observing elderly people

I developed a longitudinal research design² with two stages of data collection: *before* and *after* a new resident's arrival in a care home. I carried out qualitative interviews with the elderly people, their relatives, care home staff, and the other residents living on their unit.

The 16 elderly people were interviewed eight times during their transition, including at least three interviews before the move to the care home, plus another interview a few days after the move to record their first impressions. The next interviews were conducted after approximately four weeks, and again after about another four months, ending when the residents had been in the care home for about half a year. The semi-structured interviews revealed the 16 informants' perceptions of everyday life both at home (before the move) and in the care home (after the move), with a particular focus on eating habits, physical impairments, and the interviewees' perceptions of the home. The interviews, taking place in both the interviewees' own homes and in their private apartments in the care home, were informal. The semi-structured interviews with staff, other residents, and relatives focused on how they perceived the transition or observed any changes in the care home unit when the new resident entered.

In the interviews I immediately worked to establish a positive atmosphere, providing multiple opportunities to deepen into matters of importance for the 16 informants, the better to grasp their perspective on the transition. Observation was also an important part of my material. I used the interviews in the residents' homes as observation opportunities (Rubow 2003). In addition, I conducted observation in the nursing home from the time I arrived in the institution until I left late in the day or evening. I also conducted a series of focused observations of each resident concerning his or her behaviour in the unit during the day, with an intensive focus on the first two days. I observed at various staff meetings and breaks, and I participated in many informal coffee breaks as well.

To analyse the material, I audiotaped all the interviews and transcribed them verbatim. I took notes either during the observation or immediately thereafter. Both a close reading and a content analysis (as identified by Hardon 2001) of the interview and observation material led to the emergence of the findings.

I illustrate the findings of my study through the experiences of the residents. For example, Hans and Anna³ were an elderly married couple from Copenhagen enrolled in nursing care in May 2005. Hans described

2 The present chapter is based on parts of my Ph.D. thesis (Kofod 2008).

3 Hans and Anna are among the approximately 26,000 elderly people who each year become nursing-home residents in Denmark, and who live for an average of two and a half years in these care homes. Only 10% of elderly people in Denmark above the age of 65 live in this type of care facility for the elderly, and of these the majority (67%) are over eighty (Liveng 2007).

their expectations of life as nursing-home residents in humble terms: “*I think, well... we do not expect anything as long as they treat us properly*”. As new residents they indeed appreciated life as nursing-home residents, and Hans described the care home they had just moved in as “*probably the best nursing home in Copenhagen*”. However, within one month their appreciation had turned into disappointment. They began to find members of staff reluctant to answer their calls for assistance.

By applying a relatedness perspective (Carsten 2004) here, I shall argue that Hans and Anna’s disappointment was caused by their reluctance to establish a reciprocal relationship with the staff. Hans and Anna’s expectations were directed towards the ideal practice of the nursing home, and their expectations would have been fulfilled if the claims in the leaflets could have been believed. However, these intentions regarding ideal care practice were achieved through social relations that were often characterized by mutual obligations, and for example Hans and Anna only acknowledged this after they had been residents for half a year. Most of the new residents acknowledged this and used their relations with their staff contact persons to influence nursing-home practice in a battle with the other residents to gain attention for themselves. The word ‘becoming’ in the title of this chapter thus refers to their becoming aware of this situation and accepting it and adapting to nursing-home practice.

In the following I show how the residents involved in my study tried to establish and maintain these relationships differently. During the six months residents strove and indeed had a genuine desire to create a personal relationship characterized by exclusiveness and intimacy with the contact person. Staff also partly shared this wish, but at times they made the relationship a professional one and treated the residents according to bureaucratic regulations. From the Maussian gift-economy perspective, residents could only enter such relationships through an exchange in which they could hope for their gifts to be returned (Godbout 1998). The staff, on the other hand, had two options: they could engage in this exchange or adhere to bureaucratic regulations in which residents were treated equally. What is more, these relationships were fragile due to the high staff turnover, and they only existed, were maintained and developed in so far as the parties behaved according to mutual expectations. In addition, it was the members of staff who had the upper hand. They possessed the power to define relationships and to end them. For their part, residents were unable to choose among the members of staff they preferred as their contact person⁴.

4 Danish nursing homes are entitled to have a Relations Council (*Bruger-pårørenderåd*) to provide residents with an opportunity to discuss the quality of care. These are supposed to discuss matters of general care, safeguard the interests of the elderly and inform working relations between staff, residents and relatives (Farum Kommune 2004). However, none of the residents I followed mentioned this during the study, and I presume that they did not assert their rights through these channels.

In the following part of my analysis I will refer mainly to Goffman's (1961) discussions of total institutions, as it is necessary to take his perspective on the institutional context of the mutual relations into account to understand better the way these relations between residents and staff members developed.

Nursing homes as total institutions

Goffman (1961) argues that nursing homes are total institutions. His essential argument is that these total institutions strongly influence the residents' perceptions of self and that relationships between residents and staff are characterized by mutual hostility between the two groups because the staff embody the institutional rules and aims, thus adversely affecting the residents' selves. Below I will elaborate upon the way in which Goffman defines total institutions and their characteristics. Thereafter I will criticize Goffman's concept by discussing some of the nursing-home literature.

Goffman's use of the institutional concept is confined to an analysis of the social practice in institutions. He defines "*A total institution... as a place of residence and work where a large number of like-situated individuals, cut off from the wider society...together lead an enclosed, formally administered round of life*" (Goffman 1961, xiii). All aspects of life are carried out in the institution, and activities are tightly scheduled. One consequence of these schedules for social activities is that opportunities for expressing identities become restricted.

Concerning relationships within total institutions, distinctions between inmates (residents in this case) and staff are continually developing. Goffman states: "*There is a basic split between a large managed group and...a small supervisory staff*" (Goffman 1961, 7). This implies that a difference is maintained between two types of people within the institution. Goffman argues that "*Each grouping tends to conceive of the other in terms of narrow hostile stereotypes*" (Goffman 1961, 7). What is more, there is a high degree of anonymity between staff and residents because they have not chosen each other. Communication between the two groups is restricted, as it is "*The passage of information, especially information about the staff's plans for inmates*" (Goffman 1961, 9).

According to Goffman, the preconditions for establishing mutual relationships between staff and residents seem very limited in total institutions. One reaction to this practice is that residents apply different lines of adaptation in opportunistic combinations that allow them to "*have a maximum chance... of eventually getting out physically and psychologically undamaged*" (Goffman 1961, 64-65). Although nursing-home residents are residents until the end of their lives, Goffman's definitions of strategies supplement my understanding of the reactions of the residents in this study. He defines four lines of adaptation: "*Situational withdrawal*" represents regression, where the resident "*withdraws apparent attention from everything except events immediately around his body*". The "*intransigent line*" represents protest against the

practice of the institution, while “*conversion*” (Goffman 1961, 63) is the acceptance of the practice of the institution. “*Colonization*” represents the residents who are relatively content with never thriving very well in the institution. I will return to these at the end of the analysis, as I found the “*conversion*” and the “*intransigent*” approaches applicable, where the former generally represents the good residents and the latter generally the opposite.

Goffman’s analysis of mental hospitals was published in the late 1950s and early 1960s. Other researchers have argued that Goffman’s account is insufficient relating to how the types of total institution he describes can be compared. Stokholm (2006) argues that since the 1950s the authority of staff over inmates has been reduced in Danish institutions. Nevertheless, I find basic elements of Goffman’s definitions useful concerning the strategies adopted by nursing home residents in the face of the institutional practices they experienced, even though he developed his concept in relation to a mental hospital, which is a different context.

In the literature on nursing homes, there has been a tendency to follow primarily Goffman (1961). His perspective on institutions has been challenged in a series of ethnographic works. These works have looked closely at these aspects. Among these are Ross (1977), Myerhoff (1979), Jerrome (1992), Foner (1995) and Paterniti (2003), who, among other things, oppose the idea of institutions having a uniform process strictly limiting the ways in which residents can establish themselves as persons and their ability to influence institutional practice. In these works, residents actively appropriate parts of the nursing home through their response to institutional practice, and their acceptance or resistance to care activities may actually change some daily institutional practices and the meaning attached to them. This all indicates that a stress on the mortification of the resident as an analytical perspective (Goffman 1961) is insufficient, as this overlooks some negotiations of personal status (cf. Paterniti 2003).

Goffman’s argument that the staff acts as a single group towards the residents as another group is also questioned in the literature. An example of this is Foner (1995), who on the basis of her work in a New York nursing home discusses two different attitudes among staff towards nursing-home residents. She argues that it is the attitude of the individual staff members towards the residents that influences the character of the relationships established. That is, staff’s individual interpretations of the institutional modes of thought determine such relationships.

With the nursing-home literature I have questioned the applicability of Goffman’s total institutions in understanding the relationships between staff and residents, as well as how the former influence the “*enclosed, formally administered round of life*” (Goffman 1961, xiii). With the aim of achieving a better understanding of these relationships, I therefore now turn to the ethnographic material, applying the relatedness perspective (Carsten 2004), as it adds to the understanding

of the character of the relationships that the literature indicates are established in nursing homes.

The move to the nursing home

Expectations of a life as a nursing home resident Hans and Anna had been married for 45 years and before enrolling in nursing care still lived in the street where they once met and fell in love. Their five-room basement flat had been a porter's lodge and a place of work for Hans. In his work Hans had held a senior position. Anna was mostly confined to her bed. She was frail and had lost most of her appetite. At their son's request, they decided to enroll for nursing care. A further argument for enrolling in nursing care was that Hans did not want those now working in his previous workplace to see his further decline in the building where he once held an influential position. He liked them to remember him the way he had been before.

The first binding contact with their future nursing home was the contract defining the details concerning the flat, assistance needs, meal preferences and requirements for other facilities in the nursing home. The prospective residents signed the contracts upon being visited in their own home, where a representative from the nursing home, the future contact person in the nursing home and often a relative attended. The representative took information from home care into account and paid special attention at these meetings to the medical prescriptions required.

The contract indicates both that the prospective resident could claim certain assistance and that the relationship between new residents and staff starts off from a bureaucratic regulation according to which all residents are to be treated alike, with equal justice (cf. Foner 1995).

"I expect nothing, as long as they treat us properly." As mentioned above, this was Hans's immediate reaction to my question about his expectations of the nursing home. In addition, he expected Anna's physical condition to improve so that he, and hopefully Anna, would be able to walk around the nursing home premises, chat with the other residents and eventually make acquaintances.

Although there are two different types of nursing home in this research, the descriptions were very similar concerning the aim of the institutions, which was to provide good care for the residents in their respective leaflets. A frequent sentence in the prospectuses is: *"Our care aims at starting with your resources and not your weaknesses"* (Farum Kommune 2004). The SLE further emphasises the influence of the residents on their daily lives in the unit and their expectations regarding their ways of being social: *"You will influence the daily life on the unit"*, and later under the headline *"Staff: "* *"All staff members are here to care for you and assist you with your needs..."* (Helsingør Kommune 2005). Concerning training at the rehabilitation centres, it reads: *"If you need rehabilitation to maintain your physical abilities, an individual programme will be designed for you in cooperation with a physiotherapist"*.

Thus far Hans's expectations would have been fulfilled given the descriptions above and his undemanding attitude, everything seemed hopeful.

Moving in Hans' and Anna's son had arranged the interior of the flat before Hans and Anna arrived. I observed their arrival in their future place of residence: as they entered from the lift, they passed the other residents in the dining room. Hans nodded towards the other residents while passing, without receiving any response from them. Anna just passed the tables, walking slowly in small steps. They walked along the corridor to their flat and entered. From this moment they became residents of the nursing home.

Hans' and Anna's staff contact person had mentioned about their arrival during the preparations for lunch, which she herself was unable to attend. None of the other staff members present responded to this information, and the staff did not greet Hans and Anna as they entered. The same evening, however, they accepted an invitation to dine with the other residents. They were shown two seats at a table occupied by an elderly woman to whom they were introduced, but they were not introduced to any of the other residents by the staff. However, on the following day their contact person actually introduced herself to them. Introduction to other members of staff and residents was left to their own initiative.

Hans commented on these events with disappointment. However, his disappointment was not due to a lack of any formal introduction ritual in the nursing home but only to the fact that the management in their former housing company did not give Anna a bunch of flowers when they moved out. Staff and fellow residents in their new environment would then have seen that his work had been recognized and that he had been influential and held a senior position in his previous life. In other words, he intended to present himself as a person with social status, not as a body in need of extensive care.

Despite this initial disappointment, Hans and Anna expressed themselves very positively towards the staff and the nursing home at the first interview. Hans felt it was a great relief that there were now staff to assist Anna. Her medication was taken care of and food was available for both of them in the dining room. With the open door and staff passing just outside, they were able to hear Hans as he said with confidence, "*This is probably the best nursing home in Copenhagen*". The relief and gratitude Hans felt was shared among the other fourteen new residents in this study.

Hans and Anna intended to establish a relationship with the staff. An open invitation to sweets and port invited the staff to pass by and listen to their life stories. I suggest that sweets and port could be seen as a gift, and Hans and Anna hoped for this gift would be returned by the staff's interest in their stories (cf. Godbout 1998). The story did not start with a bunch of flowers, but Hans and Anna nonetheless intended to tell it again.

Residents' expectations The expectations that residents had of the staff were mainly directed towards their contact person, with whom the residents tried to create a reciprocal relationship.

Among the residents, there were different expectations regarding the sort of attention the staff should pay them. A resident called Mogens gave the most precise description of residents' expectations, described how a male member of staff ought to behave towards him: *"He must be helpful and quick. Additionally he must live and feel with the man and understand his pains, and his assistance must be based upon this understanding"*. I will elaborate and discuss these expectations in two parts.

First a staff member who is *"helpful and quick"* did not leave a resident waiting a long time for assistance. However, waiting time often occurred, and this was perceived as humiliating, as illustrated by the following interview with Dorte. She was suffering from a unilateral paresis caused by a cerebrovascular event. She was the interviewee in this study who had been most deprived of her physical abilities, as she was only able to move her right arm. The majority of her time was therefore spent in bed.

For the first two weeks after being discharged from hospital, she was admitted to respite care, her permanent flat being in another unit. In this unit, she found it difficult to accustom herself to the way the staff wanted her to carry out her morning toilet. She said: *"Yes, they had bedpans"* (in respite care). *"And, well, I got used to it and I found it very comfortable. Then I got the largest shock, when I arrived here – they had no bedpans"*. Commenting on this situation, she said: *"This thing about the toilet was hard for me to accept"*. Here she was lifted onto the toilet and left there for approximately ten minutes, while staff assisted other residents. She found it uncomfortable, as *"it hurts my back, sitting like that for so long"*. According to Foner (1995), this way of treating residents satisfies bureaucratic rules, according to which residents are treated alike, impartially and impersonally.

A basic characteristic of the good staff member was not to keep residents waiting a long time, as Dorte experienced, and which she felt humiliating. Residents also expected their contact person to prioritise their needs, even though high staff turnover, understaffing and frequent meetings often forced staff to prioritise among residents' needs. In a similar manner, they preferred staff not to stick to the rules and what was written in the contract, but to be flexible and to take their individuality into account in caring for them (Foner 1995).

The second aspect of Mogens' expectations emphasised staff's discretion, that he: *"Feels with the man and understands his pains"*. This implied a genuine interest in the resident and attention being paid to the resident's individual needs and preferences. Residents expected a lasting interest in their own persons and previous social status, as indicated by the missing bunch of flowers. Staff should also know the resident's needs and preferences, so that there was no need to explain them over and over again.

At mealtimes too, residents expected staff not to put them in positions or ask them to do things they were unable to do because of their restricted abilities. They wanted to avoid the exposure of frailty in the presence of the other residents. Additionally, residents expected staff to make sure that activities at the rehabilitation centres had been arranged, i.e. as soon as the new residents had entered the care facilities, they expected staff to arrange a scheduled training programme for them at a rehabilitation centre.

The staff's expectations

One staff member, referring to a resident called Oda, described how “*she had become good in the way that she took part in the activities...*”, thus living up to the staff member’s expectations about being a good resident and thereby adapting to the institutional practice. Other residents did not wish to accept the role assigned to them by the staff and were consequently not favoured, since, for instance, they used the nursing home like “*too much of a hotel...*”, as the staff members stated. I will elaborate on this aspect later, but below I shall analyse how becoming “good” implied residents empathising with the staff and acknowledging their work as important.

When staff described the ‘good resident’, this was, broadly speaking, a reference to those who had initiated and accepted close contact with the staff in their flats. They also made a great effort to use their own resources and improve their physical abilities by engaging in rehabilitation activities. In addition, they should accept that at times staff were unable to provide this level of contact and proper care. Accepting this implied that they paid close attention to the stress levels of the staff and refrained from calling for assistance when they knew that the staff were busy or that a meeting was imminent. That is, the good resident had empathy with the staff (Kydd 2006).

As regards contact, members of staff seemed to agree that the residents should be willing to talk about their inner feelings when staff were ready to listen. However, residents needed to take the initiative: “*If residents want to talk, then I am willing to listen*”, said one staff member.

When staff were ready and residents opened up to them, mutual confidence and thus contact were created. As Janni mentioned about Dorte, “*She is sweet and she is honest...and she tells me everything*”. Through knowing their needs, it became possible to assist residents in a proper manner, and the importance of the work of the staff could be confirmed. Janni said: “*When I am working, then it has been a good day, because now I have done a little for them the way I wanted to and the way they preferred me to assist them*”. This also points to the general motive for the staff’s choice of their profession: It is indeed interesting to work with elderly people.

Nevertheless, there was general agreement among the staff that residents should be prevented from seeking too close contact. Applying a distinction of Jacobsen’s (2006), staff accepted personal communication

in which residents openly talked about their lives. The aim was to listen and assist the residents by allowing them to talk freely. Staff could talk about personal matters in terms of family relations, but they kept private matters out of the conversation. What from a resident's perspective could be perceived as an invitation to exchange intimate details was from the staff's perspective at times just a professional part of the care. However, basically I found that staff shared residents' preference for a personal relationship, though they also appreciated their ability to adhere to the bureaucratic regulations.

A basic incentive for staff to provide care for the residents was that the latter appreciated these efforts. When staff listened and had close contact, they felt that they had "*receive[d] something*". Apart from the recognition mentioned above, their most favoured residents were those with a sense of humour – "*she makes me laugh*", "*Every day she has new interesting things to tell me about*" – or those in a good or cheerful mood.

What the staff looked for in the good resident was a confirmation of their importance, that is, residents who appreciated their assistance in the right way (cf. Kydd 2006). Liveng (2007) argues that the institution of the nursing home provides very little recognition of the work of staff, and staff consequently seek this recognition from the residents. Foner (1995) supplements this argument, as she argues that there are two ways of being recognised as staff. On the administrative side, appreciation is achieved when residents' rights to care are substantially documented. On the other side, what is important is recognition from the residents, where the latter emphasise passion, affection and enthusiasm.

Again, however, it is important to mention that staff had the upper hand, and if they wished to dissolve the relationship, they had the ability to do so. Residents, on the other hand, had to put up with the contact person appointed to them. As Paterniti further suggests (2003), staff could exercise power by exposing residents to extensive waiting. Staff were also in charge of the schedules and the priorities, as well as being in a position to define what was important enough to be scheduled as a care activity (Paterniti 2003).

Residents' responses to staff's expectations

That the staff were in charge of their relations with residents made the latter reflect repeatedly on how the staff regarded them. This indicated how very attentive residents were towards staff's perceptions of them, and that good residents in time realized that they had to wait for what they perceived as excessive amounts of time.

Anders described how he paid attention to the staff's expectations: "*I stopped walking in the afternoon. I had to restrain myself. I started walking late in the evening instead*". When he was living at home, he used to go for short walks twice a day. After moving into the nursing home, he felt he had to forego one of his walks in order not to be seen as too fit and therefore unsuitable for being in a nursing home. In the evenings, however, he walked the corridors.

The quote from Anders indicates that residents reflected upon the staff's expectations and mostly accepted them and adapted to the nursing home practice i.e. to the ways in which they were expected to behave. In addition, they were very attentive to staff's perceptions of whether they were behaving in accordance with the latter's expectations. The residents who lived up to these expectations were rewarded by extensive contact. That is, as long as they were able fulfil these expectations, they would win the battle among the residents for staff's attention. Paterniti (2003) suggests that residents were, if not able to manipulate staff, then at least able to influence situations.

But the residents did not all meet staff's expectations. Hans and Anna had realized after one month that at times the staff did not respond to all their calls. With disappointment Hans commented: "*All the nonsense that they are here only to take care of us*". Hans once suffered a stroke, and he couldn't help thinking what would happen if he had another one and if Anna called for help and no one came. Additionally, after six months, none of the staff members had taken the time to talk to them or take any particular interest in their lives. This had been evident, as the bowl of sweets remained nearly untouched, as was also the case with the bottle of port on their table.

Ritta was an example of a resident who accepted the expectations of the staff and was rewarded with extensive contact and a relationship prized by both herself and the contact person. Like the majority of the new residents in this study, she was mainly a representative of the "*conversion*" line (Goffman 1961, 63), according to which residents accept the practice of the institution. Hans and Anna, conversely, illustrated the "*intransigent line*" (Goffman 1961, 62) in the first months, which involved a resistance to adapt to the practice of the institution.

Hans did not pay attention to the stress levels of the staff. Despite his protest, he had to agree that everything was done eventually. The staff's reactions towards residents who did not meet their expectations were a lack of attention, empathy and care, as Hans experienced it. Rather, he and his wife were being treated by the book, as the staff stuck to the bureaucratic regulations. And they faced the practice that Goffman describes as experiencing extensive waiting. If they complained, this was brushed aside by staff with reference to the tight schedule (Goffman 1961).

Summing up the relatedness perspective enabled me to understand the relationships created between residents and their contact persons in the best cases. These were reciprocal relationships, which needed to be maintained on a regular basis or they would otherwise dissolve. Staff and residents both expressed a desire to create good, positive relationships. At the same time, the idea of positive relationships became one of the strategies that were adopted. This paradox can be explained by the residents both wanting the relationship, while on the other hand facing competition from other residents.

Danish care ideology in the everyday praxis at care homes

The care home architecture provided staff with the opportunity to provide care in accordance with the Danish policy objectives for care. Staff implemented the objectives by encouraging the residents to improve their situation by inviting them to participate in cooking activities and other social activities. By so doing the residents were enabled to maintain and eventually improve own abilities both mentally and physically. But the policy objectives were not the most important aspect for the new residents. The most important for the elderly people who became new residents at care homes in this study was the relationship established with staff members. For this relationship to be established and maintained, the new residents needed to maintain and improve their social skills to develop and improve their empathy towards the staff members. In other words, the staff demanded that residents treated them as persons as well, instead of just asking them to provide care.

In this chapter I followed the process of the institutionalisation of new residents in Danish nursing homes. In the analysis, I applied Goffman's concept of total institutions, as it provided an understanding of the nursing home context in which these relationships were established. The concept of relatedness assisted in understanding the fragile and temporary character of these relationships.

The new residents strove to be treated as individuals instead of being treated as bodies in need on the basis of sameness, with all residents being treated alike in accordance with the bureaucratic regulations (Foner 1995). To avoid the latter situation, residents sought to establish reciprocal relationships, primarily with their contact person, that is, a relationship in which the staff subjected residents to a minimum amount of waiting time and generally allowed them to influence nursing-home practice. The majority of the new residents became good residents, which also indicated that they intended to establish this type of relationship.

In the analysis, I underlined the need for residents also to be sensitive regarding the staff's stress levels and to restrict their calls for assistance accordingly. That is, the staff members had the upper hand and would eventually decide whether the residents' demands were met. The old couple, Hans and Anna, chose not to pay attention to staff's stress levels, thus not aiming to accept the staff's expectations of the residents. However, at the end of the research period Hans realized that they needed to pay attention to staff's stress levels. At the last interview he was changing his mind. Two weeks prior to this interview, two staff members went round to the residents to say goodbye. Hans had decided to give up his strategy of protest, as he now realized that *"We have to take care of the staff, otherwise they will resign"*.

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A Good Old Age? Life as a Nursing Home Resident in Denmark

Louise Scheel Thomasen

Nursing homes reflect cultural ideas about the people who live there. They are designed for a particular elderly subject, and care is organized in a way that is thought to promote a good old age for residents. This chapter is based on a Danish study of life as a nursing home resident. A phenomenological perspective combined with an analytical awareness of the cultural and institutional context has permitted insight into what life is like when frailty and disease compell a person to move into an institution to spend the last years of life. The chapter questions whether a good old age based on values of independence and activity, as it is expressed in *Staying and Living Environments*, is a meaningful old age for the people who live there.

Study design

In order to gain an understanding of life as lived in nursing homes, four months of fieldwork were conducted in three Staying and Living Environments (SLEs, “Leve og bomiljø” in Danish). Constructed in the image of the active and independent elderly, the SLEs are built to reflect a mini-society with a private and a public sphere (Jensen 2004; Kofod in this book). Access to the common spaces, or the public sphere, is easy, thereby encouraging people to take part in common activities. During this fieldwork I conducted 16 semi-structured interviews, participated in a training course for the staff, and examined various kinds of written or online published material related to nursing homes and old age in Denmark.

Although the staff were dedicated and most often deeply engaged in the wellbeing of the residents, I witnessed situations that illustrated a discrepancy between the notions of good care and wellbeing between these two groups. The following example is taken from observations of care situations in the units.

Karen uses a wheelchair and needs help to get out of bed. One morning she is helped by Birthe, senior member of staff, and Janne, who is in training as a social and health care assistant. Karen is hoisted out of bed and into her wheelchair. Janne then pushes her chair to the bathroom, and Birthe tells Janne that she just has to ‘guide’ Karen. She hands Janne a vest for Karen to put on, and Janne pulls it up half way over Karen’s arms.

Birthe: *“Ask her to pull it over her head herself. She can do it.”*

Janne (to Karen): *“You can do it.”*

Karen does not pull the vest up. Birthe turns to me and says: *“Some of them just give in completely when you help them”*, while making a gesture that alludes to rolling over and lying passively on your back. Janne pulls up the vest while Karen holds on to it.

Janne: *“Did you wash under your arms?”*

Karen: *“No, I didn’t! You can do that!”*

Janne: *“You can do it.”*

Karen washes herself under the arms a little bit.

There seem to be different agendas in play, both here and in many similar situations I witnessed during my fieldwork. Why does Karen not comply immediately with Janne’s guidance? Why is it so important that Karen should do it herself?

The example illustrates the main point of the chapter. The design of the wards, the way care is organized and the way staff interact with the residents are informed by cultural values emphasizing activity and independence. From the point of view of the residents, though, a good old age is not so much a question of maintaining physical abilities, and being able to take care of themselves in an independent way as it is a question of accepting and learning to live with frailty and dependence.

An active old age

There are certain expectations concerning the residents of SLEs. An important concept in the organization of care is self-care, a prevalent concept in Danish health care since the 1990s. When care is given as self-care it is best provided by enhancing the elderly people's capacity to take care of themselves, or their capacity for self-care. This is a capacity, or behaviour, that can be taught. It pertains to people's ability to identify and influence relevant factors in order for them to take proper care of their own health and wellbeing (Lantz 1985; Orem 1991; Nicholas 1993; Blair et al. 1996; Backman & Hentinen 1999 & 2001; Callaghan 2005). As such care is not something given to others, but to oneself. It is not so much something received as it is a competence to be mastered. As a reaction to what has been described as institutionalization and marginalization from society, elderly people are re-cast as responsible and independent within the self-care paradigm (Wagner 2002). These thoughts are fundamental in the development of SLEs, and in the way care is provided there. When Birthe tells Janne to "guide" Karen in the example in the introduction, it is a way of helping Karen to take care of herself. Karen should not be given care as a passive recipient but is expected to take an active part in caring for her body. This is an example of how staff will motivate and activate the residents¹. Ideas of wellbeing as related to being active and independent shapes interaction between staff and resident.

Setting the table and helping with the laundry are examples of other activities the old people are encouraged to take part in. Performing such tasks is believed to be a way of maintaining a level of physical functioning that will permit the residents to live as independently as possible for as long as possible. Participating in daily activities in the SLE is also believed to maintain an everyday life that resembles life in a "real home", as opposed to an environment structured by the routines of the institution.

Apart from observing how residents are encouraged to be active in caring for themselves, and to participate in the daily chores, I also hear staff members outline the negative prospects of passivity. In the worst case scenario it leads to dependence and ultimately to an early death. According to Ingrid, a member of staff, one of the residents, Mona, has got into a vicious circle. Mona has lived in the SLE for a couple of years. She uses a wheelchair and spends more and more time lying on her bed. Other staff members tell me she is feeling increasingly weak. Out of respect for her condition that seems to be deteriorating, I have not spent much time with her. Ingrid believes it is a problem that other members of staff affirm

1 There were differences between carers as to how care was provided, and in the degree to which they were set on activating and motivating residents. These differences are not included here, where the purpose is to show how cultural ideas manifest in interaction between staff and residents.

Mona is feeling weak and sick. When she is not asked to do things on her own, for example to apply moisturizer to her face in the morning by herself, it makes her feel sicker than she really is, Ingrid explains. Before she moved into the house, Mona lived on the old, conventional unit in the nursing home. There the staff had managed to cure her of her “whims”, and back then she managed to do more things on her own, Ingrid continues. It would do Mona good to be handled a little more firmly. She should be encouraged to do more things herself even though this takes more time. If not, decay will set in, and she will experience more pain. This will eventually lead to an early death. *“The way it is at a conventional nursing home, you could die from it”* because you are not activated, Ingrid concludes.

Residents like Mona, who does not show enough capacity or will to care for herself, risk being labelled by staff, and even family members, as too passive and too dependent. One member of staff is puzzled that some residents just *“give up, when they move into a nursing home. Then it’s the end, and you don’t have to do anything anymore.”* Another tells me that: *“Some people think they don’t have to lift a finger now that they have moved into a nursing home. They are used to having servants and don’t believe they have to peel potatoes and clean their own toilet.”*

Not only staff, but also relatives may think of the residents in this way. At a meeting between staff and family members, a daughter of one of the residents expresses a concern about her father. He spends too much just sitting by himself, she thinks, and she urges staff to be more insistent when trying to engage the residents in social activities.

Activity shapes the way we think of old age, Stephen Katz (2000) argues. In his analysis of the formation of gerontological knowledge Stephen Katz argues that activity is a keyword in Western notions of how to age well. Entering gerontological thought in the 1950s along with a focus on how to adjust to old age, activity grew into a regular theory. In the SLEs residents such as Karen and Mona are thus configured as specific subjects, *“encased in a social matrix where moral, disciplinary conventions around activity, health, and independence appear to represent an idealized old age”* (Katz 2000, 140). SLEs are constructed for the active and independent elderly with the purpose of enhancing residents’ quality of life. Cultural ideals of how to age well are reflected in the architecture, in the organization of care, and in interaction between staff and residents.

What, then, is going on when Karen suggests that Janne does the washing in the example in the introduction, and Karen replies by asking her to do it instead? In order to understand what is happening in such a situation, and how it is to live in an SLE, we need to understand what life looks like from the perspective of the residents. This means first and foremost to look into how it is when life is lived on terms set by a frail and sick body.

The frail body

Frailty is a fundamental life condition for old people in nursing homes. Being frail, and perhaps also sick, are the main reasons for moving from home to an institution, and, as will be shown in the following, the main reasons for leading a less active lifestyle. It can be frustrating to not be able to do as much as before. John describes it like this:

“I miss having more mobility... To be able to get up and go over there (points towards his bed) and back again without having to use the walker... to pull myself together and get up without falling and that kind of things. What irritates me most is that everything goes so slow! If I want to go in there and rearrange the cover then it takes, I don't know, four minutes or so... I have to get up, find my balance, then get a hold of the walker, get over there, park the walker... It's really annoying! Even though I do get some things done it's really slow. You can't do as much as you have perhaps set your mind on doing.”

John is annoyed at not being able to do the things the way he used to. His body gets in his way. His frustration can be understood by turning to the philosopher Drew Leder and his concept of ‘dys-appearance’ (Leder 1990). In a phenomenological perspective perception is anchored in the body. As a “from” structure it serves as the point of departure for engaging the world. As such the body is characterized by a ‘dis-appearance’: it is the means by which we perceive the world, and the body in itself remains unnoticed in our consciousness. The body is ‘dis-appearing’.

But when pain, frailty and physical discomfort enter the field of perception, it re-organizes our lived reality fundamentally: “No longer simply a “from” structure, the painful body becomes that *to* which he attends” (Leder 1990, 74). As a “to” structure the body is known through “an absence of an absence” (Leder 1990, 91), and is referred to with the term ‘dys-appearance’, instead of dis-appearance. It becomes visible, an object to our consciousness: “When functioning well this body is a transparency through which we engage the world (...) Yet when the body is rendered opaque through loss of function, we become aware of it as alien presence” (Leder 1990, 82). Dys-appearance can describe the way the residents perceive their bodies, as frailty and disease defines and organizes their world. Life with a dys-appearing body brings to the foreground an experience of the body as separated from the mind. The body, or parts of it, can be perceived of “as apart from the self”, Leder (1990, 87) argues. This experience is described in detail by the anthropologist Robert Murphy. In his book, *The body silent*, he offers insight into the process of gradually becoming quadriplegic, leaving him with no sensation in arms, legs and torso. He withdraws his sense of identity from a body functioning as a separate unit (Murphy 1990, 101). Similar processes are in play in the way the residents experience their frail bodies.

Activating care

One evening at the dinner table Mona is having difficulties in eating. As she tries to get the fork all the way up to her mouth, her hand stops half way. She sighs and makes the following comment: *“My arms aren’t long enough today!”* When a person has difficulties doing certain things, such as reaching all the way up to her mouth with a fork, it can feel as if the body itself is incomplete; as if the arms are not long enough, although they have not grown shorter. To receive help in a situation like this is a way of loaning a pair of arms that are long enough. On another occasion at dinner Mona struggles again. This time the staff chooses not to help her at first, thereby encouraging her to try to do it herself. By not helping, they try to activate her, and thus help her maintain some basic functional skills. Mona does not see it as a help, though, and neither does Anne, who is sitting opposite her. Later that day, Anne tells me:

“Well, Mona, she can’t manage anymore, so she needs help with eating. But they (staff) didn’t come over to help her, they just sat down at the other table and talked and talked, and started to eat. Then I went over to her and helped her, and she said to me: “But this is not something you should do, they should help me with that!” That is really not okay!”

Being activated can draw attention to the body as dys-appearing. When Mona struggles with the fork, and help is given as self-help, it becomes clear to Mona that her arms feel too short. Activation has the purpose of maintaining or expanding the physical potential of the frail body. This means trying to push the limits of what the residents are capable of. By doing so attention is drawn to the point where the arms are too short. Seen in this perspective the desire to receive help can be understood as a desire to be helped in a way that for a moment suspends the experience of the body as dys-appearing. If a person can ‘loan’ a pair of arms that are long enough, it is less important that her own arms appear not to be.

Observing several care situations it occurs to me that the elderly people hand over the responsibility for their bodies to the staff. I mention this to a resident, Anton:

Louise: *“So you hand over the responsibility for your body to other people?”*

Anton: *“I do, actually. I did it today too, where they needed to change – well, I actually don’t know what they did to me – it hurt a little bit when they pulled it out and changed it. Other than that I can’t say much about it. And I really don’t care as long as it doesn’t hurt too much.”*

In his account of how he has had his catheter changed Anton talks about himself as a body that someone has done something to. When the body is dys-appearing and becomes an object in itself in the consciousness, it entails an experience of a split between body and self (Leder 1990, 74). Residents describe their bodies in a detached way, and talk about care in a way that places the responsibility for the body in the hands of the staff. Their role, according to the elderly people, is to take care of their bodies

and to be ready to help whenever needed. It is characteristic that the elderly talk about care as something to be received, while staff talks about self-care, something people can take part in themselves and can master. From a phenomenological perspective it can be a heavy burden to carry the responsibility for the frail and dys-appearing body. Appealing to staff for help is also an appeal to share the weight of this burden, to share the responsibility for the frail body. Feelings of detachment towards the body may be what make it possible to 'give it away'.

Activating care, or help as self-help, may thus remind the residents of how frail they are. It draws attention to the body as dys-appearing. To receive help suspends this experience for a moment, permitting the elderly to experience themselves as something other than a frail body, as a social being, for example. When the primary focus in care situations is not on guiding Karen to 'do it herself' attention can be paid to other things, such as a conversation between Karen, Birthe and Janne. When Mona is being helped at the dinner table, she might have more energy to talk a little with other people at the table.

This discussion also implies a difference in the meaning of dependence. Activity is promoted as a safeguard against the passive and dependent life as an old person, but the examples show that dependence per se is not seen as problematic by the residents. For most it has come to be an accepted part of life, a question of routine. Nora says:

Louise: *"What's the most important thing you receive help with?"*

Nora: *"I guess it's changing the diaper. I haven't been used to that before. It's so important that it's put on properly so nothing leaks."*

Louise: *"How is it for you to be helped by others with these kind of things?"*

Nora: *"In the beginning it bothered me a lot. But not anymore. It doesn't."*

With time receiving help becomes a habit. Rather than fighting dependence, the old people are able to accept it, even though it might be a difficult process to get used to other people handling one's body in some times quite intimate ways.

Approaching the end of life

A nursing home is usually the last home in the institutionalized life course of the welfare state. For most of the residents death is seen as approaching. Talking about life often elicits thoughts about death, as in the following example:

Louise: *"Good old age, what does that mean to you?"*

Anne: *"Well, it's almost about over by now."*

Louise: *"Your old age?"*

Anne: *"I would like it to end now. I expect it to every night. I hope I can let go quickly but then again, you never know. I woke up the other night feeling an intense pressure in my chest and in my back. It's a kind of*

pain, and they have told me to call the nurse when it happens. But they can't do anything about it, they just give me some painkillers. And then I thought: well, there's no reason to call her because if it happens it would really be a good thing."

Louise: *"What do you mean by letting go?"*

Anne: *"Well, to let go into death."*

Death has a certain presence in the lives of the elderly. By the death of friends, relatives, and other residents, death presents itself in an immediate way: *"We know that next time it might be you"*, as a woman puts it. Thus reminded of, thinking of, and, possibly, hoping for death, as Anne does, affects their way of looking at the future and of acting in the present. Human existence is temporally embedded (Hastrup 2005, 5). We act in the present moment based on our past experiences as well as our expectations of what is to come: *"The future is crammed into present action, just as the past is"* (Hastrup 2005, 17). What does life look like when death is seen as approaching? One might feel that life is behind, as a woman explains to me. While she holds up her hand in midair to illustrate her point, she says: *"I'm up here, and life is down there."* Being *"up here"* implies not having any particular ambitions or goals for the future. Life is something one once had, not something ahead. Another woman puts it this way:

Vera: *"I have had a rich life with many travels. So I can't say I miss anything."*

Louise: *"Do you have any plans for the rest of your life?"*

Vera: *"No. I think I've become quite inactive because I feel so dizzy."*

The frail body not only keeps the old from being active, it also reminds them that the future might be very short. The frail body and the presence of death in their lives gives way to a focus on life as it has been, and how it is today.

Activity revisited

Nora's favourite place in the living room is by the big windows where she can look at the view: Green grass, trees and a nearby lake. I ask her what she has been up to today. *"Nothing!"* She answers. This is an answer I often hear when I ask the residents about their day. Often they continue: *"Because I'm not able to do anything anymore!"* The active life was back when she went to work, took care of the children and kept a house. As a woman illustrated by holding up her hand saying: *"I'm up here"*, the 'real', active life, is behind. It is not a question of not wanting to be active, quite the reverse. But life has come to a point where active life, as implied in the activity paradigm, belongs to the past. As a former housewife Nora also has a particular understanding of what it means 'to do something'. As she sits looking out the window I ask her: *"So what is that (to do nothing)?"* To which she replies with a smile: *"Enjoying the view!"* What

appears to be an example of passivity – an old woman sitting in a chair for hours – can be an activity: Enjoying the view.

As an old person living in a nursing home much time is spent sitting. At the meeting mentioned above between staff and family members, the daughter who urged staff to put more pressure on the residents also complained about the “*depressing sight of old people sitting quietly and doing nothing*,” that greets her when she visits her father (see also Hujala & Rissanen in this book). Doing fieldwork in the SLEs a lot of my time was also spent sitting, often without talking much with the residents next to me. As I am not accustomed to so much silence when I am together with others, it takes time to get used to. But after a while I learn to fall into another rhythm. Sitting quietly in the living room, attention flows out to the big windows to the lawns and further towards the lake. Conversation consists of remarks such as: “*Oh, someone is out walking their dog*”, or: “*It’s quite windy, look at how the trees are swaying*.” On other days we sit outside the entrance quietly dozing off in the sun, noticing other people’s business: “*Who is that? What’s he doing? Oh, he’s brought a cake*.” Watching the surroundings does not entail physical activity as such, nor does it mean complete passivity. It makes people feel as if something is happening, and of being part of it, although not in a directly active way. To enjoy the view, as Nora often does, is in this perspective to be active: Her body seems passive but her senses are active. She is engaged in the world outside the windows even though she is not acting in it. This way of being active I call passive activity.

Passive activity can be understood in terms of the way the sociologist Alfred Schutz (2005) defines actions as either open or hidden. Open actions interfere directly with the outer world from the perspective of the individual, whereas hidden actions are an engagement at a cognitive level (Schutz 2005). In this respect passive activity is a hidden action. When Nora enjoys the view she is not active in a way that interferes with the outer world, but she is active on a cognitive and emotional level. By contrast, most of the activities proposed to residents in SLEs, such as putting on one’s own vest, are open activities. Passive activity is a way of being active by which you are able to engage the world with a dys-appearing body. Just like receiving help, passive activity is a way of suspending the experience of the body as dys-appearing for a while. When a person is immersed in enjoying a view or following the activities of people passing by outside, it does not invite attention to the dys-appearing body to the same extent that open, direct physical activity does.

A good old age?

In considering wellbeing in old age for nursing home residents, the question is not so much whether or not it is possible to activate people with the purpose of living a longer, more active and independent life, but whether it is what the old desire for the last part of their lives. The definition of quality of life as being closely linked to activity and

independence does not seem to correspond to the way many of the old in this study think about their lives.

The purpose of this chapter has been to reveal a discrepancy between cultural notions of activity and independence as alpha and omega for a good old age, and the hopes and aspirations the residents have for a good life. Most importantly, they do not find meaning in fighting frailty and dependence. Being activated by staff can put an emphasis on the body as dys-appearing, which reminds the residents of their frailty and demands that all attention is directed towards an effort, for example, to make the fork reach the mouth during dinner. It has been suggested that when receiving help, and being passively active, the residents can momentarily escape the experience of the frail body as a burden.

The results of the study cast doubt on the current notions of quality of life for nursing home residents. When the residents in the study, as shown, express a certain nostalgia about life as it used to be, when they were still able to be active at work and in keeping the house, they express an attitude similar to other Danish elderly people who link quality of life with activity and independence as has been shown in other studies (Munkøe 2005; Johannesen 2006). A major difference between the elderly in the studies by the occupational therapist Anette Johannesen and the anthropologist Line Munkøe, and the residents in this study is that for the latter the project of fighting for independence is regarded as less realistic and thus less meaningful. The elderly people in the two other Danish studies are still living at home. Even though they experience frailty, and are not able to be as active as before, it is still a relevant and realistic project for them to manage more or less on their own. The nursing home residents, on the other hand, have reached a point where frailty has become accepted as a matter of fact. Although they are not yet dying, they do not see it as a meaningful project to struggle with the old body in the ways suggested by staff in the activating practice.

The strong focus on physical activity, participation in daily routines, and taking responsibility for one's own care seems to not take adequate account of how frail people are when they move into a nursing home today. Linking quality of life and independence means that we transfer ideals of the good life from one group of elderly people – those who are still willing and able to manage on their own and fight for the active life – to a group of people who perceive their lives in a different way. There seems to be a need to distinguish between different stages of old age, and to add more nuances to a perception of what a good life in old age is. It can be frustrating to be met with expectations one is either unable or unwilling to meet. A resident puts it this way:

“We have a lot of influence here, and we’re also supposed to help with things. But as I say to them: What’s the use of it when you aren’t allowed into a nursing home before you aren’t able to do anything no more? Then we can’t help with anything!”

To create a good place for people to live the last years of their lives means designing a home for people who, like Anna, does not wish to, or do not feel able to fight frailty with physical activity, and yet strive to create a good life. It also means a more nuanced perception of what it means to be active, and to organize care in a way that pays more attention to the social and sensory aspects of life, rather than excessively to the physical aspects. Activity does not always have to be open and intervene directly in the outer world. Enjoying a view, listening to music, or simply watching other people's activities, visitors or staff, can be engaging activities. It also means being aware of how activation can bring attention to the body, and be an exhausting reminder of frailty and incompleteness. Choosing to give help, rather than motivating residents to help themselves, gives people a choice of how to use their limited physical resources, and enables care situations to also be a socially stimulating situation, be it with staff or other residents. Care should be given in a way that not only motivates, but also enables resources to be directed towards the social and sensory aspects of life.

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Organizational Aesthetics – a New Dimension of Wellbeing?

[Anneli Hujala & Sari Rissanen](#)

In this chapter we consider the wellbeing of residents and staff in care homes from the perspective of organizational aesthetics. Organizational aesthetics refers to the material, physical world which we can sense around us through all our senses. We believe that this approach has potential in enriching the traditional wellbeing concepts. The empirical material of the study presented here was collected in 2009–2010 using observation and interviews in eight Finnish elderly care homes¹.

¹ This chapter is based on previous publications Hujala & Rissanen 2011 and Hujala & Rissanen 2012b.

The forgotten materiality of organization

Our interest in the material dimension of organization was aroused some years ago when we analysed the discursive construction of care management in elderly care homes. Along with discursive practices, we directed our attention to issues such as how and where the residents seemed to spend their time and the kind of room in which the staff meetings took place. We also noticed that the managers of small care units usually did not have a room of their own and that the staff offices were very small, not to mention the size of the private space of the clients. From the perspective of management, these material dimensions of care organizations were more or less unspoken and taken-for-granted.

Indeed, the concept of organization includes an interesting paradox. We, as human beings, have constructed the concept in order to describe the idea of our own coordinated, goal-oriented action. Thus, by origin, organization is a totally abstract issue. People, however, have reified the concept so that nowadays it is usual to refer to organization as if it were something concrete, as if it could be treated as a thing (Berger & Luckmann 1967; Kärreman & Alvesson 2001). Organization culture, for example, is compared with the metaphor of an iceberg: the biggest part of the culture remains 'hidden' below sea level.

At the same time, people seem to have forgotten that organizations also exist as physical, concrete realities around them. Working, producing services, serving clients and managing always take place in a certain physical space. In addition to concrete spaces and artefacts, materiality also includes other sensual characteristics of organization, such as the visual-aesthetics of design, soundscape, scents and flavours. Similarly, organization members themselves are not only mental but also corporeal beings with physical bodies.

Traditional organization and management theories have largely ignored the material dimensions of organizations, taken them for granted or considered them merely as a context of study. Recently, however, materiality and embodiment have been raised as topics of research, so that we can even refer to 'the material turn' in organization and management sciences (Dale 2005; Bechky 2008; see also Lindberg et al. 2012). Alongside the material turn, organizational aesthetics has lately become quite a popular issue in international organization and management research (e.g. Strati & Guillet de Montoux 2002; Taylor & Hansen 2005; see also Martin 2002).

Aesthetics is an extensive discipline, and includes, in addition to traditional philosophical and arts-centred approaches such sub-disciplines such as aesthetics of nature and environmental aesthetics. Recently the approach to everyday aesthetics has also been given special attention (Saito 2007). Organizational aesthetics, accordingly, refers to the presence of aesthetics in organizational contexts, and in this study particularly in care homes as places for elderly people to live in and staff to work in. Aesthetics is embedded in organizations' physical settings, but it is also present in the everyday practices and routines of our daily

lives. In a way aesthetics is thus connected with our entire existence in the organization, “how it feels to be in an organization” (Taylor 2002, 838). The material world of an organization, experienced through the senses, often affects human beings in unnoticed and unconscious ways. The approach of organizational aesthetics makes it possible to pay attention to such effects from the perspective of wellbeing.

In this study we use organizational aesthetics to address the sensory relationship between a human being and his/her material, physical environment: the senses are a bridge between them. Thus organizational aesthetics is concerned with all kinds of materiality we can sense in organizational contexts, through all our senses. Through the perspective of organizational aesthetics we aim to increase and diversify the understanding of wellbeing in the context of elderly care organizations. In the following, we describe the aesthetic world of elderly care homes and consider how organizational aesthetics is connected with the wellbeing of elderly residents and staff.

The aesthetic dimension of wellbeing

Wellbeing has been studied extensively for decades from multiple perspectives and in diverse fields of science (see more detail in Rissanen in this book). Research on the wellbeing of elderly people has also been extensive, not to mention studies concerning the well-being of staff in general (see Kokkonen in this book). However, the material and aesthetic dimensions of organizations have seldom been the topic of studies on wellbeing, even though the connections between materiality and wellbeing have been recognized.

The physical environments of health and social care have been studied from the perspectives of functionality and safety (Devlin & Arneill 2003; Barnes 2006; Dijkstra et al. 2006). There is also a considerable amount of research concerning the living environments of elderly people with dementia, focusing in particular on perception and pleasantness (Day et al. 2000; Falk et al. 2009; Topo & Kotilainen 2009). Some research has shown that materiality also influences the wellbeing of elderly people (see e.g. Barnes 2006; Cutler et al. 2006).

Earlier research combining materiality and organizational aesthetics has been focused on organizational facilities, such as office decors, artefacts and their connections with organizational image, the identity of managers and workers, control and power (Strati 1992; Harding 2003; Elsbach 2004). Some research also exists on so-called aesthetic labour and aesthetic leadership (Witz et al. 2003; Hansen et al. 2007). In the elderly care context, Patricia Martin (2002) has explored the aesthetics of elderly care homes from the perspectives of the spirit of the place and the use of power.

The origin of the word aesthetics resides in the senses; the Greek verb stem ‘aisth’ means the same as ‘to feel’ (Dale & Burrell 2003). Human beings observe and perceive their environment through all five senses; they see, hear, smell, taste and touch the world around them. Thus

the core of aesthetics in our approach here is the sensory relationship between a human being and his/her external physical reality. People themselves, too, are physical bodies who are involved in their concrete surroundings, including when they are working or otherwise acting in organizational contexts. Organization is not only a cognitive and social phenomenon, but also “derives from the knowledge-creating faculties of all the human senses” (Strati 2000, 13).

Conventionally, aesthetics is often defined as the philosophy of the beautiful and of art and connected particularly – and sometimes solely – with beauty. This does not do justice to the aesthetic approach, even though beauty can also be defined as a broad concept. We can certainly recognize that beauty gives us pleasure (Strati 1992) and therefore it is easy to combine beauty with wellbeing. In addition, aesthetics can refer to harmony and peace; simple and complete; provoking and challenging; surprising and innovative (Weggeman et al. 2007, 347), and we can easily recognize the connections of these expressions to wellbeing.

In our daily lives aesthetics is present in many ways. Our homes, cars, shops, parks and cities are planned and defined more and more intentionally in order to appeal and to give diversified sensory sensations (Weggeman et al. 2007). In advertising, image-creation and for other similar business-related purposes aesthetics has long been utilized intentionally. Needs for extreme experiences have also generated commercial business in a ‘hyperaesthetic’ manner (Weggeman et al. 2007, 348). In a sense, all these aim to increase the appeal to sensory experiences.

However, in order to understand the aesthetic dimension of wellbeing thoroughly, attention should also be paid to ‘an-aesthetics’ (Dale & Burrell 2003), the consequences of unpleasant phenomena as well as conditions characterized by lack of sensory experiences. Antonio Strati and Pierre Guillet de Montoux (2002) state that studies of organizational aesthetics should not pay attention only to the beautiful, because aesthetics also concerns issues that are not so pleasant and attractive. Alongside beauty, Strati (2000) names such aesthetic categories as ugly, sublime, tragic, grotesque and sacred. While the essence of organizational aesthetics resides in sensory experiences, everything we perceive around us, whether it is appealing or not, is included in it.

In point of fact, from a sensory-based perspective, Finnish sauna is an excellent metaphor to express the relation between aesthetics and wellbeing (see Figure 1.) Here it is essential to remember that in Finnish culture the original and genuine sauna experience is a familiar and important way to relax. The interpretation of ‘sauna’ may differ in other countries due to the various applications of sauna which have taken place around the world. In other cultures, however, some corresponding aesthetic metaphors surely exist. Anyway, those who have enjoyed a pleasant authentic Finnish sauna experience can easily recognize how the good relaxed feeling is achieved. In sauna you are very concretely ‘in touch’ with your physical environment through all five senses. You

can feel the touch of hot steam on your skin. You can hear relaxing voices, such as the hiss of the water thrown on the sauna stove stones. You can smell the branch of twigs and the smell of cleanliness. The taste sensations of a cold drink afterwards completes the feeling. Visual sights, such as a lake and birch trees, are also important. In addition to the holistic sensory experiences, sauna is also a place of action: many important decisions, for example, are taken in sauna. For the Finns diverse individual and social emotional experiences and cultural traditions are also intertwined with the sauna experience. In Finnish everyday culture sauna has traditionally been a semi-sacred ritual, possibly equated with the aesthetic category of ‘the sacred’ (Strati 2000). Päivi Topo and Helinä Kotilainen (2009, 49), in their description of a friendly physical environment for people with dementia, also mention sauna as affording a feeling of full life.

The touch of heat on your skin

The smell of bath whisk and feeling of cleanliness

Relaxing sounds: the hiss of water on the hot sauna stove stones



Visual experiences: birch trees and a lake are de rigueur

Taste experiences: cold drink afterwards

Action: in Finnish culture sauna is a perfect place for conversation and decision-making

Figure 1. The aesthetics of authentic Finnish sauna

Elderly people as well as care workers in care organizations are human beings surrounded by their physical environment and using their all senses. In a metaphorical sense they are in a similar situation to those having a sauna bath. The salient question concerning the wellbeing of elderly people is how much the opportunities for sensual experiences decrease when they have to leave their own homes and move to a residential care home. From the perspective of the staff the question about organizational aesthetics is somewhat the opposite. Working in other people’s homes restricts the work identity (see Martin 2002). This, alongside other aesthetic qualities of the work environment, may also have considerable effects on the wellbeing of care staff.

We believe that the approach of organizational aesthetics enhances the understanding of wellbeing in the context of elderly care. For example, the wellbeing categorization ‘having’ (referring to the standard of living), ‘loving’ (focusing on social relationships) and ‘being’ (emphasizing self-fulfillment) by the Finnish wellbeing researcher Erik Allardt (1976; 1998) may be complemented with an aesthetic dimension. Aesthetics binds the concept of wellbeing clearly to the material

environment, but is by no means restricted to it. An aesthetic approach also concerns tiny sensual experiences of people's mundane everyday lives, and, through these, produces more extensive dimensions for wellbeing.

The aesthetic world of care homes

The empirical material was gathered in eight Finnish elderly care homes during 2009 and 2010. Four of the care homes were public and four private for-profit organizations, all providing residential services for elderly people.

Two researchers (both authors) took part in the observation visits. Data was gathered both through observing and through direct and indirect interviews with managers and staff. As many of the residents had dementia, no interviews were conducted with them. The average duration of an observation visit was 3–4 hours. The interviews were not recorded, but the presence of two researchers made it possible to take detailed field notes on both the interviews and observations. Altogether 19 staff members were interviewed, seven of them being in managerial positions. The interviews were semi-structured, partly planned in advance and partly based on ad hoc questions. After preliminary interpretation, further interviews were conducted by the first author in four of the organizations (four front-line managers and three care workers). These 'feedback discussions' were recorded and transcribed and used as supportive data in the final interpretations. In addition, visit reports and photographic material gathered by other members of our research group in 17 care organizations were used as complementary data.

In the dialogical analysis we categorized the empirical material into themes by content analysis. In the analysis, organizational aesthetics was considered from the principles of social constructionism (Berger ja Luckmann 1967; Gergen 1999; Gergen & Thatchenkery 2004; Hujala & Rissanen 2012a) and critical management studies (Alvesson et al. 2009). Both these approaches question the taken-for-granted nature of the materiality and the unnoticed effects of the physical environments on human beings. The connection between materiality and people is reciprocal: while human beings construct physical spaces the spaces also construct the people (Burrell & Dale 2003). These assumptions were used as guidelines in the interpretation.

Accordingly, aesthetic experiences are not born separately from the social world around the people but are connected, for example, with previous life experiences and emotions. Spaces, places and artefacts are important not only as functional objects but also for the feelings they arouse. These meanings are constructed both at individual level and together with other people. For example, many smells serve to recall earlier life experiences. From the social constructionist point of view, the material cannot be separated from the non-material, thus we cannot separate human beings from their physical environment (Gergen 1999).

The challenges of obtaining and interpreting aesthetic knowledge were recognized in the analysis (see e.g. O’Toole & Were 2008; Warren 2008). As Steven Taylor (2002, 823) states, “translation of holistic aesthetic experience into the more discursive signal system of language” is not easy. However, the social constructionist and critical basic assumptions of the study made it possible to accept that the tacit knowledge and aesthetic judgments of the researchers themselves were part of the analysis process (Strati 1992). Thus the findings of such a study are always highly interpretative and not generalizable as such. However, the findings will hopefully serve as important examples of the relevance of the research issue and also hints for further discussion and research on the topic.

The general picture based on our observations on the aesthetics of elderly care organizations was somewhat confusing. First, as researchers we expected to find elderly care homes to be places with a feel of life where diverse sensory stimulation such as voices, smells etc. are present (Martin 2002; see also Thomasen in this book). Our expectations were based on the fact that, compared with many other organizational contexts, residential care organizations are, nevertheless, homes for elderly people. Instead of places full of life, what we encountered in many care homes was silence and inactivity, and, instead of being cosy and homelike, the atmosphere in some care homes was highly institutional. This institutional distance was concretized, for example, as follows:

“Six old ladies sitting silently in a communal space. The TV is on, with a low-volume programme in English. One old lady has her hair in rollers. One is browsing a magazine, the carers are still showering the last residents. We walk backwards and forwards a few times in the corridor... For X [one of the researchers] the silence was a shock. I, too, was surprised at it.” (Field notes, 1PUB)²

Second, although we were aware that the premises and equipment in many Finnish care homes do not meet the general quality requirements, we were surprised at the unsuitability of the surroundings and the poor condition of the equipment, which caused a lot of trouble for the staff.

In the following, we describe in more detail the aesthetic world of elderly care homes, firstly from the perspective of the wellbeing of elderly people, and secondly from the perspective of care workers.

Aesthetics of elderly residents’ everyday lives

It is important that normal life around people continues although their own activity diminishes as they get older. In elderly care facilities, this aim is pursued through the ideal of homelikeness (see Vihma in this book). In some of the units in this study, the atmosphere mediated a feeling of normal home life with sounds, sights and smells. In particular,

2 In the interview extracts, care homes are identified by numbers (1–8). Letters refer to public (PUB) or private (PRI) ownership of the care home.

this was to be seen in smaller units, where the tasks of the staff included daily chores such as cooking and the residents were able to watch and partly even take part in everyday actions. However, some of the places we observed showed that a care home may be a 'sensory void', a place with very few opportunities for everyday sensory experiences. We called this 'an atmosphere of silent inactivity'.

"Old people sit silent at tables." (field notes, 3PUB).

"Stimulating activation is an eternal question, no time for it." (5PUB)

"Old people of this generation are content with little." (3PUB)

It is clear that a considerable part of this is explained by a shortage of care resources and working in haste that are common problems in the care sector.

"Sometimes it would be nice to sit with a resident and just sit...that you could sit [beside them] with a good conscience." (3PUB)

"We would give time to everyone and sit with them if only we had the time." (4PRI)

Thus, sitting beside someone, looking at old photos and discussing memories seemed to be a rarity in everyday work. However, care units seemed to differ in what kind of staff work was emphasized in the daily schedule. The manager-owner of a small private care home described the basic task of the organization as follows:

"...if we think that this is for these residents, this is home. What do we do at home? We do these: we wash clothes, we clean up, we cook." (feedback discussion/manager-owner, (2PRI)

On the other hand, in a public care home one of the employees had received advice from her manager showing quite a controversial orientation to the problem:

"You don't have to feel guilty for not being able to arrange stimulating activities [for residents]." (3PUB)

Sarah Dyer and her colleagues (2008, 2032) write how "the provision of care is rationalised to a series of tasks" and thus the emotional and aesthetic dimensions of care are forgotten (see also Waerness 1984). This was shown indirectly by staff members in some units when they described how an ordinary day 'goes' at a nursing home. The schedules were determined by meeting the basic physical needs of residents such as times for eating, washing and going to bed. Instead, the time between meals was mainly referred only to as 'resting time for residents' or 'a quiet moment for sitting'. Thus, in addition to haste and lack of resources, there may be differences in how the core of care work is defined and implemented in practice. If emotional and aesthetic aspects are not recognized and concretized in daily schedules, arranging sensible things for residents to do or enabling them to take part in everyday chores may become more the exception than a regular part of working practices.

Aesthetic sensory-based experiences are closely interrelated, thus in this study, too, it was somewhat difficult to separate them from each other. In addition to a holistic sense of life – or the lack of it – mentioned above, some specific and quite concrete aesthetic experiences seemed to be closely connected to wellbeing. In the interviews with the staff such issues as food, getting outdoors and taking a sauna bath, above all, were regarded as being of considerable relevance in producing enjoyable aesthetic wellbeing experiences for residents.

Good food is a generally known element of everyday wellbeing, which was clearly confirmed in the talk of the staff members. Small care units with a kitchen of their own – which certainly is a rarity nowadays – were able to meet the requirements of good food better than those to which readymade meals were provided from big central kitchens. In public care units in particular the quality of the food was criticized by the staff:

“Tasteless, tough meat, not suitable for old people.” (3PUB)

By contrast, in some small private care homes’ menus were planned by their own catering staff and the food was prepared on the spot. Good food was described by senses of both taste and touch:

“This porridge tastes of something and this is hot.” (6PRI)

“There is pepper and salt and spices and butter.” (6PRI)

Staff members indicated that it was good practice if at least breakfast and a light evening meal were prepared in the unit, because it gave residents an opportunity to follow the preparations made by staff and possibly take part in them. Such arrangements naturally also increased the aesthetics affordance such as smells and homelike sounds. A positive example of how to change practices was achieved in one of the public units between the observation visit and the feedback discussion. Earlier food has been delivered to the unit from a big central kitchen in ready-made portions. In the feedback interview the manager of the unit stated:

“... now the old people like it better, the smell of the food is different when food comes in big containers and is then served out on the spot.”

(feedback discussion/front-line manager, 1PUB)

Getting out of doors is important for everyone, not only because it offers an opportunity to move physically but also for other sensations that produce good feelings: fresh air, wind, rain, warm sunshine and the smells of nature. Going out also means extending one’s territory and not being stuck inside four walls. Naturally elderly people’s frailty often restricts their chances to go out independently. In addition, in dementia units it is frequently necessary to shut off indoor facilities from the rest of the world.

Going out was regarded as very important for wellbeing, but the opportunities to get outdoors were considered insufficient in all the care homes observed. The hopelessness of the situation was described by care workers as follows:

“We try to get out when summer begins.” (6PRI)

“We put them to sit out if we have time to take them out.” (4PRI)

Several staff members expressed the wish to be able to concretely do something out of doors instead of just hanging around.

“How nice it would be if you could do a flowerbed for example...” (5PUB)

Small gardens seem to be quite a rarity in these Finnish care homes, even though “green care” has been shown to increase the wellbeing of elderly people (see e.g. Rappe 2005). In many units, fencing was needed to securely restrict residents’ movement.

Sauna was the single matter mentioned most often by interviewees for increasing the wellbeing of elderly residents. Thus problems in taking a sauna bath were regarded as a considerable shortcoming. In some units residents could not go to sauna at all. Most often the reason for this was lack of staff resources:

“No chance to arrange sauna with this number of staff.” (1PUB)

Also, taking a shower required so much time and helping resources that in most units it was only possible to arrange for residents to shower once a week. Thus, sauna and shower as holistic aesthetic experiences seemed to be more a speciality than a part of everyday life. They were perceived as an infrequent ‘wellbeing luxury’.

To conclude, the holistic wellbeing of elderly people requires that opportunities for everyday sense-based aesthetic experiences should be present in institutional residential care in a similar way as at home. Enjoying good food, getting out or having a pleasurable bath are small and simple, usually taken-for-granted aesthetic constructors of people’s everyday wellbeing. It is the very lack of them which shows their importance.

The other side of homelike aesthetics – the care home as a work environment

The connection between organizational aesthetics and wellbeing of staff was seen in particular in two aspects. Firstly, the poor conditions of the work premises caused frustration and made the work physically heavy. Secondly, the ‘reverse side of homelikeness’ turned out also to be an issue to be considered from the wellbeing point of view. Both these aspects are important for staff’s wellbeing, which, in turn indirectly affects the wellbeing of the elderly residents.

The nonfunctionality of care premises as a work environment and the impracticality of the equipment were obvious in many care units observed. Comments on the impracticality of the premises most often concerned the toilets and shower rooms, which were too small, especially when the help of two care workers or mobility aids was needed. In particular, these shortcomings concerned public care homes. The statements of the care workers supported this notion:

“The toilet is a small ‘cell’ with no room for anything.” (5PUB)

“The shower chair is awful.” (1PUB)

“We absolutely need adjustable beds.” (7PUB)

“No one has considered that people go with mobility aids. They [the toilets] fulfill the requirements, but the requirements themselves are insufficient.” (3PUB)

It is clear that many buildings serving as elderly care homes were originally designed for other purposes than elderly care. However, problems related to too small shower rooms and toilets, as well as inadequate storage space for mobility aids, were also found in recently built care homes. Care work is to a great extent heavy physical work. Nonfunctional spaces and equipment made the work feel even harder both physically and, due to frustration, also mentally.

“It is awkward for carers to do their everyday work.” (7PUB)

By contrast, good practices and functional arrangements were presented with delight.

Care staff also criticized the inadequacy of the premises from the perspective of residents’ wellbeing. For example, shared rooms (which still existed in some units), too small rooms and lack of space to socialise with relatives were considered to impair the quality of life of the elderly people. The poor condition of the premises, e.g. cold or inconvenient shower rooms, also had an indirect influence on staff’s work motivation. Just as haste impedes emotional work, an unaesthetic care environment constrains the implementation of aesthetic work (Witz et al. 2003).

The reverse side of homelikeness manifested as a lack of adequate ‘organizational’ space and staff’s private space. Organizational space refers e.g. to meeting rooms and staff offices. In some units there were no separate meeting rooms at all; all staff meetings took place in common premises such as residents’ dining rooms. The staff’s offices were also often too small.

“We have our team meetings here [in the residents’ dining room] so that we are accessible at the same time.” (7PUB)

“[The nurses’] office is too small: stuffy, not enough space.” (7PUB)

There was also a lack of staff’s private space, that is, places to have a rest or a break. Separate coffee or dining rooms for staff were lacking, especially in small private nursing homes.

“We eat while we feed the residents – ‘with the other hand’ ... A lunch break would be nice, but it feels like... it is not for us...” (4PRI)

Martin (2002) states that the lack of organizational and private space is connected with the problem of the home paradox and the holistic nature of care work. Although homelikeness of elderly care environments is an essential feature from the residents’ point of view, it may have counter-productive effects on the wellbeing of staff. Constantly being a ‘family member’ may cause problems with coping if there is no pause from the

work even during lunch breaks. Architectural solutions intended to emphasize the homelike effects may strengthen this tendency. Lack of organizational space such as meeting rooms and offices may emphasize the role of care as doing ‘only’ lower-level and physical work. Thinking, alongside other kinds of work, also needs its own space. The aesthetics of the work environment is thus connected to professional identity, status and appreciation issues (Dyer et al. 2008; see also Cunha et al. 2008; Hujala & Rissanen 2011).

Aesthetics as a challenge for management

The management of care is largely the management of wellbeing. Alongside the social, mental and physical dimensions of wellbeing, the aesthetic dimension of wellbeing is worth taking into consideration in care organizations. Organizational aesthetics is always present in care, even though its effects are mainly unnoticed and unrecognized.

We hope that bringing organizational aesthetics in its own right into the wellbeing discourse offers one opportunity to diversify the interpretation of wellbeing. For example, aesthetics may be seen as one part of the wellbeing affordances, the opportunities that living environments provide for action in care facilities (Topo & Kotilainen 2009). The previous wellbeing dimensions of ‘having’, ‘loving’, ‘being’ presented by (Allardt 1976, 1998) as well as ‘doing’ (Niemelä 2010) could be accompanied by a dimension of ‘feeling’, referring to the aesthetic knowledge about how one feels one’s being. On the other hand, delimiting aesthetics as a dimension or category of its own contradicts the holistic nature of the aesthetic approach (Taylor & Hansen 2005).

The findings of our study show that the aesthetic experiences of elderly people living in care homes are often restricted in many respects. In order to enhance the holistic wellbeing of elderly residents, it is important to recognize the significance of everyday life and everyday ‘small’ experiences. It is also important that everyday aesthetics is connected to the earlier lives of residents as well as to the world outside the care home. From the perspective of care staff, organizational aesthetics may influence motivation and commitment issues and thus affect the wellbeing of staff.

The wellbeing of elderly people and the recruitment of professional care staff are the most demanding challenges for elderly care management both in Finland and internationally. The task of elderly care management is to ensure that the living environments of elderly people are satisfying and that the care field is attractive enough to workers, too. Thus, organizational aesthetics may be one of the future competitive advantages of the field and should be taken into consideration at different levels of elderly care management.

For example, at operational management level, aesthetics should be taken into consideration in everyday practices, e.g. in the division of labour and in planning of the staff’s daily work. Further, when new residential premises for elderly people are planned, different actors

should be included in the planning and design process at as early a stage as possible.

At a more general level the issues concerning the living conditions of elderly people and the aesthetic quality of their lives are also a question of societal values. For example, Miguel Pina e Cunha and co-workers (2008, 944) state that food is a very social phenomenon and that the quality of food functions as a symbol for status and respect. Further, Burrell and Dale (2003) emphasize that through space arrangements we are also creating power structures and constructing distinctions between different groups. If we condone the fact that elderly people live restricted lives in poor conditions – and care staff work in unsatisfactory work environments – we may begin to consider that this is a ‘normal’ state of affairs and part of the identity of these groups of people. This kind of ‘material ideology’ (Lundgren 2000) may be influenced through paying attention to organizational aesthetics, in addition to many other relevant issues. For example, aesthetic dimensions could be regarded in quality recommendations and guidelines for designing elderly care premises (see Kälviäinen in this book).

Organizational aesthetics as part of organizational studies was born as a challenge for a cognitive and rational paradigm (Strati 2000). Care homes producing wellbeing services for elderly people need not be “cold places of reason and cognition” (Cunha et al. 2008, 938). Paying attention to aesthetics may result in a novel understanding and wisdom regarding the management of elderly care. Mathieu Weggeman and co-workers (2007, 348) state that in many commercial products “the aesthetic is no longer the ‘software’ around a material ‘hardware’ but more and more the essence, the core of a product and that this tendency is also apparent in many service industries. Residential care services for elderly people – both from the perspectives of residents and workers in care homes – seem to be far from the ideal where aesthetics would form the core of the wellbeing service.

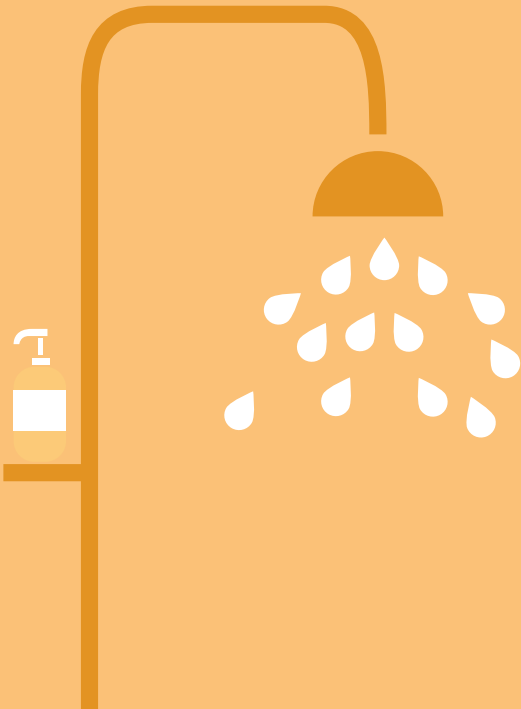
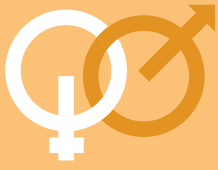
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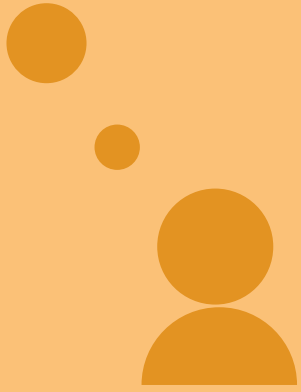
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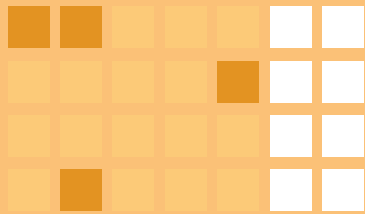
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Working in Care: *Balancing Contradictions*



Multiculturalism in Everyday Care Work

Laura Alalauri & Anneli Hujala

The aim of this chapter is to describe how the members of a care work community discursively construct their social reality. Our original interest in the subject arose from the idea of exploring multicultural organizational culture: How people with different cultural backgrounds together construct the social reality at the workplace and if multiculturalism is visible in this construction. We present a study based on focus group interviews in a Finnish multicultural care organization. The chapter describes the discourses related to care work in general and pays attention to the influence of multiculturalism on organizational culture and everyday life in a care work community.

Social construction of organizational culture

The term social reality refers to the idea that everyday reality is socially constructed and reconstructed in interaction between people. The original notion of the social construction of reality was presented by the sociologists Peter Berger and Thomas Luckman in the 1960s (Berger & Luckmann 1967). Social construction has subsequently been studied by several theorists, such as Kenneth J. Gergen and John Shotter (Shotter 1993; Gergen 1999). From the social constructionists' standpoint organizational reality is considered as an outcome of social processes, being built by continuous discursive practices, that is, in conversations through language (Grant et al. 1998; Marshak 1998; Kuusela 2002; see also Hujala & Rissanen 2012).

The construction of social reality can be considered through the concept of organizational culture. There are several theoretical insights on organizational culture. Since Edgar Schein (1985) introduced this term, researchers in various academic fields have shown interest in the subject. For example, Hannele Seeck (2008) uses Linda Smircich's division of organizational culture: Organizational culture can be seen as a variable or as a metaphor. As a variable culture is seen as something that organizations possess, and researchers are interested in the cultures of successful organizations and attempt to form categories of cultures. Seeing culture as a metaphor means seeing an organization as a culture, as a product of its own culture. Compared to earlier mechanical metaphors of organizations, such as machinery, the culture metaphor highlights the social and psychological processes of organizations and also introduces the idea of an organization as a conscious embodiment of its members.

The discursively oriented organizational theorist Mats Alvesson (2004) claims that organizational culture has a significant role when it comes to understanding and explaining diverse organizational life and behaviour. According to Alvesson, there are two different perspectives on organizational culture research: cultural and discursive. The cultural perspective sees language as a part of organizational culture; language is central in producing culture but the meanings embedded in culture are 'deeper', moderately stable and exist prior to linguistic acts. The discursive perspective, instead, sees the organization as a totally discursive entity. The organization is created through discourses and discursive practices and reality beyond language is nonexistent or at least very limited. Thus, according to the discursive approach, organizational culture is constituted, maintained and/or changed in discursive interaction between human beings and it has no deeper existence beyond discourse.

Here we approach organizational culture from a discursive perspective and see it as an emerging metaphor. Culture is first and foremost constructed through language. Organizational culture is embodied in discourses, which are constructed in social processes.

The workers shape, renew and strengthen existing discourses in their everyday interaction.

In contemporary society, multiculturalism is a fundamental issue that influences and modifies organization cultures (Proudfor & Nkomo 2006; Kymlicka 2007; Lott 2010). In Finland care work communities are gradually becoming more multicultural following the example of other Nordic countries because of the lack of care workforce. Increasing numbers of immigrant workers are needed to ensure the care of the increasing number of elderly people in Finland. Thus it is a very suitable time to analyse how social reality is discursively constructed in care work in general and what kind of influence multiculturalism has on everyday life and organizational culture in a care work community.

Focus group interviews

The focus group interviews of this study were conducted in 2010 in one unit of a nationwide care enterprise in Finland. The unit employed approximately 20 people, including Finnish and eight other ethnic backgrounds. Interviews were conducted in three groups with four care workers in each group, altogether 12 people. Every group consisted of two workers with foreign backgrounds (from Asia and Africa) and two Finnish workers. The interviewees with foreign backgrounds had moved to Finland at some stage in their lives; thus none of them were so-called second generation immigrants. Group interviews took place in the care unit where the interviewees worked. The focus group interviews were based on a theme framework prepared in advance, including the nature of care work, the values of care, what it is like to work with people with different cultural backgrounds and how multiculturalism affects care work.

The focus group interviews were recorded, transcribed and analysed through discourse analysis. Discourse analysis is research based on language and symbolic meanings, analysing in detail how social reality is produced in diverse social practices. Thus the special focus is on how language use constructs, reproduces or changes social reality (Potter & Wetherell 1987; Fairhurst & Cooren 2004). Language neither describes nor mirrors social reality as such, but reality is constituted through discursive practices. In this study the organizational culture of a care work community represents the social reality that workers construct and reconstruct discursively and in interaction with each other.

The salient idea of this kind of discursive research is that the discourses in an organization influence how individuals think and how they make sense of the organization. At the same time, discourses are tools through which members of the organization create the reality that frames their action (Kuusela & Kejonen 2008).

In the following, we will introduce the four discourses identified in the analysis of the interviews. The discourses constructing the social reality of the care work community in question were familistic discourse, humanistic discourse, discourse of excellent care and discourse of

conflicting values. In addition, we consider language problems in general and institutional inequalities related to multiculturalism.

Emphasizing belonging and similarity

Through familistic discourse the members of the work community build and strengthen the sense of community and amplify the uniqueness of this particular group. Familistic discourse is a source of work related social identity and the underlying values of this discourse are collective and respectful towards members and membership of small close communities. Familistic orientation is typical for care work communities in general due to the nature of care work and especially in organizations which serve as a home for elderly residents.

In familistic discourse, which could also be named collective discourse, the work community and its interaction are referred to as family. In the accounts of Katariina and Robert¹ family serves as a metaphor for work community:

Katariina: *This is in a way a family, a small community.*

Robert: *It's more or less like a family here, which is... very positive in my opinion. I mean aa... It's a small place, or... is easy to, to work together as a family, as a big family in that sense.*

[Robert's account was originally presented in English]²

Co-workers are regarded in the same way as family members; they are cared for because they belong to this small community. A difference of opinion may occur every now and then, but they are natural and talked through. In this discourse elderly residents of the care home and relationships between residents and staff are also seen in a family way. Familistic discourse is manifest in conversation through frequent use of first person plural “we” and through emphasizing the importance of team spirit.

In this discourse the special nature of an interviewee's own work community is emphasized best when it is compared to something from outside. In the following extract Evelyn is thinking back to her previous work and colleagues and she sees that the current situation differs a lot from her previous experiences.

Evelyn: *She only thought that on the last day of this month it's payday, that some people don't understand what they're doing. They just work for the pay.*

Interviewer: *mm*

Evelyn: *But it's a bit like. Here I've noticed that we are close and friendly and...*

1 The names of the participants have been changed.

2 The interviews were conducted in Finnish and the accounts were translated into English. Accounts presented originally in English are so noted in the text.

Leena: *It comes straight from the heart and*

Evelyn: *Yes, from the heart. We hug a lot here and kiss and...*

Although familistic discourse is commonly used for constructing togetherness and cohesion of the work community, it can also be used for placing people or groups outside the community. In the following, the personal pronouns are used again, but with different consequences. Leena rather separates the workers of foreign background as a group of their own by using the personal pronouns so that she detaches 'different nationalities' ('you') from the 'original' work community ('we').

Leena: *What have you yourselves felt, how have we received you in this workplace?*

Evelyn: *You?*

Leena: *Yes, you.*

Evelyn: *(laughs)*

Leena: *Well different nationalities...*

Familistic discourse mainly sees multiculturalism in a positive way as a resource. On the one hand, strong communality and the emphasis on 'togetherness' calls for similarity of organization members, which may be seen as a pressure to assimilate. Partly this kind of orientation may diminish the benefits gained from the diversity of multicultural organization. In practice the salient question may be how easily workers with multicultural backgrounds are accepted as 'family members' and whether there is a danger that the familistic discourse will be used to distinguish some groups from others.

Respecting diversity

Humanistic discourse defines how organization members view the idea of humanity and diversity. Respecting diversity is apparent in the talk of a care work community in a way that cannot be regarded as mere tolerance. Diversity is seen as a resource rather than as something that needs to be tolerated and managed. It is in everyone's interest that the members of a work community have different types of skills, everyone is good at something and contributes to the work with their own skills.

Katariina: *Certainly that each one can give something to it, that no-one is so omnipotent and perfect that necessarily, that... It may be that Irja notices something and then I am like...just like that. So here we all do this work together, that if so many of us were not needed here, then there would be just one person who did it all (laughs) so that*

Katariina: *That*

Irja: *one grows*

Katariina: *to complement one another.*

The humanistic discourse constructs a picture of the work community whose functionality is composed of a combination of the different skills of individuals. Everyone is good at something and everyone is

able to participate according to their own competence. Co-operation between different people can be based on the like-mindedness of actors or on broad acceptance and tolerance (Vartiainen-Ora 2007). Like-mindedness emphasizes similar values and strong team spirit. Broad acceptance and tolerance, instead, highlight that it is important to understand different ways of working and thinking. In the humanistic discourse of this work community, respect for diverse work methods and perspectives was underlined, which implies broad acceptance.

The humanistic discourse emphasizes the uniqueness of human beings and human dignity that is independent of one's cultural or other uniqueness. For example, Evelyn from Africa states that the quality and nature of care are not dependent on culture (such as being an African), but dependent on a human being herself.

Evelyn: *In my opinion it doesn't depend on cultures, it depends on the person*

?: *mm*

Evelyn: *Different care, do you understand?*

Leena: *No.*

All: *(laughter)*

Evelyn: *That*

Mary: *Good*

Evelyn: *you can care*

Leena: *Explain*

Evelyn: *for residents differently from me, but it doesn't mean that... because I am*

Mary: *Yes yes*

Evelyn: *an African*

Leena: *mm*

Mary: *Ahah! Good*

Evelyn: *and you are a Finn. It is just...a human being.*

From the point of view of multiculturalism the emergent approach on organizational culture is in focus in the humanistic discourse. The individual is considered an active actor with perspectives and ways of doing things that are independent of her/his culture (Fougère 2005; Heikkinen 2009). Respecting different points of view can be seen in a positive but also in a negative light. Regarding tolerance, the members of the work community seem to have at least some understanding for the racist attitudes of elderly residents towards the foreign members of the care work community. The following extract also shows how Evelyn, who has herself faced crude racist namecalling, remains typical for the humanistic discourse as regards tolerance.

Evelyn: *I don't, it doesn't, I react to nothing. But some people might get upset. I don't get upset at all. Quite the same... I loved one resident who*

Ulla: *mm*

Evelyn: *sometimes says that*

Ulla: *soot*
Evelyn: *blacky (laughs)*
Leena: *(laughs)*
Ulla: *Yes and blackface and all sorts*
Evelyn: *Yeah*

The ideal of good care

The discourse of good or ‘excellent’ care is a sort of an ideal of care pursued by employees and to which ones’ own work is compared. In a similar way to the familistic discourse, the discourse of good care is also characteristic of care work in general.

Care workers’ professional identity and appreciation of care work is produced and maintained within this discourse. In the following extract, Ulla, who has worked in the care field for a long time, and Evelyn and Leena define what it is like to work in care.

Ulla: *Well, now, on the one hand it is heavy work, but it also rewards the worker, so, like, it’s really nice to see that some resident thanks you for it, or then you get a smile from some person who cannot speak and*
Evelyn: *mm*
Ulla: *So that you, like, feel you are really needed and*
Evelyn: *mm*
Ulla: *And that, well, for me this is valuable work.*
Leena: *Underpaid*
Ulla: *Yeah, mm*
Leena: *Valuable work, so that you have to have your own character*
Evelyn: *mm*
Leena: *Character that you go in for this care kind of care work.*

In the discourse of good care, the moral basis and norms of care work are constructed and suitable ways of working are negotiated. In the following account Irja articulates explicitly what she finds most important in her work.

Irja: *Yes it like, having respect for such an old person*
Katariina: *mm*
Irja: *It’s important*
Katariina: *It is*

However, this discourse also makes it possible to criticize co-workers’ work and refer to different conceptions of the ideal of excellent care. When different values lead to different ideas of what good care is about, cultural and individual differences in ways of working also become visible in an ethos of good care. For example, Colleen from Asia emphasizes diligence and the tendency to work hard when describing her own style of working and wondered how her colleagues had time for sitting about while working. In Colleen’s account ‘we’ refers to her national identity and ‘they’ to her colleagues.

Colleen: *If you are in the work, so we are used to work work and work, we have no times specially we we are sitting*

Robert: *mm*

Katariina: *mm*

Colleen: *and that's why, I'm used if we are in the work, I'm used to work, work*

Robert: *mm*

Colleen: *And sometimes I, I, I observe that aa maybe, I understand also, that maybe they are tired and that's why they are sitting.*

[the original accounts were presented in English]

Cultural variation in attitude to old people was also apparent. Those from Asian cultures especially favour having respect for old people and perhaps a hierarchical attitude to old people is also obvious in Colleen's comments.

Colleen: *I want here to serve them, to make them happy. Because they are old people and they need our help. They are incapable some of them are incapable to walk. So I think they need us. So I'm here to serve them.*

[Colleen's account was presented in English]

Differences in treating elderly people also emerge in the choice of words. Mary, who originally came from Asia, uses the word 'love' when she describes her relation towards patients.

Evelyn: *Whom do you love, now I was a little...*

Mary: *Aah...the carer loves...*

Evelyn: *resident?*

Mary: *Resident.*

Evelyn from Africa emphasizes the reciprocal interaction between staff and elderly residents. She feels that care workers also get something important for themselves from the elderly.

Evelyn: *We always say we help the residents... we help, but THEY help us, too. Sometimes I have a really bad day and I come to work. And for example as soon as I talk to somebody, or one resident, with the residents*

Leena: *mm*

Evelyn: *I straight away feel good.*

The ideal or ethos of good care can be considered as a wider discourse to which the following discourse of contradictory values is subordinate. In the challenging work conditions of the care community, the ethos of good care is justified and defended through the conflicting themes embedded in the following discourse.

Balancing between contradictory values

The discourse of contradictory values includes two contradictory but closely related themes: emotional work and efficiency. Through the theme of emotional work it is possible to understand the work as

something done with feeling. The work is not mechanical, the worker can make use of the feelings involved as a tool and hence one important aspect of care work done with feeling is the ability to control one's emotions. As a result of this emphasis on emotion involved in the care work it is possible to create a humane and valuable work reality. Sometimes the relationship of the care giver and the care receiver will evolve into a really close relationship and in this case it is important that the care giver is able to use his or her emotions as a tool and is able to control them when needed.

Working with feelings involved is something that is valued in the work community and is highly appreciated as an ideal of good care. However, this ideal of good care cannot always be achieved because of factors such as staff resources, economy measures and time resources. These factors, among others, are quite challenging for the ideal of good care and lead to care givers working mechanically or following a routine. Whereas the theme of emotion/emotional work is accomplished through individual worker reflecting the ideals of the work community, the theme of efficiency is based on the management of the organization. It is the employer and not the employee who constructs the theme of efficiency. This leads the employee to feel powerless when faced with demands that he or she cannot change while trying to fulfil the ideal of good care (in the work community).

Tero: There could be a few more workers when there are severely demented people, and they if anybody need time and talk and and and what takes time that there it's it's not like conveyor work and this is not at all a suitable place for it so that's why there should be enough workers, but the situation is what it is.

The theme of efficiency constructs reality with not so much value for emotional work, the emphasis being rather on the demands of efficient physical work. This, furthermore, lowers the appreciation of the work and, according to the care workers, the demands of efficient physical work consequently impair the quality of life of the old people who are the receivers of the care. Moreover, the accelerating pace of work is a risk for the wellbeing of the employees and the attitude of treating them only as a pair of hands accomplishing physical tasks instead of as human beings working in a meaningful and interactional environment has an impact on the appreciation of the meaningfulness of the work accomplished.

Broadly speaking the theme of efficiency is usually considered as a pressure from the employer. In some cases the demand for efficiency was also experienced as a good tool for individual work methods. For example, the input in the discussions by one of the workers, the African Robert, clearly indicates that he appreciates a strict pace of work at least in his own work style and in the next extract he describes his personal working techniques.

Robert: *For example I I like to work very fast. And sometimes*
 Colleen: *m-hh*
 Robert: *I just [unclear word: except?] this person also to go to that pace, but then I come to myself; oh come on, okay, he or she is a different person*
 Colleen: *Yes*
 Katariina: *mm*
 Robert: *I have to slow down*
 Interviewer: *mhh*
 Robert: *because if I don't [unclear word: take care?] I can do the work for the two of us I can do it*
 Katariina/Interviewer: *mhh*
 Robert: *with ease on short time. So that is also another thing, but yeah.*
 [the original accounts were presented in English]

It is interesting why it is just Robert who appreciates the efficiency and ability to work fast more than other employees. The reason for this behaviour may be his language skills, he hardly speaks Finnish, and by emphasising efficiency it is possible for him to bring out the strengths of his working style. In the hectic atmosphere of today's working life, effective working can be understood as a virtue of a worker. Efficiency is recognised as a valuable tool, but not at the expense of feelings.

Through the discourse of contradictory values, the holistic picture of working principles is constructed. In addition, this discourse enables workers to justify their own ways of working as well as their personal choices and prioritizations related to work. These may be partly justified through cultural differences, too.

To conclude, through the discourses described above care workers create the meanings of their everyday work, and at the same time, these discourses guide the actions of the workers. Different discourses have their own function in the culture of the work society; they are used to justify one's own ways of working, maintaining professional identity or communality and to consider how to react to differences and handling moral questions of the multicultural work society.

Language gap and ethnic inequality

According to this study, the important aspects of multiculturalism were the problem of language skills and the so-called 'institutional racism', that is, inequality based on ethnic division of labour.

In the group interviews, the most obvious element of everyday multiculturalism was the communication through different languages. In the following, Robert is formulating the problem of interacting with clients:

Robert: *I personally find that the challenging is my aaa language, because of the language barrier I am not able to, aa, sort of, integrate well with*
 Interviewer: *Right*

Robert: *the with with the clients*

Interviewer: *Okay*

Robert: *That would [unclear word?] so perfect for me, if I could, sort of, interact with them more.*

Katarina: *mm*

Robert: *I miss I miss doing that, you know just,*

Katarina: *mm*

Robert: *getting close to them, that is what is lacking, but yeah.*

[the original accounts were presented in English]

In the interaction-centred care field the common language is a salient factor as regards fluent working. Some of the workers of foreign origin did not understand or at least did not speak Finnish, while some Finnish workers did not speak English. The language skills of the elderly residents were restricted to Finnish, and naturally they were not assumed to communicate in any other languages. This resulted in situations where workers had to help each other when the language skills of the workers and elderly people did not match. This is an obvious challenge for cooperation between elderly and staff.

The lack of a common language impedes equal discussion between organization members, because they have not similar resources to take part in the construction of the discursive reality of the work society. Those workers to whom both Finnish and English were challenging languages were in a particularly disadvantaged position. Those with better language skills have easier access to discursively fluctuating realities of work community and thus they also have more power in producing the social reality of the work society. For example, they can probably influence the division of labour more than those with less adequate language skills, and may thus have better opportunities to get more diversified work.

In the work community of this study the language problems were resolved so that language-skilled workers interpreted between other workers and clients.

Colleen: *Aa, for me, working together is very nice. Specially, aa for my language, I am not good in Finnish. So if some of my patient ask me and I don't understand, I have some someone to, to ask for example Katarina. Katarina, could you please interpret what she say.*

[the original account was presented in English]

Assisting in interpreting is concrete help but it is also part of the interactive relationships and organizational support. For instance Lotta Kokkonen (2010) in her study on immigrants has noted that assistance in language skills is also experienced as an emotional support and may increase the feelings of acceptance and being part of work community.

Lack of language skills was also found problematic by a Finnish worker, who could not speak English.

Irja: *Although we don't even see him [indicates a worker of foreign origin] every week necessarily...But I don't know if I always understand him but many times try to explain so maybe it goes [laughs]. Or through somebody else then... So the language sometimes...because I can't like speak [other languages], of course it makes difficulties.*

One of the key assumptions in multiculturalism is that the mainstream culture accepts and does not suppress cultural differences and does this through coexistence, instead of integration (Prasad et al. 2006). From a multicultural point of view, the idea of the coexistence of different cultures is fulfilled here. Irja apologizes for the deficiencies in her own language skills and lack of a common language, thus it is not an automatic assumption that only those with foreign backgrounds should assimilate to the majority language.

More generally it is extremely important that organization members have a common language. It enables internal communication between colleagues and clients and is also important for safety at work. As the care sector becomes increasingly multicultural, language skills should be taken into account in recruitment. Employers should also pay attention to the language proficiency training of staff.

Professional hierarchy is conventional in the care field and inequality based on ethnic origin may perpetuate the convention of hierarchical order. For example, Jeanette Laurén and Sirpa Wrede (2008; 2010) discovered that the hierarchical nature of the care field may enable an ethnic hierarchy where immigrant workers are assigned to a lower level in the hierarchy. Thus ethnicity may emerge as a new hierarchy, together with the traditional hierarchies of profession, gender, age and education. For example, management practices, including division of labour, may lead to the emergence of an ethnic hierarchy and confirm its existence. The organization's general attitudes towards prejudiced and racist clients may also promote an ethnic hierarchy and inequality in the work community.

In this study, no ethnic or any other kind of internal hierarchy between the workers was in general perceived in the interviews. However, Irja's account of the importance of talking with clients contains a tacit assumption of division of labour on ethnic grounds. Irja implies that Robert, who cannot speak Finnish, could concentrate on the basic care of elderly clients while she herself can give them more in an interactional sense. Thus here the lack of language skills is associated with inequality issues.

Irja: But you come to it, this thing that if you can't speak

Robert: *mm*

Irja: *like I can speak Finnish for instance*

Robert: *mm*

Katariina: *mm*

Irja: *So then you get for example because you can't speak Finnish in the same way about those things that those people... since we are in*

Finland, we are Finns.

Robert: *mm*

Irja: *I know about these people in a way*

Robert: *mm*

Irja: *because I have own parents and in a way the grannies and all*

Interviewer: *mm the culture so*

Irja: *I know the background*

Katariina: *mm*

Irja: *and for example I can give them maybe more then*

Robert: *mm*

Irja: *than you, then you can then do like those, those care things.*

Multiculturalism and care work

Care is a culture-dependent concept as such (Harrington Meyer 2000) and the multiculturalism within care field brings out further questions and challenges. In a multicultural work society, the diversity of cultural backgrounds and possible differences embedded in the values of diverse cultures are part of the social construction of care work. However, it seems that somehow elderly care is quite a universal issue in different cultures. At least in this particular study the general discourses of care appeared to rise above multicultural discourses, because multiculturalism had already become an established part of everyday practices of care work.

In Finland, the process of the multiculturalization of care work is in its early stages compared to other Nordic or Western countries, but the consequences are already apparent. Global labour markets have increased the number of care workers of immigrant origin. Because of the shortage of labour in the care sector, recruiting multicultural workforce is becoming increasingly topical in Finland, too. The main recruitment processes have been targeted at Asian countries such as Thailand and recently, during the current European recession, at Spain. In many other European countries the multicultural nature of the care sector is already a normal part of everyday care work.

Multiculturalism is always related to questions about humanity and how to cope with diversity. Multiculturalism is also assumed to be an important managerial issue in the elderly care sector in the near future, including those countries where, as in Finland, it has so far been a minor issue from the management perspective. In future, not only staff but also the clients of care will have different cultural backgrounds as the population of immigrant origin ages. Knowledge of cultural differences will be needed and multiculturalism must also be taken into account in the management of care organizations. The conventional understanding of the basic values of care, the ideal of good care and, through these, also the definition of wellbeing of both elderly people and care staff may be subjected to change when the social reality of work is constructed and reconstructed within the framework of multiculturalism.

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Care Work in a Swedish Nursing Home: Gendered Norms and Expectations

Palle Storm

The picture of a traditional care worker is changing. Nowadays more men and immigrants of different backgrounds are working in nursing homes. This chapter describes and analyses how gender, interacting with ethnicity and sexuality, is expressed by male and female care workers in a Swedish nursing home. What kinds of feminine and masculine stereotypes occur and how is care constructed by different care workers? It seems that the intersection between various identity categories, such as gender, ethnicity and sexuality will create different opportunities and limitations for the care workers in the increasingly diverse nursing homes of the future.

The dualistic picture of a care worker

The normative picture of a “real care worker” is a white, middle aged, heterosexual woman with a working class background (Sörensdotter 2008). This picture is changing. In Sweden more men are working in this sector and, as in several other Western countries, more women and men with immigrant backgrounds are paid care workers (Jönson 2008; Anttonen & Zechner 2011; Jönson & Giertz 2012). However, in the Nordic countries there has been very little research on whether the more heterogeneous composition of the care workforce has affected the everyday life of care.

Care work has been a focus for feminist scholars for a long time. As Fine (2007) points out, feminist researchers were the first to discuss and analyse the concepts of care (see also Anttonen & Zechner 2011). In the body of feminist research on care it is possible to identify some core perspectives. From a *social policy perspective* many feminist researchers have drawn attention to the Nordic Welfare model (e.g. Lister 2009). Compared with the Anglo-Saxon countries, the Nordic countries are characterized by generously funded services provided according to individuals’ needs, not to their purchasing power (Szebehely 2005). It is also characteristic of the Nordic countries that a comparatively larger proportion of women are gainfully employed – with many of them working in the publicly funded care sector. This has led to an extensive discussion from a social policy perspective about the importance of the Nordic welfare state for women’s lives as mothers, workers and informal carers but less so about the consequences for paid care workers (Dahl 2000; Anttonen 2002).

In the *philosophically oriented* feminist Anglo-Saxon research on care, two perspectives have dominated. According to Wærness (2005), one perspective has focused on the positive aspects of care, and has described care as something valuable in women’s lives. The aim of this stream of research was to make care more visible and valued. The other perspective has focused on care as alienating work based on the oppression of women, and this approach has been criticized for disregarding the positive aspects of care. Both perspectives were developed in the 1980s, and in the Anglo-Saxon tradition these studies have focused mainly on women’s unpaid care work for family members rather than on paid care work (Abel & Nelson 1990; Anttonen & Zechner 2011). In contrast, in the Nordic countries feminist scholars have investigated the everyday lives of paid carers and the organizational conditions under which the work, particularly home care, is carried out (Eliasson-Lappalainen & Nilsson-Motevasel 1997; Wærness 2005)

Does the fact that feminists have long been interested in care work imply that we do not need more studies on care work from a gender perspective? In a review of Nordic research on working conditions in elderly care, Trydegård (2005) distinguished two trends. Firstly she found that the home care sector has been more studied than the nursing home sector. Secondly, she found that even if most studies note that the

sector is female dominated, this does not mean that a more theoretical gender perspective has been used. Care work is still under-theorized from a gender perspective (Gunnarsson & Szebehely 2009) and we know even less about the intersection of gender, ethnicity and sexuality in the elderly care sector.

The aim of this chapter is to analyse and describe how gender, interacting with ethnicity and sexuality, is expressed by male and female care workers in a nursing home. How do the norms and expectations of these categories affect the care workers, and does the interplay between the categories generate different challenges and limitations for the individual care worker in the everyday life of care?

Gender in paid care work: a Swedish perspective on research

In this review I have concentrated on Swedish research around gender in elderly care. Firstly, there is no doubt that elderly care is a female dominated area. National statistics indicate that in Sweden more than 90 per cent of the workers and 70 per cent of the care receivers are women (National Board of Health and Welfare 2004). As mentioned in the introduction, (increasingly) more men, and more women and men of non-Swedish origin are working in the elderly care sector. In Stockholm today more than 40 per cent of care workers were born outside the Nordic region, the vast majority in countries outside Europe. While only a small proportion of care workers born in Sweden are men, one in four care workers born in Africa, Asia or Latin America are men (Szebehely 2010).

The issue of the low share of men in care work has raised attention in the Swedish gender equality debate, but the discourse about more men in care work could be described as normative and stereotyped. Common arguments are that more gender mixed groups would improve working conditions, that more men would increase the status and visibility of the profession, and that male clients need contact with other men. Notions like these often ignore differences within the group of women and men. Furthermore, these assumptions have taken for granted that women always perform femininity and men always perform masculinity.

An important contribution to the Swedish research on gender in elderly care was a study conducted by Anders Bergh (1995). Through participatory observation he studied the expression of gender in home care and in nursing homes. He found that expressions of gender were more obvious in the home care sector. He argues that traditional norms in domestic tasks in the home have shaped a female standard for the occupation, which in turn has led to different expectations of women's and men's abilities. For example, some home help clients did not expect that men could manage domestic tasks as well as women and male care workers might therefore be over-appreciated for simply doing the job. At the same time the male care workers' ability to manage the work was called into question. Furthermore, some female clients refused to accept

help from men, particularly help with personal hygiene. From this point of view, male home care workers were questioned more than women.

Bergh did not find this same gender pattern in nursing homes. In the nursing homes women and men were expected to work in a similar way, and men's physical strength was seen as an advantage. He concluded by arguing for the importance of considering the meaning of place in analyses of gender whereby nursing homes are places that restrict the expression of gender.

Many studies on gender in care work draw attention to the fact that male care workers may be rejected by both female and male clients (Andersson 2007; Sörensdotter 2008; Storm 2009). Therefore a core question is how gender equality can be achieved in a work environment where men are not always wanted as carers and co-workers (Johansson 2002; Lill 2007). From an everyday life perspective this can also be problematic for female workers. As Andersson (2007) stresses, female care workers have to help all those clients who refuse help from men, which can lead to extra workloads for the women. Some of the women in Andersson's study on home care also highlighted that their male colleagues could be sloppy as regards domestic tasks in the client's home. Therefore Andersson raises the issue whether more men in the elderly care sector may actually contribute to the subordination of female care workers.

Sörensdotter (2008) found in a study on gender, class and ethnicity in home care that both women and men can contribute to the process of perpetuating the traditional expectations of gender. In a gender mixed home care group she noted how traditional norms about men and masculinity were reproduced despite the fact that men were in the minority (see also Storm 2009). This suggests that traditional assumptions about gender can also be reproduced in a context where women dominate numerically.

Gender, ethnicity and sexuality in a qualitative study

My theoretical standpoint is to regard gender as a central factor that organizes society, and renders our bodies and actions understandable. But gender, as a separate category, is not enough to analyse social life and inequalities between women and men. Other factors such as class, ethnicity, sexuality and education must also be taken into consideration. Harding (1986, 18), for instance, stresses that "gender is always also a racial category and race a gender category." This perspective, of analysing the interplay between different aspects of identity is often conceptualized as *intersectionality* (Phoenix & Pattynama 2006).

Critical men's studies are another set of theoretical perspectives that have broadened gender studies. This approach has explicitly argued that masculinity must be analysed in relation to other identity characteristics. Connell (1995) emphasizes how masculinity should not only be analysed in relation to women; relationships among men can also shape different

kinds of hierarchies that can produce subordination between groups of men.

In this chapter I analyse gender and other characteristics of identity as processes that we constantly express in our interactions with others. According to West and Zimmerman (2002, 13) to do gender means “...creating differences between boys and girls, and women and men, differences that not are natural, essential or biologic.” This perspective considers femininity and masculinity as an effect of social and cultural convention, not as fixed or essential characteristics (Connell 1995). To understand the expression of gender it is important to analyse more than the individual expression of gender. Harding (1986) and others conceptualize gender as three dimensions: the individual, the structural and the symbolic. Harding notes the importance of how these dimensions interact with each other and that we need to keep them in mind in order to understand the importance of how gender affects society and social life.

In this study I have chosen to interpret my material in relation to gender, ethnicity and sexuality, and, inspired by the intersectionality perspective, I have analysed the interplay between these three categories. The empirical part of this chapter is based on a qualitative study conducted in a small-scale nursing home in Stockholm. The facility had seven floors, with ten residents living on each floor. All residents had their own apartments with a kitchenette and bathroom. As in all Swedish nursing homes, residents brought their own furniture and belongings when they moved in. All meals and common activities took place in the combined kitchen and living room on each floor. In terms of size, architecture and interior resembles most Swedish nursing homes (Szebehely 2009).

I observed the daily life in one of the care home units where eight women and two men lived. All residents had physical or cognitive disabilities and all were in need of extensive care. Eight care workers, five women and three men, worked in the unit. All of them were assistant nurses, and all had worked more than eight years in the elderly care sector. Four of them were born outside Europe. This study draws on two months of ethnographic field-work and interviews with care workers. I made observations during both day and evening shifts. Some days I followed a care worker for a whole shift, other days I spent time in the unit to achieve a more general impression of the daily life of the nursing home.

I also conducted interviews with six of the care workers, three women and three men. The interviews were held after I had made my observations, which gave me the opportunity to ask the workers to reflect on some of my observations. For me, this led to a more profound understanding of my observations.¹

1 A more extensive description of the methodological and analytical procedures is presented in Storm 2009.

Norms and routines as gender neutralizers

During the interviews most of the care workers reflected on the nursing home routines and norms. These routines and norms were something that both women and men had to adjust to, and were seen as a contrast to individual behaviour. Some of the workers argued that gender did not matter; all of them had to perform the work in the same manner.

Even if they described gender mixed work groups as stimulating they argued that gender did not matter in this nursing home. This argument was based on existing norms that the entire staff was supposed to work in the same manner. In my study, as in other nursing home studies, standardized norms and routines affected the care workers' freedom to adapt their daily work to the varying needs and habits of particular residents (see Harnett 2011).

Well, you check that they eat and move themselves. When they live at home they do as they please, even if it is bad for their own health. In the nursing home, the residents feel much better when we are arranging things, but it may be bad for them not to make a single decision. But I don't think it is bad, rather necessary. Otherwise they would not eat or maintain their hygiene, so routines are important. (Female care worker)

This statement reflects some of the care workers' attitudes towards norms and routines. Almost all of them described how their discretion was limited by organizational demands. During my observations I noticed one principle that characterized the work: *the principle of interchangeability*. This principle was not openly stated, but was rather an internalized norm, and could be understood in the light of the heterogeneity among the staff.

The work group was very diverse in terms of gender, age and ethnicity, and there were also many workers employed by the hour in the nursing home. This led to a wide variation of care workers during the day. Some parts of the day only women worked, at other times of the day there were only foreign born men and so on. Therefore it was important for the organization of the everyday life of the nursing home that residents would accept help from all the care workers regardless of gender or ethnicity. Even if the care workers told me about the importance of being nice and empathetic in care encounters, it was important for the organization that all workers were interchangeable. This could be one reason why they initially tended to under-emphasize the impact of gender and other characteristics. However, parallel to these more gender-neutral descriptions, the interviews and observations indicated that the workers did have expectations about gender, and that in their minds gender was clearly connected to specific skills and experiences.

The feminine stereotype: care as a feminine ability

During the interviews, I asked the care workers to reflect on differences between women and men, and how these differences were manifest in their daily work. Female care workers pointed at a distinct difference between themselves and their male colleagues: they situated their own ability to care to be female, and argued that the capability to do care work existed in every woman.

As women we have, especially if we have kids, tenderness, an ability to care. We have male colleagues who are nice and warm too, so it's hard to say. But I think women have the love and care within themselves more naturally because we have children. The gentle side is needed when you care for a person. We have a feminine way to handle a particular situation. So I think it would be a pity if too many men came to work with care, but it's good that not only women work here. (Female care worker)

When female care workers talked about the connection between women and care work, they described care as an inherent ability that women have been socialized into by their life experiences. They also stressed the similarities between their paid care work in the nursing home and the unpaid care work they carried out in their families. For example, one woman stated, “*I do ordinary domestic tasks; just like I do at home you can say*” when she described her work. Several also mentioned similarities to the private sphere by talking about the residents in a family discourse: “*I treat her like my grandmother.*” None of the male care workers talked about the work or the residents in this manner. From this point of view women care workers did not draw a clear boundary line between their private sphere and the work sphere.

The women’s statements regarding care can be analysed from two perspectives: norms about *women* and norms about *care as work*. Norms about women often draw attention to women as more care-oriented than men. In a study of women’s work in a nursing home, Franssén (1997) writes how female care workers talked about the importance of being caring towards the residents. But in the everyday work she noted that most of them preferred to spend time with their colleagues rather than with the residents. Franssén’s conclusion suggests that the women care workers’ statements about being care-oriented must also be analysed in relation to normative assumptions of what is the expected behaviour of a “real” woman.

The symbolic values connected to care work can also be used to analyse the women’s statements. As Harding (1986) writes, female coded values are often less recognized than those connected to masculinity. Related to care, England (2005) uses the concept of “devaluation” to interpret how cultural ideas about women and care work can explain the low status and payment of this work.

Care researchers emphasize that care is not only about practical tasks but also has emotional and relational aspects (England 2005).

The skills needed, the content of the work, and the results cannot be as easily measured as they can in many other occupations, in particular jobs dominated by men. But the emotional aspects of care work are often undervalued compared to the more obvious aspects of the work. From that point of view, the women care workers' talk could be understood as a strategy to upgrade themselves and their work as proper wage labour. As James (1992) states, it is the physical components of care work that are most visible and are therefore acknowledged as "real work." This became obvious when I asked the care workers to reflect about the male worker's abilities.

The masculine stereotype: physical strength and efficiency

In contrast to the more diffuse talk about women's caring capacity, when they talked about the male care workers' skills, the care workers focused on practical tasks. None of the men mentioned women as being generally more care-oriented than men. Instead they considered the connection between women and caring as an effect of social conventions which could be challenged. From the interviews two main stereotypes around men emerged – the *physically strong man* and the *rational and efficient man*. The most deep-rooted stereotype was the idea of the physically strong man. The men I interviewed did not question this assumption; rather they described it as something natural.

If we take service as an example, like cooking, women have been at home with their children and have cooked and so on, and then it has been seen as an ingrained behaviour. But – how can I explain... – it's a habit and it can be changed. But you cannot change the fact that men are physically stronger than women. Sometimes it happens 'can you help to lift, you're a guy', you know? I'm a guy and I'm strong. (Male care worker)

In a similar way, the stereotype of the rational man was well established in the nursing home. Even if there were solid gender-neutral norms in the workgroup stating that all should work efficiently and in the same manner, with the residents' best interests in mind, the workers claimed that male workers were those who best embodied the ideal. They also contrasted men's way of working to women's more complex way of organizing work.

Yes for example, if it's about the residents or something else we [women] have to do it in the same manner, but everyone wants to do it in different ways, and we cannot come to a decision. This does not happen when you work with guys. I love working with guys, I could imagine working only with guys. (Female care worker)

However, when I compared the talk about men's strength and efficiency with my field notes a paradox emerged. I could not see any obvious differences between women's and men's ways of working. If the residents were physically heavy the staff – both men and women – used a lift or two workers helped each other. Neither did I observe any signs of men

being more efficient than women in their actual work. One difference between women and men I did observe was that some men were rather private and rarely discussed their family life or other private issues with their colleagues as most of the women did. Instead the men's talk could be described as more work-oriented. This boundary between the private sphere and work-oriented talk might be one reason why they were perceived as more work-oriented than women.

Not one of the men questioned the assumptions about the strong and efficient man. One reason why the men did not challenge these stereotypical assumptions could be because this discourse coded men as carriers of something qualitatively different from women. This could also be understood in relation to the fact that the presence of men could create problems. The workers had experienced that both female and male residents might avoid receiving help from men, even if this was not a major problem at the time of my study. But in relation to traditional gender norms, the men were those who represented the "different gender", and sometimes, the unwanted gender.

By talking about the strong and efficient man, the male care workers were positioned as carriers of something different, which could be seen as a way of legitimizing men's position in the workplace, and could act as a boundary line between them and the women (Williams 1995; Storm 2009). It also gave them the opportunity to perform and do masculinity in their everyday work. I interpret the fact that both women and men were involved in maintaining the discourse about the strong and efficient man as a production and reproduction of a traditional gender order despite men being in minority.

Gender in interplay with ethnicity and sexuality

The meaning of ethnicity was an issue that engaged many of the care workers; probably because several of them were born outside Europe and had darker skin. The interviews and observations also clarified the connections between ethnicity and skin colour. For example, no one talked about ethnicity in relation to whiteness. The meanings ascribed to ethnicity varied depending on its interplay with gender. Ethnicity could create problems in the everyday life of the nursing home as many of the workers were born outside Sweden while all the residents were born in the country. Some of the residents refused to accept help from a care worker with a non-white appearance. Both women and men born outside Sweden told me about situations when they were mistreated by the residents because of their skin colour. This is in line with earlier Swedish studies that found that older people may refuse help from care workers who do not look Swedish (Lill 2007; Jönson 2008; Storm 2009).

Although workers claimed that some of the residents tended to avoid help from foreign born staff, it seemed especially to affect the male workers. One reason could be that some of the residents in the nursing home, as mentioned earlier, avoided help from men generally, irrespective of the men's ethnicity. Therefore some of the foreign born

male care workers could be excluded in two ways: as men or as foreign born – and sometimes as both. Foreign born, male care workers also had to defend their work and their competence to some of their female colleagues. Unlike the female care workers (irrespective of ethnic background) and the Swedish born male care workers, foreign born men met doubts about whether they really did the work with passion or whether they had chosen care work only because they could not get another job.

Many of the men who work here do it because they have to, there's a lot of men here, foreign born. I have seen how some of them are a little bitter about it. They would like to do something else, but there are no other jobs. In contrast, women can do it more from the heart. You can see they are not pleased with the job. They don't have to be bad at work, but you can see they are not happy. (Female care worker)

Stereotypes of foreign-born male care workers can be described as an effect of the interplay between race and gender, and interestingly, were only expressed by female care workers. One interpretation of why this particular category of men was more questioned than others is in line with Lill's (2007) discussion about gender and class. As Lill writes, a working class man is rarely associated with care capital. The image of working class men is often connected to physical strength and aggressiveness, not to caring activities. Similar stereotypes are also common in relation to men of non-European origin (Jonsson 2007). The result of such stereotypical norms is that foreign-born male care workers were the group who had to struggle the hardest to be recognized as competent and confident care workers within the nursing home.

In the interviews and observations, homosexuality was noted as a subject many care workers referred to. When the care workers spoke about homosexuality it seemed to be implicitly related to Swedish-born men. Female and male care workers of foreign origin were assumed to share a heterosexual identity. Homosexual care workers were coded as a category of worker with special abilities to work in care.

Bildt and Sahlström (2006) stress that “non-heterosexual men” in female dominated jobs often thrive at work. Among the possible explanations they mention is that these men, ‘despite’ their sexuality, are still men, with higher status than women. A strong discourse in this nursing home was that homosexual male care workers could combine more female coded attributes such as caring and kindness, with more male coded attributes such as strength and efficiency.

Well, they are a bit feminine, but it is no problem. All I know are working well and are kind. But gay men are also efficient. You notice when working with a gay man. The work is done more quickly than if you are working with three women. (Male care worker)

The talk about the homosexual workers was characterized by various stereotypes. The most prominent was that this category of workers

could combine traditional masculine characteristics such as strength and efficiency, with the female coded characteristics of being gentle and caring. Homosexual men were also the most valued category of all the care workers. Yet this prominent position had a price. For the homosexual men the stereotypes gave them a high position in the workplace, which could be seen as something positive. On the other hand, these stereotypes limited their freedom to express other dimensions of masculinity.

Conclusion: gender, ethnicity and sexuality matter

A nursing home is a contradictory place, and has different meanings for different people. For the residents it is a private home, for the employees it is a place for wage labour where they earn their livings. This implies that the daily life in a nursing home occurs between private and public spheres.

The care workers' talk about gender was obviously influenced by these contradictions. On the one hand they described their work as routine-oriented labour with limited opportunities to act outside standardised norms. On the other hand they stated that gender, ethnicity and sexuality had meaning in the daily work of the nursing home. It appeared that gender-neutral descriptions existed mainly on the surface. During the interviews and observations a clearer picture emerged whereby men and women were seen as carriers and doers of separate abilities and skills, in an interface with expectations regarding the interplay between gender, ethnicity and sexuality.

An important theme in the interviews was the concept of care. Both women and men talked about care as something traditionally connected to women and femininity. For the women, care work was nothing novel; they were already expected to be capable of caring and to have all the necessary qualifications for the job. For them, it was important to upgrade their work and their qualifications from the private sphere. The women's talk about specific feminine care ability can be interpreted as a strategy to achieve recognition for the more invisible parts of the work. Men do not have this same kind of normative connection to care and the proportion of men in elderly care is small. This means that men constitute the "different" category in the everyday life of care. At the same time men and masculinity have a higher status in society than women and femininity. Harding's (1986) notion about the interactions between the structural, individual and symbolic levels of gender is important to take into consideration in analyses of social life, and also in this case. The higher value of men and masculinity may be the reason as to why the discourse about more men in elder care is so strong.

This study also draws attention to the importance of not looking at gender as an isolated category. The interplay between gender, ethnicity and sexuality affected the scope of action for both men and women, but in different ways. In general, men seemed to be more affected than women. Positive stereotypes of the strong and gentle homosexual man

born in Sweden stood against negative stereotypes of the immigrant man. This could be understood in the light that men are the minority in this environment and therefore easier to identify and stereotype.

From a management perspective, it seems important to reflect on how the intersection between various identity categories creates different opportunities and limitations for the care workers in the organization. Arguments that both women and men are needed in the organization often imply that women always do femininity and men always do masculinity. From a gender-perspective it seems important to challenge this essentialist perspective.

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“How are you, manager?” A Literature Review of Care Home Managers’ Wellbeing

Kaija Kokkonen

Managers’ wellbeing is crucial to the organization, even though they are often forgotten in the discourse on work-related wellbeing. The issue is also topical in the context of care, because the circumstances under which managers work today are increasingly challenging. In fact, practices promoting and supporting managers’ wellbeing would probably be a significant competitive advantage for care as a branch of activity. The purpose of this chapter is therefore to summarize what is known about care home managers’ work-related wellbeing in light of earlier research. In addition, some reflections on the effects of physical environment on managers’ wellbeing are presented.

Work-related wellbeing of care managers

In the care home context managers face many complex challenges when endeavouring to solve the human and ethical dilemmas typical in care work, such as providing care which is both cost-effective and high quality. Moreover, the manager promotes organizational and cultural changes from long-term care ideology to more client-centred home-like living, which is one of the main strategic objectives in elderly care throughout Europe and indeed the whole world (e.g. European Commission 2008; Brune 2011; Næss et al. in this book).

In order to analyse what is already known about care home managers' wellbeing, a literature review was chosen as the research method for this chapter (see Perry & Kraemer 1986; Rozas & Klein 2010). The process of searching for relevant studies on care home managers' wellbeing proved challenging because of considerable variation in the use of concepts for wellbeing. Using the concept of wellbeing and related terms such as job satisfaction and happiness and contrasting terms such as stress was one possible way to collect a relevant body of studies on the topic. Managers' wellbeing in this specific context was a far less studied subject compared, for example, to those numerous studies on employee wellbeing in the same context. Before presenting these studies in more detail the somewhat complex concept of work-related wellbeing is discussed.

The term "wellbeing" is an equivocal and extensively used concept even in relation to working life. Historically, both organizational sciences and psychology have been preoccupied with the negative aspects of work-related wellbeing (Wright & Cropanzano 2004). This means that there is a long tradition in research specifically addressing stress and burnout in working life and a tendency for wellbeing to be seen as the absence of these. During the last decade a more positive approach to working life and work-related wellbeing has consolidated its own position both in organizational sciences (see Luthans 2002) and psychology (see Seligman & Csikszentmihalyi 2000), but also in working life practice (see Henry 2004). Taking a positive approach, work-related wellbeing is described and studied using positive definitions such as subjective wellbeing, happiness, satisfaction, work engagement, while also looking for positive factors associated with wellbeing. Most commonly wellbeing has been studied as an emotional experience such as perceived job satisfaction or happiness (Diener & Lucas 1999; Wright & Cropanzano 2004). However, negative aspects in scientific studies still predominate over those examining positive states (see Wright & Cropanzano 2004).

Work-related wellbeing is affected by work characteristics, which can be traditionally divided into job demands and resources. The Job Demands-Resources model (JD-R model) by Demerouti and co-workers (2001, see also Bakker & Demerouti 2007) divides the demands into psychological, physical, social and organizational aspects of work requiring sustained physical and mental effort on the part of the worker. Job resources refers to the psychological, physical, social and organizational characteristics of work which are instrumental to

achieving work-related goals, reducing demands, and to stimulating personal growth and development. Job demands, such as physical workload and time pressure, lead to dissatisfaction and burnout, but they may also inhibit the positive consequences of job resources. Job resources (e.g. autonomy, supervisor support), increase engagement in the work and the organization, but may also protect the employee against the negative consequences of work demands (e.g. workload).

In empirical studies managers' wellbeing in other fields of working life than care homes has been shown to be associated with a wide range of job demands and resources. For example, job demands like workload (Ho 1995), managerial role and personal responsibility (Lu et al. 2000) and organizational change (Lindorff et al. 2011) may lead to stress and impaired health in a manager. Similarly social support, autonomy, rewards, participation and feedback (Demerouti et al. 2001), training (Salanova et al. 2005), challenges, enriched jobs (Cavanaugh et al. 2000), family circumstances (Bakker et al. 2005) and ethical culture in the organization (Huhtala et al. 2011) serve as resources for work engagement and wellbeing.

Poor or excellent work-related wellbeing has various consequences. Research in fields other than care homes has shown that managers' wellbeing has implications at least for employees' wellbeing (see Skakon et al. 2010), employees' loyalty, job security (Lindorff et al. 2011) and organizational commitment (Acorn et al. 1997). Work-related wellbeing of managers probably also has indirect effects on the wellbeing of the residents in care homes.

The scientific findings on wellbeing and its implications are nevertheless difficult to compare with each other. It has been suggested that the primary reason for this mixed evidence is that work-related wellbeing and its consequences have been operationalized in many different ways and many different measurement instruments have been used (see Wright & Cropanzano 2004; Taris & Schreurs 2009). For instance, many concepts such as job satisfaction and happiness are only one part of work-related wellbeing and do not alone suffice to account for wellbeing. The second reason for measurement problems is the effects of interaction of variables which have been less studied than main effects (e.g. Bakker & Demerouti 2007). Altogether, more scientific research is needed on the ways in which organizational and extra-organizational factors and personal resources may mediate or moderate the relationship between managers' wellbeing on the one hand and job resources and demands on the other (see Bakker & Demerouti 2007; Skakon et al. 2010).

Narrative literature review

A narrative literature review of studies on managers' wellbeing was used in this chapter in order to describe the managers' wellbeing and classify job demands and resources according to the JD-R Model (Demerouti et al. 2001). Answers to the following questions were sought in the articles selected : 1) What is the state of managers' wellbeing in the care home

context? 2) What demands and what resources account for managers' wellbeing?

A literature search for the review was undertaken in January in 2012 in the following databases: SocIndex, Cinahl, Business Source Elite and Academic Search Premier. Only articles in English in peer-reviewed journals were eligible. The following terms were used as keywords in the search: management (and related terms, i.e. manager, personnel management), administration (and related terms, i.e. administrative personnel, organization, administration) leader*, concepts for context such as care home, nursing home, long-term care, institutional care and aged care and concepts for wellbeing like occupational wellbeing and related terms such as happiness, job satisfaction, quality of life, wellness, engagement and commitment and antonyms like stress, burnout and anxiety.

After the search a list of relevant references was obtained through a two-step process. In the first step potentially relevant papers were selected for further reading based on titles and abstracts. This was followed by a full text review. The relevance and appropriateness of the reference materials were verified for inclusion/exclusion at both steps. Of the 162 references originally identified, 12 papers were deemed appropriate for inclusion in the final review list. The studies had been published during the period 1986–2010 and five of these 12 studies were published in 2010. Thus it is clear that managers' wellbeing has been paid more research attention in recent years.¹

Findings on managers' wellbeing

In the 12 studies selected for this review the managers' wellbeing was studied mostly from the perspective of perceived job satisfaction among care home managers. In addition, there were comparative studies evaluating managers' wellbeing in different countries and in different management fields. Next these findings of primary studies are discussed.

Managers' wellbeing in the care home context was evaluated mainly from the perspective of job satisfaction. Job satisfaction was operationalized in many different ways, and the most common way was to use various scales such as the Nursing Home Administrator Job Satisfaction Questionnaire (*NHA-JSQ*) (Castle et al. 2007). Other ways to measure job satisfaction were questionnaires based on job characteristic theory (Deckard et al. 1986) or using only one general statement such as "I am satisfied with my job" in the questionnaire (Holesek et al. 2010). Besides job satisfaction, many researchers studied other items related to wellbeing, such as psychosomatic reactions (Westerberg & Armelius 2000; Abdelrazek et al. 2010), empowerment

1 The number of articles eligible for review was small in the first search, so a new search was conducted with the added terms of 'dement*' and 'old people' in October 2012, but produced no new articles for review.

(Abdelrazek et al. 2010), organizational commitment (Murphy 2004; Castle 2006; Holesek et al. 2010) and flow at work (Nielsen & Cleal 2010). All the studies except one were concerned with first-line managers' wellbeing. One Swedish study addressed middle managers' wellbeing in a municipal organization (Westerberg & Armelius, 2000).

According to these studies, it seems that managers in the care home context rated their work-related wellbeing quite high, but in studies published in the 2000s the results on this vary. In the 1980s Deckard and co-workers (1986) found that first-line managers in care homes had extremely positive perceptions of their job satisfaction. Managers in long-term care were satisfied especially with their significant responsibility, particularly regarding the planning, scheduling and delivery of services. They also perceived their satisfaction with job characteristics like skill variety, task identity, task significance, autonomy, feedback and context factors like job security, co-workers and supervision to be consistently higher than in other management fields. A decade later, Gillies and co-workers (1996) also found that first-line managers in long-term care reported a high level of job satisfaction. The managers were most satisfied with interaction, autonomy and professional status and less satisfied with agency policies, pay and task requirements. The researchers considered that perhaps pleasant interaction with peers, administrators and clients compensated first-line managers for their dissatisfaction with job responsibilities, work conditions and salary level.

In 2007 McGilton and co-workers evaluated supervisors' job satisfaction and job stress using the Nursing Job Satisfaction Scale. In this study, supervisors reported a moderate level of job satisfaction and a higher level of stress. Both Kash (2010) and Holesek (2010) and co-workers reported somewhat ambivalent views on managers' wellbeing. Kash and co-workers measured job satisfaction with the General Job Satisfaction (GJS) instrument and empowerment with the Perceptions of Empowerment Instrument (PEI) and reported that nursing directors (first-line managers) evaluated their satisfaction and empowerment like autonomy, responsibility and participation relatively high. Thus most of respondents were satisfied. However, as many as 15% of the managers intended to leave their current workplaces. This was connected with perceived dissatisfaction. Holesek and co-workers (2010) evaluated nursing home administrators' satisfaction through respondents' reactions to one simple statement "I am satisfied with my work" and 74% of respondents were reportedly satisfied in their present administrative positions. Conversely this means that every fourth manager was dissatisfied with his/her administrative position.

Four studies compared managers in different countries or different fields of management. Abdelrazek and co-workers (2010) published a study comparing first-line managers' job satisfaction (SWQ), empowerment (CWEQ, Spreitzer's scale), psychosomatic health (SWQ) and management skills (LaMi) in long-term care between Sweden and

Egypt. Self-assessed management skills and psychological empowerment were quite high in both countries, but first-line managers' self-assessed job satisfaction and psychosomatic health were mostly only moderate. Most of the study variables were rated higher in Egypt than in Sweden. The authors of the study attributed the managers' higher perceived wellbeing in Egypt to the greater respect there for elderly people.

In three studies managers' wellbeing in the care home context was compared to the wellbeing of managers in some other field. The research evidence in these studies, too, was contradictory. In 2004 Murphy compared job satisfaction (JDI) and job commitment between nursing home administrators and their counterparts in other management fields. She noted that nursing home administrators reported more dissatisfaction with their co-workers and pay than their peers in other branches. Nielsen and colleagues (2010) reported opposite results, namely that managers in elderly care perceived flow more often than did their counterparts in accountancy. The third comparative study was the only one in this review to focus on middle managers. The study focused on the wellbeing of middle managers in long-term care facilities in the Swedish public sector (Westerberg & Armelius 2000). The researchers were interested in middle managers' psychosomatic reactions and differences in job satisfaction between different types of departments in municipal organizations. It was observed that middle managers in elderly care reported more reactions in the form of psychosomatic factors and less job satisfaction than those in the other departments like child care, schools and street maintenance. In contrast to other departments, managers in elderly care were more often female (also in child care) and had lower salaries in spite of a higher level of education. The results showed the authors that being a female manager in a predominantly female work activity is connected with heavier workloads, less job control and social support and more psychosomatic reactions compared to those of male managers in male-dominated departments.

Job demands and resources

Identifying and understanding work-related characteristics associated with managers' wellbeing both positively and negatively can develop care homes into better working environments, also for managers. Below we present some examples of care home managers' job demands and resources. In addition the implications of work-related wellbeing will be discussed in light of the findings of the primary studies of the review.

This review suggests that the educational demands or resources are the most studied area of managers' wellbeing in working life, especially from the competence perspective. Managers' level of education (McGilton et al. 2007) and opportunities for continuing education (Gillies 1996; Wilson 2005) increase their wellbeing and commitment. In addition, competence in planning, problem-solving and evaluation (e.g. Nielsen & Cleal 2010) and autonomy increase perceived wellbeing

(e.g. Deckard 1986; Gillies et al. 1996; Wilson 2005). Probably these results are connected in part to managers' hopes regarding working life, because studies show that managers rate their autonomy and job control quite high (Deckard et al. 1986; Westerberg & Armelius 2000) but that they may also have some tasks and expectations (Abdelrazek et al. 2010) which decrease perceived wellbeing.

Social support for care managers is also an extensively studied area. It seems that social resources like a strong sense of solidarity with peers and superiors and managers' support for care managers (see e.g. Deckard 1986; Gillies et al. 1996; Westerberg & Armelius 2000; McGilton et al. 2007) have a positive effect on managers' perceived wellbeing. As mentioned above, social factors also seem to compensate managers for their dissatisfaction with job demands like working conditions and salary level (Gillies et al. 1996). Yet the managers' perceived quality of social interaction varies between primary studies. Deckard (1986) and Westerberg and Armelius (2000) observed that managers perceived support from their own managers to be appropriate but Murphy (2004), McGilton (2007) and Castle et al. (2007) reported that managers felt dissatisfied with co-operation with colleagues and support from their own immediate superiors.

Some organization level questions like salary and ownership of the organization were also addressed in the studies reviewed. Low salary level decreased managers' reported wellbeing (Murphy 2004; Holecek et al. 2010) and managers in the for-profit ownership setting were less satisfied and perceived a lower level of empowerment and autonomy (Kash et al. 2010). The study by Holecek et al. (2010) also focused on the impact of the nursing home regulatory process on wellbeing. This kind of study design and its results are very interesting for those countries where the regulatory processes of care homes have only recently assumed a more structured format.

The physical characteristics of environments were rarely mentioned in the studies on managers' wellbeing in the care home context. In the articles reviewed only one study addressed physical factors. The study by Westerberg and Armelius (2000) shows that the physical work environment is related to perceived job satisfaction but the relation is weaker than the impact of psychosocial factors. According to that study elderly care managers are also less satisfied with their physical working environments than managers in other public departments.

The articles reviewed show that the most meaningful consequences of diminished wellbeing is the increasing and recurring turnover of managers, intention to leave and actual leaving (Murphy 2004; Castle 2006; Castle et al. 2007; Kash et al. 2010). For example, Castle and co-workers (2007) found that the yearly turnover rate for nursing home administrators in the USA was 39% and in almost all cases (87%) these managers had previously exhibited low commitment to their organizations. In addition, managers with lower job satisfaction are more likely to leave the care sector and take up employment in other

sectors (Castle et al. 2007). These results merit extensive attention both in research and practice, because turnover of managers can have direct consequences, for example, for the quality of care (Castle 2001; Castle & Lin 2010; Decker & Castle 2011) in the care home context.

Unnoticed physical characteristics – one further challenge for managers' wellbeing

This review presented a summary of studies focusing on managers' wellbeing in the care home context. The limited number of studies included in this review prevents generalization of the results or the formulation of any precise description of the wellbeing of care home managers. Yet it would appear that managers' wellbeing research continues to be quite one-sided because work-related wellbeing has tended to focus on only a few factors, such as perceived job satisfaction. Thus it is easy to concur with the claims of Orsila and co-workers (2011) and their broader approach to wellbeing as a multidimensional, physical, psychological and social phenomenon would yield new knowledge for the discussion.

Longitudinal research and qualitative research might well offer new perspectives on this issue, because the studies included in the literature review were mostly based on quantitative and cross-sectional approaches. In addition, the primary studies presented in this review focused mainly on the same questions as managers' wellbeing research in general, typically psychological and social characteristics, yet the organizational and physical characteristics would also merit attention.

As mentioned earlier, managers in care homes nevertheless rate their wellbeing relatively high, but there is a suggestion of a weak signal of a deterioration in managers' wellbeing in the past decade. Researchers conjecture that lower professional status with low salaries (Westerberg & Armelius 2000) and lower respect for elderly people (Abdelrazek et al. 2010) may serve to diminish managers' perceived work-related wellbeing in western countries. In addition, increasing economic pressures and competition in the care home field may have decreased perceived wellbeing.

Given the focus of this book on physical care settings, we next present three examples which combine managers' wellbeing and issues of physical environment. These tentative remarks point out that the relation between managers' wellbeing and physical environments can be identified as problematic at various levels of organization and management practices.

Firstly, the environment of care homes includes many different kinds of technology applications (see more Karlsson in this book). Some of these are managerial tools specifically developed for the needs of knowledge management. Besides the question of how relevant the information in ICT knowledge systems is for managers, another question is the availability, usability and visibility of these and other technological instruments in care environments. What does it mean for the care work

ethos and management practices? In daily use impracticality of ICT tools may well complicate management, causing frustration and reducing commitment.

Secondly, according to the literature review, competence is an important part of managers' wellbeing. There is a need to improve managers' ability to recognize the relevance of physical environment for care work and management practices. Thus when the care home environments are taken in a more modern direction stressing homelike rather than institutional living, managers' competence in such issues will be increasingly important. Successful co-design practices both with new or old environments require a profound understanding of the environmental needs of elderly people, of employees and managers and of how to meet all such needs. Design should be multi-professional work, so care home managers need to be competent to discuss and make decisions together with different professionals.

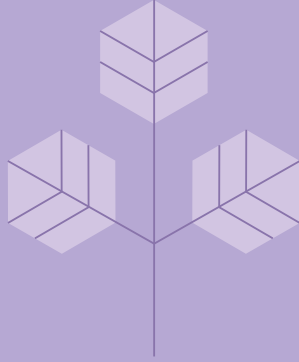
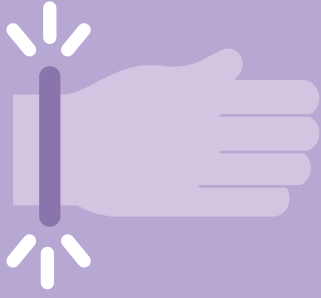
The third and final point is virtual management and its consequences for work-related wellbeing. Virtual management is one typical consequence of centralization in organizations and a challenge not only to the wellbeing of the staff but also to that of managers in elderly care (see e.g. Acorn et al. 1997). Centralization may lead to challenges for managers regarding distances and environments. Long physical distances between managers and staff change the nature of management and, for instance, daily communication and co-operation may become difficult. The growth of virtual management, which has already occurred in many other fields may in future affect managers' wellbeing in the care sector, too.

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Looking at Design: *Confronting Expectations*



The Match between Design Guidelines and Care Home Reality

Mirja Kälviäinen

The aim of this chapter is to present and consider some existing and emerging guidelines for designing the physical environments of elderly care homes. In addition, the solutions actually realised and the atmosphere currently prevailing in some care homes are further analysed by referring to a Finnish study using photographs of these care homes as a stimulus. In creating environments for wellbeing, more attention should be paid to the real application of the existing guidelines.

Descriptions of design guidelines for elderly care homes

The existing care home design guidelines from the USA, Finland and UK were chosen as examples of the typical current content. The US example is the InformeDesign designers' database while the Finnish and UK examples are the official quality guidelines and regulations by the national ministries. The aim of these national guidelines, regulations and the information steering connected to them is to ensure a minimum level of quality for the residents and their care.

An extensive and detailed set of guidelines for elderly care facilities can be found in the InformeDesign (US.) interior designers' database, which provides evidence based guidelines for elderly care homes collected and extracted from a multidisciplinary set of research papers looking at different areas of interior solutions (InformeDesign sources from the years 1999–2009 on elderly and care home guidelines were data mined). The result of the search in 10 years of accumulated guidelines provides general guidance such as conditions reminiscent of a private home, small enough household units, meaningful objects, homelike feeling, informal furniture and fabrics, and replacing symbols of institutional care. Specific areas of guidance list the following technical-functional aspects:

- accessibility in all of the facilities
- easy bathroom conditions and small person per bathroom ratios
- safety (fire extinguishers, smoke detectors, flashlights, escape routes, falling and hazard prevention, non-skid floors, handle rails and glare prevention)
- lighting (bright light, sunlight, motion sensor night lights, work lighting)
- avoidance of distracting sounds
- assistive devices and furniture.

The InformeDesign guidelines further emphasize mobility and opportunities for residents to be active such as walking space, environmental signage, places to rest and stimulating, changeable features in social areas (bird watching, aquariums, pets, artwork, bulletin boards, music, family videotapes). Access to the outdoors and nature, with outdoor seating and activities, has also been proven important. Rooms with scope for personalization (furnishings, art, memorabilia) and options for own control provide privacy, as well as socialization with shared communal space, shared but still intimate mealtimes, and semi-private visiting or activity areas. The guidelines also mention that it is important to consider the differences in residents' cultures and personalities, cognitive abilities, and the tendency to physical or mental fatigue.

The latest Finnish National Framework for High-Quality Services for Older People of 2008 states that the care environment should meet the requirements for pleasurable, safe, and activating living reminiscent of home, making privacy possible and supporting functionality. This is

described more concretely as activity equipment and activities, joint happenings, opportunities for eating together and supporting relatives' visits and participation. Self-regulation, privacy and participation, even with poor functional abilities, are also emphasized.

The separate necessities listed in this Finnish framework include technical and concrete issues similar to those in the InformeDesign guidelines excluding the atmosphere or social psychology of living issues. The separate elements mentioned are the following:

- barrier free environment (with passages, steps, ramps, no thresholds, doors and lighting)
- facilities for joint activities, cultural and other activities and being outdoors
- minimum resident room size, single room recommendation
- adequate equipment and furniture
- technical and functional safety
- storage rooms
- hygienic surface requirements and air conditioning.

The UK Care Homes for Older People National Minimum Standards and Regulations (2006) focus the guidance more than the Finnish ones on the service users' quality of life, residents' personal and health care needs and everyday preferences. The individual resident approach includes privacy, dignity, autonomy, choice and lifestyle preferences in the built environment. Provision for social, cultural and religious activities, common dining room(s), private visitor space(s) and outdoor facilities are mentioned. As in the Finnish recommendations, technical-functional elements such as minimum space requirements, accessibility, disability equipment, equipment storage, good lighting, safety, good maintenance, hygiene and proper ventilation are listed.

However, in comparison to the InformeDesign and the Finnish guidelines, the British instructions include more definitions of how users' individual and collective needs are met in a comfortable and homelike way. These relate to domestic lighting, furniture and carpeting or with a new build requirements placing the bedroom window so that it enables the resident to see out of it when seated or in bed. Residents' rooms and furniture are described more from the residents' point of view, stating that the users should enjoy comfort, safety and privacy in their bedrooms with their own possessions around them. In the absence of residents' own furniture the British instructions cover the domestic bedroom setting with a bed, overhead and bedside lighting, comfortable seating for two, drawers and space for hanging clothes, a table to sit at and a bedside table provided by the care home. The home's philosophy of care and its size, design and layout are seen as interwoven and instructions on the solutions are given: a home with family-like care would need small, divided communal domestic scale units and a hotel-style home could serve with one large semi-public environment.

To conclude, the existing care home design guidelines for physical environments presented here promote accessibility, care, personal

identity and social, cultural and mobility activities (freedom), often by defining concrete space elements but also describing environmental factors affecting through multiple senses, including smell and hearing. The value descriptions of care homes in general, instead, seem to describe and promote emotional and social-cultural factors such as coziness, friendliness and domestic character that are not directly related to the concrete elements and demand of the people who apply the guidelines not only element based, but also style based, solutions. The interior design combining the elements and choosing the style for the purpose of trying to create this kind of atmosphere are left in the hands of the managers, staff members and possible designers. In the assessment of the homes in accepting the desired domestic atmospheres the matter is at the mercy of the quality assessors.

Contradictions in care home design

Developing care home guidelines for supporting public quality requirements and design practice is a challenging task. Many problematic or controversial issues arise from these environments as they have diverse stakeholders, namely elderly clients, care personnel, cleaning and facility caretakers, elderly clients' relatives and friends and either private or public care home organizations. The environment should resemble a home but also provide assistance, barrier-free functionalities and support the care personnel in fulfilling statutory health care and hygienic requirements. With restricted economy good guidelines should also help to utilize existing spaces, equipment and furniture and take limited staff resources into consideration. Elderly clients' socialization and life enriching demands may entail meeting requirements other than those of privacy, personalization, peace and freedom. Client dependency poses very interesting challenges since the elderly are not a homogenous group. Clients with cognitive disabilities require different solutions from those who are physically fragile or disabled. Notions of 'home' and 'everyday life' vary immensely through different life experiences, education, work histories, lifestyles, religions and other cultural heritage.

The regulations mostly prescribe separate elements and functional care home demands contrary to the multidimensional demand background described above. However, environmental elements are also associated with psychological needs and wants, creating emotional experiences and constructing meanings. These are often expressed as attributes experienced, value judgments, or as category descriptions of the meanings understood in creating positive or negative atmosphere. Some descriptive concepts or attributes are presented referring to publicly accepted care homes' values, emotional and social-cultural aspects, such as 'comfortable', 'friendly', 'safe' and 'home-like'. As guidelines these usually remain rather vague and their application is left to the discretion of the designers' and assessors' cultural concepts and preferences. The design or care home guidelines seldom try to describe

how the functional solutions might produce the desired homelike atmosphere and what the style choices might be for elements that would produce the required emotional and atmospheric experience.

As a basis for quality assessment, the existing guidelines pose problems. Professionals and users have different viewpoints that might overrule requirements such as comfort. Is it the residents' homelike feeling or the care and health or safety requirements which should be primary? If the last mentioned come first, the homelike quality may be arbitrarily superimposed over the care environment resulting in an unauthentic home solution. Research results show (e.g. Parker et al. 2004; Popham & Orrell 2012) how, for example, safety and health regulations may conflict with residents' quality of life measures.

Emerging guidelines for care home design solutions

Through these multilayered problems and emphasis on the residents' point of view new approaches for care home design are emerging. Next some examples of these from the UK, the US and Denmark are described.

The Sheffield Care Environment Assessment Matrix (SCEAM) proposes a system for examining the physical care environment within the framework of elderly quality of life (Parker et al. 2004). The requirements of frail older people living in care settings are used as the 'domains' of the assessment. Compared to previous guidelines The Sheffield Care Environment Assessment Matrix has some aspects similar to the previous ones, but there are also some new points. It seems that privacy can be guaranteed with small, private seating areas and by separating resident bedrooms from public areas and views. The residents' rooms and entrances should provide personalization opportunities with their own furniture, pictures, ornaments and also plant choices. Choices for social interactions and activities include spaces such as a quiet TV-free lounge, kitchenette, an activity room, diverse forms of seating, and baths and showers. The building should reflect the residents' differing cultural expectations. Health and safety should be guaranteed with adequate lighting, fire protection, non-slip floors, easy bathroom and toilet rescue, hot-water temperature control and safeguarding dementia residents from wandering out. Impaired mobility, muscle strength, vision or hearing aids should be supported with accessibility, room to manoeuvre when using mobility aids, appropriate light levels, visual contrasts and easily gripped fittings and implements. Cognitive frailty aids include individualized bedroom doors, clearly indicated directions and external views through windows to support resident orientation. Maintaining awareness of the outside world means allowing the time of day, weather and season to be visible with low windowsills and a view of outside activity and nature. A sense of normality and authenticity can be created by domestic spaces, materials, furniture, lighting and décor even in spaces requiring medical fittings.

Comparing existing environments with residents' experience of quality of life (Parker et al. 2004) showed that a number of SCEAM

domains had a positive relationship with quality of life. In buildings with good choice and control residents showed greater wellbeing. High provision for community meant more active residents, good support for cognitive frailty produced more positive emotions and physical frailty support helped residents to move around and control their immediate environment.

In the USA attention has also focused on the resident's quality of life: autonomy, dignity, privacy, meaningful activity, enjoyment, relationships, comfort, security, functional competence for being independent, sense of being valued and spiritual wellbeing (Kane et al. 2003). The assessment emphasizes concrete observables clustered from the resident life perspective as function-enhancing or life-enriching features, resident environmental control and personalization. The Life Enriching Features construct, for example, includes outdoor views, chair(s) in the sleep area, telephones, flowers, living plants, movable chairs in lounge, own/shared TV, radio, CDs, religious items, games, animals, pictures, newspaper, flat work spaces, computers, exercise equipment or even a popcorn machine.

In addition to individual elements, the interest is in general solutions, for example, in long distances between individual rooms and bathrooms, corridor clutter and noise, and the general absence of life-enhancing features. The aim has really been to shift the assessment to the individual residents' perspective: their rooms, their care units, nursing facilities, and then aggregating data elements into composite indices relevant to quality of life. The checklists used are based on the literature and expert rating exercises, but the developers point out that other sources might have suggested different items. The findings show how a separate item can influence several quality-of-life domains: inadequate ventilation, low light or poor controls are relevant to dignity, privacy, comfort, security and functional competence (Cutler et al. 2006). Trade-off options in the environment exist. Life-enriching features in the distant environment may compensate for the lack of these features in the immediate environment if the residents are capable of reaching them. A similar trade-off does not work in terms of function-enhancing features (Degenholtz et al. 2006). The care support functions point to the importance of the service process in connection to the total experienced environment. The garden does not serve you if you cannot move and no one takes you out.

These American holistic approaches have even led to such concepts as Green House homes, which are total solutions towards individualized, person-driven planning empowering the front-line staff with the ideal of maximizing each resident's individually defined quality of life, personal autonomy and daily functioning. Instead of a 'good care' perspective, the whole concept, the ensuing design and service are created to support the residents' good life and lifestyle. The preliminary comparison results (Kane et al. 2007) already show that resident quality of life measures are higher in this kind of concept environment than in a conventional care home. The quality of life measurement domains were physical

comfort, functional competence, privacy, dignity, meaningful activity, relationship, autonomy, food enjoyment, spiritual wellbeing, security and individuality.

In Denmark a model programme (Modelprogram for plejeboligar 2010), utilizing multidisciplinary research, ethnographic user understanding and workshops, has published a detailed checklist of concrete features and an information database for solution planning and support for real, situated co-design processes. The user perspective covers both individual and care homes through organizing different spaces and activities. Effective action of the care personnel, health and safety requirements, sustainability and new technology are also considered in the background. The main idea is to provide a home experience for the residents promoting the opportunity for the joy of life, also bearing in mind the future diversity of the elderly in terms of physical and mental condition, ethnicity, religion and sociocultural background. The concept for home building is guided through activity tactics with private, social, everyday, cultural and ritual options, including slow observation and meditation. The instructions include territorial solutions for private and diverse activities, resident-chosen social groups and interactions, and paying attention to the overall atmosphere for certain resident groups. The model programme emphasizes the impossibility of general guidelines given the diversity of the future elderly and then points out the necessity of co-design with the differing resident groups in building a suitable lifestyle experience for them.

Photograph-based interviews in Finland

A pleasurable living environment can, according to Kyttä (2003), be composed of physical, social and emotional environmental offerings or *affordances* divided into community feeling, aesthetics, safety, recreation, activities and the needs of different resident groups. The designers need to bridge the gap between real environmental and functional elements and their manifold emotional and meaning based experience effects to capture all these.

One empirical sub-study of the CoWell project searching for these bridging options was conducted in Finland in 2009. This study used photographs of existing care homes' public spaces and a focus group type of free discussion about pleasure reactions to this care home photograph stimulus. The photographs chosen presented physical environments from four different care homes. In each of the four selected care homes a picture of the public living room, dining, bathroom and corridor facilities was presented.

The photographs were shown and discussed in seven focus groups. The participants included elderly people (two groups), care workers, care entrepreneurs, students of health and social management, design students and experts in design. The visual stimulus driven discussions were held in small focus group interviews with each stakeholder sector

as a separate group, but here the results are presented as a composite analysis. The focus group sessions were conducted in eastern Finland and in Helsinki by different members of the CoWell project.

The results concerning the general feelings experienced, the atmosphere and affordances of these perceptions are presented here as they emerged from the discussion material. Further reflection of the results is also presented as concepts that the respondents seemed to have from the presented images of the care home. The analysis was done in such a way that the concrete environmental element mentioned and the associated feeling or affordance descriptions were linked together in a table as the participants stated them in a positive or negative sense and then related wider concepts describing environmental understanding were also listed beside the elements, feelings and affordances. Although the result resembles the affordances described by Kyttä, the analysis was not conducted on the basis of her pleasurable living environment factors.

Positive and negative characteristics in care environments

In specifying required care home elements the current guidelines do not describe how these inevitably form certain holistic combinations associated with certain impressions, emotions and feelings. The responses in the visual stimulus discussions reported here revealed translations between emotional impressions and environmental element constellations explaining how positive and negative emotional experiences and feelings are created by the space, colour, light, materials and the visual style of objects and environments. There seems to be a certain pleasurable middle space: the well-thought-out, comfortable setting with domestic furniture, items and plants, warm colours and good lighting. This seems to form a pleasure zone with ideas of a homelike, comfortable and respectful atmosphere. Too much clutter is disturbing, mentally noisy, often stigmatizing and lacking in respect for the residents. The bare environments with cold colour and lighting, public space items and settings form an unpleasant, even scary, institutional atmosphere.



Figure 1. Space with clutter, pleasurable domestic setting, institutional bare corridor

Environments (Figure 1) that are filled with clutter, typically assistive and cleaning devices, messy and difficult to see notice boards, too many colours, differing styles of furniture and stimulation material, are just too confusing. Mobility aids cause experiences of the stigma of being disabled. Cleaning items send a message of constant cleaning and of an unclean environment. Childish materials can reduce the residents to children's level and are reminiscent of children's institutions. Clutter features easily point to institutional environments. Even though assistive devices are practically supportive, they send stigmatizing and nonhuman signals of an undignified, institutionalized environment and disabled people. The cluttered environments are also associated with a lack of respect as they send a message that the people attending to the environment do not care about making it tidy and beautiful.

In the middle image above the positive environment has light, warm colours, enough but not too much colour, and a good proportion of furniture and other items of home origin, good quality, domestic and warm materials and a selection of plants all in a well thought-out and comfortable setting. This is associated with ideas of a respectful, warm and homelike atmosphere. In the discussions it was interesting to find that for the elderly such product constellations as a sofa, a TV, a rocking chair, domestic carpet, an oven and a bookshelf with real books on it together presented the concept of a private living room. The bookshelf filled with real books also represents the difference between authentic, positive and fake negative environment as a consideration in the discussions.

At the empty, bare end of environments the cold colours, institutional spaces such as long corridors and furniture, lighting and items reminiscent of a publicspace created a displeasing, cold, boring and institutional atmosphere where respondents imagined that the noises

would be echoing. The institutional understanding evoked was often related to a hospital or a health centre and even to emotions of fear. In the search for domestic quality with homelike furniture the end result may be weird and fake rather than pleasurable when randomly chosen furniture is scattered about a former hospital ward and the basic nature of this environment with institutional room arrangement, materials and lighting still dominates the setting.

Conventions inviting or inhibiting certain kinds of behaviour or experiences lead to perceived affordances in our minds (Norman 1999). The respondents saw the environments as having positive or negative affordances connected to physical, social and mental activities. It was important to see the environment as a space (especially empty) which offered opportunities for moving with different mobility problems and when using assistive devices. The environmental settings were also seen to provide opportunities for social meetings and interaction. Stimulus affordances were also considered, such as pictures helping one to remember nice things, enjoyable nature views or the environment offering empty places to put nice things in. The opportunities for peaceful meditation were observed when there was a suitable secluded setting. Another important affordance was to sit and observe others or life outside the home.

In the following tables the concrete environmental elements (A) pointed out by the participants of the photograph discussions are described. The tables present how these concrete elements of care environments were connected with either positive or negative atmosphere descriptions (B). Here atmosphere refers to the general emotional feeling that the environment evoked. Wider concepts (categories, concepts) describing environmental understanding (C) connected to concrete elements are also listed.

Table 1. Positive elements of care environments

Positive elements (A)	Atmospheres (B)	Categories, concepts (C)
Windows, views to the outside, plenty of light	Spacious, bright, lively, interesting	Domestic, family home
Warm and light colours, plants, flowers	Beautiful, stylish, colourful	Mother's home
Consistent and private home style of furniture	Homelike, cosy, comfortable, warm, soft, peaceful	One-family house
Domestic carpets	Dignified, valuable, genuine	
Oven, sauna		
Tidy surfaces		
Wooden materials		

When looking at the real care home pictures the focus group participants recalled through their earlier socio-cultural experience

certain conventional categories (column C, Table 1. and Table 2.) that could be used as positive or negative concepts for care home design. These categories represent both private and public, even very institutional, environmental concepts. A concept can be described as a unit of meaning or knowledge, built from other units which serve as typical concept characteristics. Thus it is a unit of meaning but also feeling-making. For private space the perceived concepts were home, mother's home, old person's home, living room, home garden, cellar, lobby and barn. Public space reminders were hotel, motel, hostel, shop, kiosk, health spa, industrial or other workplace canteen. Even more institutional categories included school, health centre, hospital ward, barracks and even a prison.

Table 2. Negative elements of care environments

Negative elements (A)	Atmospheres (B)	Categories, Concepts (C)
Hospital equipment, interior landry and cleaning devices scattered around	Restless, noisy, cluttered	Institution (especially for disabled people)
Mobility aids stored in bathrooms and toilets	Cramped, tight	Hospital/health centre
Rusted pipes and worn out surfaces	Stigmatizing	Coffee bar at a petrol station
Cold colours and materials	Unclean, unhygienic	Motel/hostel/dormitory
Institutional layout, empty spaces, narrow corridors, anonymous doors, public lights	Indifferent, disrespectful, cheap, undignified	School
Non-matching (assorted) furniture and items of both public and domestic nature, mixture of conflicting styles.	Efficient, clinical	Barracks
Childish visual images and stickers	Impersonal, boring	Prison
Carelessly hung paintings	Cold, scary, stale, dreary, grim, uncomfortable	
Fireplace without fire, bookshelf without books	A fake scenery (the life enriching and domestic features seem artificially superimposed on an institutional environment)	
A bare big clock on the wall	Humiliating fake look of a home	
	Forbidden and restricted	
	Regimentated	

The categories were interpreted by the participants from a single item in the environment sending a strong, usually negative, message. An example is the food servery with metal railings resembling a prison environment even if the dining room in general was considered pleasant. Several characteristics or the whole atmosphere of a certain environment provided stimulus for the respondents to relate the environment with a certain category. The public and institutional categories were seen as more negative and the private ones more positive,

but not as an entirely consistent dichotomy. Different environmental concepts can cover different characteristics such as aesthetics, feeling and social or activity affordances of the environment. Thus the question is if we can identify some leading positive care home concepts and what elements, style, affordances and compositions make them positive.

Reflections on the guidelines and their application for a positive atmosphere

When searching for guidance to create positive care home atmospheres, attention should also be paid to the real application of the existing guidelines. The analysis of the focus group discussions based on photographs shows that it is possible to extract translations of how environmental elements and characteristics create pleasurable and positive feeling experiences, affordances and categorisation into pleasant concepts. The responses to the Finnish care home pictures also revealed some general principles for understanding how a positive care home atmosphere could be created. These relate to suitable lighting, warm colours, no clutter but still enough stimuli and a selection of well thought-out domestic decor. Accessibility and barrier-free solutions are important but they should not be stigmatizing. The tactile quality, noise and odours should be considered as part of the domestic atmosphere. Respect for this being a home for adult, elderly people should be the primary guideline, with social affordances but also opportunities to observe others and for peaceful contemplation and the enjoyment of nature. The element, style, space and compositional constructs for the positive environmental feel concepts should be researched or co-designed, especially from the residents' point of view. They are, of course, issues that vary culturally and hence also stylistically.

As in Finland many care homes are built in some former health care institution, much more attention should be paid to the spatial order, style and colour features reminiscent of this kind of original purpose and to how to transform them into domestic and homelike signals. The storage of institutional clutter should be resolved since assistive and cleaning equipment are stigmatizing and associated with an institutional environment. Too much fussy information or too many decorative stimulus items scattered around the environment is usually the result of well-meaning care personnel who should understand that, rather than being pleasing, such material can make the environment unpleasant, disrespectful, childish, ugly, institutional and disturbingly noisy. Much more consideration should therefore be used in storing equipment and designing how and what to display as extra material. Maintenance is also important. Clutter and rusted, worn out surfaces signal a careless, undignified attitude to the residents' environments.

There is also a need to be critical. How specific can the guidelines become as the instructions given at the detailed level may not apply to real life conditions? The problem in practice is that care home environments constitute a very diverse set of application targets. They

may be new building projects, converted premises, or existing care homes with improvement intention. They may be parts of a building complex, blocks of flats or separate houses with their own gardens. They may be situated in the city or in the country. At a detailed level model examples showing how to apply the guidelines and elements in different environments could be given and the guidelines themselves could be at a generic, inspirational, good examples and co-design process support level, as was successfully done on the Danish model project (Modelprogram for plejeboligar 2010).

With the question of affordances we are actually discussing the major feel issue of how the environment invites people, residents and personnel to behave. Does it invite home behaviour or institutional hospital behaviour? The education and socialization of the nursing staff may follow hospital or healthcare rules, not home rules. The ideology we should cherish as important for the creation of a care home encompasses the highest level of abstract values and the execution of the smallest of details. The concrete visual and other sensual expressions of the ideology and the abstract ideas following guide our behaviour in the environment. In the UK hotel-style care home solutions even the personnel working positions and behaviour, services and activities offered are geared towards the typical personnel and activities of a hotel to communicate to the residents this kind of a pleasurable holiday environment instead of an care environment.

How the ideology influences the assessment process is also important. Results from the same environment may be very different when evaluated from the viewpoint of resident quality of life compared to the efficient care perspective. This difference was evident even with the focus groups of personnel and managers, who saw some environments as being practical for work and then also saw that they would be unpleasant for the elderly user. The photographs from existing care homes received a lot of institutional and negative experience responses in the focus groups although they are places approved in quality assurance processes. Have the domestic and comfort requirements been taken seriously in the assessment process or are they overruled by the safety and health requirements?

Different resident groups have different past lifestyles and we cannot put all the elderly into similar care homes. Common guidelines cannot take into consideration the personal tastes and lifestyle requirements of all the changing residents. The resident intake process could include tools for getting to know the residents' identities and their personal requirements and everyday routines, but also their environmental tastes. The process could provide a set of pictures from the residents' own homes and surroundings, real life situations, family constellation and roots, everyday life habits, tasks and timetables, occupational and cultural background, hobbies, roles, important things for identity and values, meaningful issues in life and environment, lifestyle preferences (e.g. for security or adventure), social networks, and interaction habits

(Kälviäinen 2002). Elderly residents have long life histories and the interests of the personnel to support the elderly in continuing their preferred lifestyle is vital. A general understanding of promoting resident wellbeing can be reflected through psychological aspects which also seem to relate to what real elderly people see as important (Miller & Kälviäinen 2012 in this book). A general understanding for the creation of a positive care home atmosphere, activities and organization of the staff work should be integrated with the personal life histories, home concepts and home activities of the real residents.

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Physical Environments of Care Homes – Some Finnish Case Examples

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The aim of this chapter is to describe physical environments in private and public care homes using the design and care recommendations as an analytic tool in the description. Here the physical environment is seen as an integral part and concretization of the organization and its culture. An interesting question is if the ownership of the organization has any systematic effects on the environmental solutions especially in Finland, where the number of private care businesses has increased in recent decades. In addition, design guidelines are extensively used in design processes, but what results they produce in care home environments is a matter of critical concern.

Physical environments of public or private care homes

An organization, such as a care organization, can be defined in many different ways, for example, an organization can be seen as a system with a certain goal or it can be seen as a controlled system (see more Pfeffer 1982; Schein 1985; Martin 2003; Harisalo 2008). According to functional definitions, organizations can be seen as planned systems intended to accomplish some specific tasks (Harisalo 2008, 17). Some definitions of organizations indicate a commitment to the interaction of organization and environment. In that case, organization theory suggests that the environment will impose limits and offer opportunities for the structures and strategies of organization (Sofaer 1994).

In this article we are not interested in a comprehensive understanding of the environment and its interactions with different forms of organizations (e.g. ‘machine organization’ versus ‘professional organization’). We focus more specifically on the concrete, physical environments of care homes from an organizational studies perspective. Pfeffer (1982, 155, 260) has stated that the physical environment is part of the organization and a key factor in the examination of organizations and the differences between them. Public and private care homes are seen as organizations intending to provide good care and wellbeing for residents. It is very common that elderly people as residents need homelike care with basic nursing, therapy and social activities for long periods of time (see more Blank & Eggink 2001; Reed et al. 2003; Kane et al. 2004). As Degenholtz and his research group (2006) have pointed out, different kinds of physical environments may limit individuals physically and cognitively or enable them to retain as high a level of independence and functioning as possible. More than 50 years ago Frances M. Carp (1966) already stated that physical and social conditions increase residents’ satisfaction with living arrangements.

Also according to Barnes (2006), daily activities and space can improve elderly people’s quality of life. This only happens if residents can achieve a feeling of owning the environment by adapting their own routines and preferences. In principle, it has been stated that care homes should be primarily homes or places of residence rather than clinical working environments for social and health care workers, yet the prevalent notion persists that care homes seem to undermine the residents’ privacy, respect, comfort, safety and operational skills (e.g. Cutler et al 2006; Popham & Orrell 2012). Mattiasson & Andersson (1995; see also Thomassen and Hujala & Rissanen in this book) also take the view that everyday life and working processes in care homes are organized mostly by a firm structure for the daily tasks. In this chapter first an attempt is to ascertain if the ownership of the care organization (private entrepreneur or public municipality) has any effect on the physical environment and its affordance as regards holistic wellbeing in these organizations.

Private and public care homes as organizations can be defined simply from the ownership point of view, so that the public organization is owned and financed by central or local government while a private organization

is owned and financed by private individuals or foundations (see Scott & Falcone 1998). In 2010, 27 per cent of Finland's elderly clients were living in intensive residential care units owned by private companies, 28 per cent were living in units own by non-profit organizations and 45 per cent were living in municipal, public units (THL 2011).

However, the ownership or the source of funding is not the only distinguishing factor. According to Rainey and co-workers (1976) the private and public sectors can be divided according to environmental factors, organization-environment transactions and internal structures and processes. Probably all these factors are connected to each other and in fact, any health and social organization can be expected nowadays to be more like a hybrid organization in the sense that partly the same funding mechanisms, laws, norms and control factors limit or enable their operations. Thus the public and private care homes can also be seen partly as hybrid organizations; since there are at least the same funding mechanisms in both of them (e.g. municipalities use their tax revenue to purchase residential care from the private organizations as well as to organize their own services). Nevertheless, empirically in this article the distinction between public and private care homes is made based on the ownership of the organization.

In the care home context one concrete issue affecting the quality of the care and care environments is the increasing supervision. In the past the Finnish legislation governing private social services (2011) and control of systems applied only to private care homes, but since 2009 public units must also meet the recommendations (Valvira 2010). These recommendations also take into account the physical environments in public and private settings. These recommendations (2008) and the *InformeDesign* (1999–2009) database with home care guidelines (see also Degenholtz et al. 2006 and Kälviäinen in this book) are used in this study as an analytic tool to evaluate the environments of private and public care homes.

In this study our assumption was that similarities or differences in physical environments tell something about the organizational cultures of private and public care homes, especially as regards wellbeing. Wellbeing is very extensive concept as discussed in wellbeing research and its operationalization is a challenge (e.g. Stanley & Cheek 2003; Ransome 2010). Thus the second aim of this article is to understand what kind of a picture of wellbeing emerges if the starting point is the environmental elements mentioned in design and care recommendations.

Observing care homes

The data of the study presented here consists of observations in public (8 units) and private (9 units) care homes in Eastern Finland. Comparable units from the private (nine units) and public (eight units) sectors were selected (see more in Komu et al. 2011). Background information on these units was collected before the observations were made. The observations

lasted altogether 81 hours and were made by seven observers, at least two of them visited the same care home at the same time. The observers had educational and working backgrounds in nursing, health care management or in design.

The elements to be observed, as previously mentioned, were based on two kinds of materials 1) InformeDesign (1999–2009) database with care home guidelines data from the U.S. (see also Degenholtz et al. 2006) and 2) the Finnish National Framework for High-Quality Services for Older People from year 2008 (see more in Kälviäinen in this book). Based on these two sets of recommendations, a checklist of elements for care home environments were produced and used as a protocol for the observations. The checklist included such elements as safety, lighting, mobility options and facilities for common activities. In addition, the observers were interested in other environmental elements which might affect the residents' wellbeing.

The observation elements were classified under two topics 1) general remarks and 2) topics connected to the traditional understanding of wellbeing as a physical, social and mental phenomenon (see more Allardt 1998; Kytä 2003; Topo & Kotilainen 2009; Rissanen in this book). In addition, some aspects are mentioned which were not addressed in the recommendations even though they seem highly relevant from the perspective of person-environment-wellbeing. This way the analyses make it possible to tentatively assess whether the recommendations can be used as tools to raise important environmental elements from the perspective of holistic wellbeing. Table 1 summarizes some main findings from the observations.

Remarks on physical environments

The age of the 17 care units observed ranged from seven to 37 years in the public care homes and from five to 45 years in the private care homes. In the public care homes there were from four 4 to 25 employees (on average 11.5 employees per home) and in the private care homes from 8 to 27 (on average 15 employees per home). The educational distribution of the staff in the public units was on average 8.8 primary nurses per care home and one registered nurse per care home. In the private care homes there were on average 9.4 primary nurses and 1.9 registered nurses per care home (see more in Komu et al. 2011).

General picture of physical environments The recommendations emphasized most of all accessibility and safety in public spaces. These recommendations were recognized and implemented quite well in the care homes observed. For instance, almost all units had put a lot of effort into safety issues such as wide corridors and number of doors to access outside premises easily. However, even if an automatic water sprinkler system is currently obligatory for new or renovated care homes in Finland, it was still missing in most of the units. Similarly the lighting of shared spaces, which was one detail connected to safety

issues in the recommendations, was insufficient in some of the public and private units. The design of the lighting was moreover seldom homelike. In addition, the limited storage spaces in the environments were noteworthy. Partly this is quite understandable because the recommendations do not recognize the need for spacious storage facilities for items such as assistive devices. The same problem was also noted by the research group on visits to other Nordic countries.. The existence of assistive devices, like shower chairs in communal spaces can stigmatize the residents and cause harm to residents and visitors alike (see more Jacobson 2010).

Table 3. Some main remarks from the observations

Observation element	Public (8)	Private (9)
General remarks		
accessibility:		
indoors	8Y	8Y, 1N
outdoors	6Y, 2N	7Y, 2N
effective lighting	5Y, 3N	5Y, 4N
spacious storage*	8N	9N
security equipment: such as automatic water sprinkling system for fire	3Y, 5N	1Y, 8N
existence of assistive devices	8Y	9Y
cleanliness	7Y, 1N	8Y, 1N
effective soundproofing	5Y, 3N	5Y, 4N
quality of air	6Y, 2N	9Y
signage	1Y, 7N	4Y, 5N
home image	3Y, 5N	6Y, 3N
high quality in furniture*	4Y, 4N	2Y, 7N
high quality in floor materials*	7Y, 1N	6Y, 3N
high quality in wall materials*	6Y, 2N	4Y, 5N
high quality in roof materials*	6Y, 2N	5Y, 4N
Elements connected to wellbeing concept		
Physical perspective – emphasis on privacy		
Single rooms	5Y, 3N	9N
Facilities for maintaining hygiene on own initiative	5Y, 3N	2Y, 7N
Social wellbeing – emphasis on daytime activities		
Separate spaces for daytime activities	3Y, 5N	9N
Mental wellbeing – emphasis on religious experiences		
Respect for religious beliefs*	8Y	9Y

Explanations:

Y= seen in the care homes observed

N= not seen or operational in the care homes observed

*= not mentioned in the recommendations

The studies by Talvenheimo-Pesu (2009) and Devlin and Arneill (2003) revealed that residents want the environment to be clean and spacious, which are also important factors for hygienic reasons. The observations showed that the general cleanliness of the care homes was good, but there was one home in both sectors which did not comply with these recommendations. There seemed to be some insufficient soundproofing and shortcomings in air quality in some units. Most of the soundproofing failures were in old facilities that were lacking any renovation.

Both sets of recommendations supported homelike feeling and replacing symbols of institutional care. However, in some care homes at least the functional values seemed to take precedence over the homelike atmosphere. Partly the lack of homelike feeling was due to the “neutral and functional” materials commonly used in care homes because durability and easy cleaning are often mentioned as requirements for these in care homes. Nevertheless our observation showed some variation in the materials between the units, for instance less than half of the units had high-quality furniture. It seems that materials depended on the age of the unit and also on the ownership of the unit. Mostly the quality of materials was lower in some private units than in public units. The materials used and similarities in different care homes have an effect on the image of the unit as a home or an institution. Our research visits to care homes in the Nordic countries and in the UK have shown, for instance, the prevalence of some materials and colours in care home environments. It is an interesting question from the management perspective how much national or international main suppliers of materials (including furniture) influence the similarities of images of care homes in different countries.

Elements connected to the wellbeing concept All the foregoing general remarks influence overall resident wellbeing and have clear connections to the organizational aesthetics approach presented in the earlier chapter (Hujala & Rissanen in this book). Yet physical environments can also be observed more specifically through the various aspects of wellbeing. It seems that the recommendations generally supported various wellbeing aspects, but inside those aspects, only some quite narrow elements were emphasized as recommendations. Broadly speaking, it seems that physical wellbeing aspects focused on privacy elements and social wellbeing aspects on opportunities for daily activities. Mental aspects connected to wellbeing were mentioned in general terms, for instance, with emphasis on residents’ cultural and personal differences which should be taken into account in the environments. The mental aspect was more difficult to observe than other aspects when the list of elements based on the recommendations was used as a protocol for the observations. The problem was how to operationalize the general terms into elements which could be observed and quantified. Yet it seems that the emphasis of mental wellbeing aspects seems to be on religious

experiences, as an impression was easily gained from the environments and the elements used in them.

Concerning the physical wellbeing aspects, the recommendations include some issues that are important in order to guarantee care home residents' privacy. The size of the care home unit is one of the factors affecting privacy; the recommended size is usually from 9 to 15 residents per unit. Enhancing privacy also calls for private toilets and bathrooms for each resident, which were not available in all units.

A resident's own room is described by Talvenheimo-Pesu (2009) as a valuable space, which contains everything needed by an elderly person. In the private care homes observed there were single, double and even triple rooms for residents although according to the Finnish



recommendations (2008) each resident should have a single room with en suite washing and toilet facilities unless he or she specifically wants to live with a spouse or another resident who prefers company. In the public units the situation seemed to be slightly better; there were five care homes with single rooms for everyone and three care homes with some double rooms. Most of the rooms included personalization possibilities with a resident's own furniture and memorabilia, although some units had forbidden carpets for reasons of safety and insisted on automatic beds for residents' needs and employees' wellbeing.

Figure 1. Resident's room

Both sets of recommendations include criteria for recreational activities and daytime activities. Older people need something meaningful to do in daytime, but these needs may vary between genders (e.g. Park et al. 2009). Such activities have a versatile performance-maintaining effect from the holistic wellbeing perspective. However, here we have interpreted daily activities from the point of view of how they enhance social wellbeing in particular, because it seems that the recommendations connect them mostly to this aspect of wellbeing.

Three of the public care homes at issue had separate spaces for daytime activities. In the private care homes there were no such spaces. Daytime activities were often held in dining and lounge spaces. All public and private units' dining and lounge spaces supported joint social interaction and all the public and almost all the private units' facilities also offered opportunities to hold festive events such as having a small-

scale party with relatives, for example. However, there was a lack of spaces for informal interaction, especially spaces where older people could have peaceful moments with their relatives or other visitors elsewhere than in their own rooms. The private rooms were usually quite small, with only one spare chair to sit on, and there were hardly any opportunities to do anything with the resident such as having some coffee together. This is an issue which has not been taken into account in the Finnish long-term care recommendations. Excellent exceptions were noticed in one private unit offering facilities for relatives to stay overnight with the residents.



Figure 2. Dining environment

InformeDesign (1999–2009) recommended considering differences in residents' cultures and personalities, cognition and fatigue in design processes. The Finnish recommendations used in this study mostly emphasized the special needs of clients with dementia, but this especially from the safety perspective. The checklist elements for these recommendations were difficult to create, because culture, personality and cognition are very broad and many dimensional concepts, so actually the checklist mostly lacked these elements. The reality of the care home environments showed that religious symbols especially were presented in care homes as seemingly important items of cultural affordances.

In the future this tendency to emphasize the Lutheran or Orthodox religion as the sole or main cultural orientation will be open to question from the multicultural perspective. Firstly religious needs are taken into account in a narrow way resulting in unequal treatment if the residents are from many different religious backgrounds or indeed have no religious convictions at all. Secondly the mental wellbeing includes many

non-religious forms of mental and spiritual activities which should also be promoted through the design solutions. For instance, the experiences of various art forms and nature were still quite rare in the care home environments. Altogether it seems that multiculturalism as a broad concept was not yet recognized in the care home environments.



Figure 3. Religious elements in a care environment

The relevance of the physical environment

The number of case units observed was small and observed by many different observers so caution is required when interpreting the results or drawing any conclusions. In addition, the use of a checklist based on recommendations focused the observations on those elements which were easy to operationalize. Actually it seems that recommendations and guidelines should address the social and mental wellbeing aspects more specifically, otherwise these wellbeing needs may be underestimated in design processes. The danger is that design processes with limited financial resources focus increasingly on those recommended environmental elements which are easily quantified, checked and easy to understand, such as safety and single rooms. So this kind of checklist based understanding of wellbeing may simplify wellbeing into separate and simple elements and disregard its nature as a holistic entity.

Physical environments can still be seen as a manifestation of organizational culture. For instance, care home environments can be interpreted as manifestations of how the different stakeholders, such as owners, managers and staff members, understand wellbeing. Critically seen, the present environmental reality in the care homes seems not to be at a satisfactory level in all units and as a result the

physical environments do not meet the residents' holistic wellbeing needs (e.g. Hofstede 1993, 258). Such a result calls for further study of the connection between the artefacts of wellbeing, like environments and their elements and the basic values of wellbeing from the point of view of organizational culture research (see more Smircich 1983; Schein 1985).

Moreover, public and research discussions (e.g. Amirkhanyan 2008; Sinervo et al. 2010) frequently ask if there are some quality differences between private and public care homes. This study focused on the physical environments, which could be interpreted as one part of the structural quality factors (see more in Donabedian 1966 and 1987). The observations showed that there are no obvious differences between public and private care home environments. A more important question seems to be the age of the building (see also Komu et al. 2011). Naturally, newer units respond better to the recommendations than older ones, but still it is worrying that not even these units always meet the obvious basic requirements, for instance for spacious toilets and storage spaces, to provide for the basic needs of resident wellbeing. Similar findings were reported after visits to care homes in other Nordic countries and the UK.

Care services for the elderly are under continuous debate and time will tell how much pressure there will be to change the physical environments of care homes. In 2012 the new Act on Care Services for the Elderly (STM 2012) is in the process of preparation and public debate on staffing ratios in institutional care has been heatedly debated. This question is relevant for the quality of the care, but partly the need for staff is also partly dependent on the environmental solutions in care homes now and in the future.

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Elderly Users and New Technology: The Case of Care Homes and Other Contexts

MariAnne Karlsson

Elderly people living in care homes are increasingly surrounded by technology. Part of the technology is necessary to assist care processes and part for supporting the wellbeing of the elderly, for instance for maintaining social relations outside the care homes. What technical solutions are available will be determined by a number of factors such as rules and regulations, economic resources, as well as staffing and manufacturer-related aspects. This chapter focuses, however, on the elderly individual and presents some theoretical and empirical approaches in order to understand elderly people as users of technology, in particular their adoption of new technical solutions and the requirements this imposes on technology design.

Technology as a means to improve wellbeing

New and innovative technology is regarded as an important means of improving the independence and overall quality of life for elderly people (e.g. Freedman et al. 2005), for those living at home as well as for elderly individuals living in care homes. Concepts such as ‘technology for the elderly’, ‘gerontechnology’, as well as the objectives of several national and international research and development programmes support the notion that technology can be effective in ‘... *enhancing the quality of life of residents*’ and ‘... *increasing efficiencies of care*’ (Freedman et al. 2005). At the same time it has been concluded that ‘... *the socio-technical connection between elderly human beings and new technology does not occur easily*’ (Bouchayer & Rozenkier 1999, 11). Older individuals have been regarded as a category which is least likely to accept, i.e. have a positive attitude towards, and adopt, i.e. become aware of, embrace and use new technological solutions. The question is, however, if age *per se* is a determining factor for people’s acceptance and adoption of new technology or if other factors may explain the observations made. This, in turn, leads on to other questions: Does, for instance, elderly users’ assumed reluctance to adopt new technology apply to all technical solutions or only to some? Will some technical solutions be more easily accepted and adopted than others? Do elderly individuals differ in their attitudes towards new technical solutions? If so, do residents in care homes differ in their relation to new technology from elderly people living at home?

Searching for theories

A few theories and models can contribute to our understanding of users’ acceptance and adoption of new technology in general. According to the Theory of Reasoned Action, TRA, (Fishbein & Ajzen 1975; Ajzen & Fishbein 1980), a person’s performance of a special behaviour – such as adopting a new technology – is determined by his or her behavioural intention to perform that particular behaviour (Figure 1). Intention is thus a predictor of actual behaviour. The behavioural intention is determined by a person’s attitude to the behaviour and by subjective norms. Attitude in turn is determined by the individual’s beliefs about the consequences of performing the behaviour, weighted by an evaluation of those consequences. An individual may, for instance, believe that a new technical solution will save time, be difficult to learn and expensive to use. Each of these beliefs will be weighted and saving time may be more important than the cost associated with use. Subjective norms are affected by normative beliefs and the individual’s motivation to comply. This means that individuals are influenced by the beliefs of others in their social environment. Some may encourage adoption of the new technical solution, others may argue against. The beliefs of these other people, weighted by the importance an individual ascribes to each of

their opinions, will influence the person’s behavioural intention. Other factors possibly influencing behaviour do so indirectly.

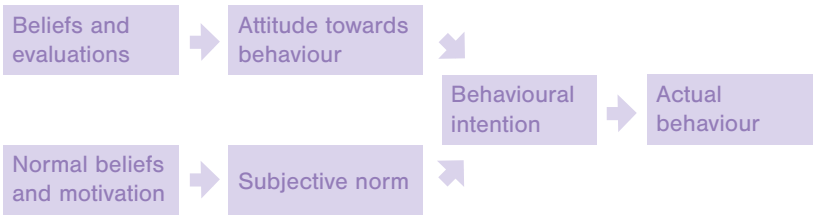


Figure 1. The Theory of Reasoned Action

The Technology Acceptance Model (TAM) is an adaptation of TRA, originally tailored for modelling user acceptance of information systems (Davis 1986; Davis et al. 1989; Davis 1993) but later applied to other contexts. Even though it uses TRA as a theoretical basis, TAM concludes that perceived usefulness and perceived ease of use are of primary relevance for acceptance behaviours (Figure 2). These factors shape the individual’s attitude towards using which, in turn, affects the individual’s intention to actually use the new technology. Later, Venkatesh et al. (2003) have extended the model and developed the Unified Theory of Acceptance and Use of Technology (UTAUT), which distinguishes between factors determining use behaviour (i.e. performance expectance, effort expectancy, social influence and facilitating conditions) and factors mediating the impact of these constructs. Mediating factors include gender and age.

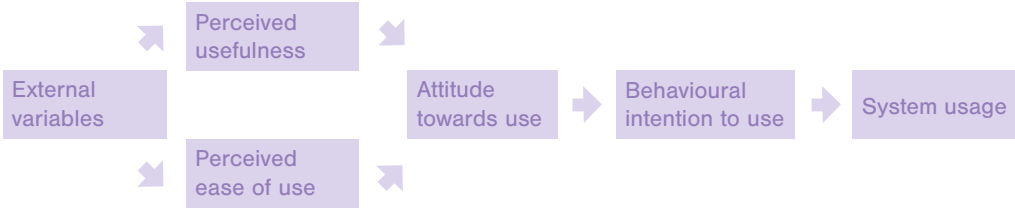


Figure 2. The TAM model.

According to the Diffusion of Innovation Theory (Rogers 1995), which is one of the earliest theories on the topic, there are four main elements that are assumed to influence the rate of adoption. Firstly, there are some characteristics of the innovation itself: (i) relative advantage (that the innovation is perceived as better than the idea it supersedes), (ii) compatibility (the degree to which an innovation is perceived as being consistent, for example, with existing values), (iii) complexity (the degree to which the innovation is perceived as difficult to comprehend), (iv) trialability (the degree to which an innovation may be experimented with), and (v) observability (the degree to which the results of an

innovation are visible to others). There are also non-technical aspects such as how the innovation is communicated and the channels used for communication. In addition, the individual's peers and personal network play a key role. Time is a third element in the diffusion process where the so-called innovativeness of the individuals will have an effect. Five categories are proposed: (i) innovators, (ii) early adopters, (iii) early majority, (iv) late majority, and (v) laggards. The innovators, who are usually younger people, are the first to adopt a new idea, while the laggards, who are often older people, are the last (Rogers 1995). Diffusion occurs, however, in a social system and in order to understand the phenomenon, the social structure of that system must be also considered. Again, communication is an important factor, as are the existing norms (cultural or religious for instance) of the social system. Opinion leaders play an important role in enhancing or inhibiting changes.

Thus one theory emphasizes the characteristics of the individual, another the characteristics of the technology, while a third approach integrates the two aspects in a socio-cultural setting. Whereas age appears to be a factor to consider it is apparently neither the sole nor the decisive aspect – “... *there are many products that older consumers will not be interested in but it is important to recognize that resisting innovation is not something particular to older consumers.*” (Szmigin & Carrigan 2000, 509 cited in Essén & Östlund 2011). A number of additional factors need to be considered in order to fully understand people's acceptance and adoption of new technology, including those of elderly people.

Turning to empirical work

Turning to empirical studies, the conclusions regarding elderly users and new technology draw primarily on investigations of information and communication technology (ICT), computers, Internet and related e-services, such as home shopping (e.g. Karlsson 1999), remote monitoring (e.g. Reder et al. 2010), tele-care (e.g. Bouwhuis et al. 2012), and from investigations of mobile phone usage (e.g. Kurniawan et al. 2006). Studies on assistive technologies such as bed alerts, fall detectors, hearing aids, various mobility aids, or safety alarms appear almost non-existent from a technology acceptance and adoption perspective. A study by Lesnoff-Caravaglia (2005) is one of few exceptions. As a result of a survey of over 130 healthcare institutions in the U.S. she found that the diffusion and utilisation of high as well as low technology were limited. Furthermore, most investigations target elderly people living at home, whereas very few studies consider people living in nursing homes or other long-term care facilities. Freedman et al. (2005) concluded that ‘... *only a few studies have explicitly focused on factors influencing the adoption of technological innovations in this sector*’, i.e. the residential care sector. Indeed, if new technology in long-term care is considered, the targeted users are for the most part the nursing staff – “*The new lifting system was found to reduce the number of staff necessary to execute patient lifts. This staff saving amounted to 50% of one full time equivalent*

person per nursing unit.” and *“Nurses perceived that less effort was required using the new lifting system compared to a conventional floor model wheeled lifting device.”* (Holliday et al. 1994) – even though elderly users should be considered if not as primary then as secondary users. An example of the importance of considering this aspect is provided by Mahamoud et al. (2009). In one project, a solution was designed for staff members to verify medication by scanning the patients’ wristbands to identify them and then scanning the medication to ensure that the right medication was provided to the right patient. Patient wristbands are a common means to ensure this but the residents living in the specific nursing home did not wear wristbands because of integrity and dignity concerns. Consequently another solution had to be sought in the project.

Nevertheless, although the relation between new technology and elderly users in long-term care has not been a specific theme, the investigations of elderly users in general may still provide some important input that can help to understand and approach new technology in a long-term care context.

Focusing on the individual

Consistent with the Theory of Reasoned Action and the focus on the characteristics of the individual, a common theme in the literature is attitude. Elderly people have been found to have a negative attitude, fear of or even hostility towards new technology, but the findings are far from consistent. Some early research on elderly people and computers indicated that elderly users had a significantly higher so-called ‘computer anxiety’ than younger adults (e.g. Laguna & Babcock 1997), but other studies have concluded the opposite (e.g. Czaja et al. 1989; Dyck & Smither 1994). Czaja and Sharit (1998) reported, as an example, that as elderly people increase their experience with computers, they develop more positive attitudes towards computer technology, and Leonardi et al. (2008) proposed that the age-related ‘technophobia’ that has been represented as the main obstacle to older individuals’ technology usage is slowly disappearing. Having a more negative attitude to one specific technology should not, however, be mistaken for a negative attitude towards other technical solutions or towards technology in general. There are studies (e.g. Karlsson 1995; 1999) which show that elderly people may have a very positive attitude towards technology in general, actually even more positive than do younger adults, but a slightly less positive view of some specific technical solutions when they cannot see that they benefit from neither learning how to use nor use them.

Another factor that has been found to influence the way elderly people approach new technology is self-image. This has an impact on whether or not the individual wants to keep up with new developments and is motivated to learn, at least to some extent. However, not only the elderly person’s self-image and capabilities matter. Several studies have concluded that elderly users are influenced by the perceived or actual expectations and attitudes of other people, such as children,

grandchildren and other relatives, nursing staff and other caregivers, as well as of society as a whole. These other people may create obstacles, partly because they may themselves lack experience of certain technologies. For instance, nursing home staff has been found to have limited technical knowledge and low comfort with technologies in general (Freedman et al. 2005), and also limited experience of using computers specifically in a professional context (Mahamoud et al. 2009). However, the same individuals can also become important change agents (cf. Rogers 1995), triggering elderly people's awareness of and interest in the new technology, as well as offering an opportunity to try it. Not least elderly people's grandchildren have been found to be important mediators in this process by providing access to the new technology which is a key issue in the adoption process (cf. Rogers 1995). An elderly person's confidence can be considerably enhanced by the provision of opportunities for experimenting and exploration (cf. the concept of triability).

In addition, elderly users evidently come with a background and their former education and professions are factors that affect their self-image (e.g. Specht et al. 1999). From a technology adoption perspective former experience and familiarity with technology play an important role (e.g. Baack et al. 1991; Karlsson & Kaulio 1993) as previous experience of similar technology is argued to help form an "... *imaginary use*" of the new product (Caradec 1999) which helps in the learning process. It should be emphasized that elderly individuals have, in general, considerable experience of technical changes (e.g. Östlund 1995), for example from the diffusion of electricity and the developments within the transport sector. Today many older people have experience, for instance, of mobile phones, as well as of computers and the Internet (Figure 3), and will have even more in the future. This will have a considerable impact on the requirements for their future long-term care living.



Figure 3. The author's father at his computer.

However, they may still not have the same knowledge and experience as younger individuals of more recent technical developments – resulting in what Leonardi et al. (2008) described as a lack of a language by which the elderly user can relate to technology.

Willingness and the ability to learn how to use a device have been found to be further decisive factors for the elderly user's adoption of new technical solutions (Ziefle & Bay 2004). An example is the findings in a study on elderly users and mobile phones (Renaud & van Biljon 2008), in which impaired ability to learn was evinced as a main reason for rejecting a new type of telephone. In another study, the users said that they were willing to undertake training to be able to use a new type of health monitoring system whereas a health care professional claimed that this most often proved not to be the case (Steele et al. 2009). However, there is no evidence that age as such hinders someone from learning new things even though learning may require more time and pedagogic approaches specifically adapted to the older learner. At the same time it must be conceded that there are considerable differences between individuals. Numerical age does not necessarily correlate with functional or social age, which means that two people may be the same age, but differ considerably in their mental and physical capacities as well as in their social habits and roles.

What about design?

With the Technology Acceptance Model and the Diffusion of Innovations Theory as a basis, explanations for elderly user's adoption or rejection of new technology must be sought beyond the characteristics of the

individual and also, or perhaps instead, in the design of the new solutions. For instance, Specht et al. (1999) argued that elderly people reject new technology not because they have a negative attitude but because the new technology is primarily designed for younger and more able users. On a more fundamental level, older users have to deal with technical equipment that does not match the ageing person's physiological or cognitive abilities. With age, including normal aging, there is a decline in the individual's physical capacity, particularly sensory capacity, and an elderly person has a slower sensory-motor performance than a younger person. In addition, there is a slowing in the rate of information processing, particularly the activities of working memory (e.g. Strayer et al. 1987; Lovelace 1990). Several investigations stress the importance of considering these matters in design. When elderly individuals use mobile phones perceived usability problems are associated with buttons too small for discrimination, screen sizes and fonts too small to read, and menus with too many options to provide a good overview (Mallenius et al. n.d.; Kurniawan et al. 2006). A more recent study on computer use among elderly people in long-term facilities illustrates the problems in seeing what was displayed on the monitor, understanding and remembering terms and abbreviations, and, due to poor manual dexterity, in using the mouse to click on the correct spot (Namazi & McClintic 2003).

On another level, older users have to cope with technology that does not meet their more fundamental needs. Leonardi et al. (2008) identified a lack of engagement in older users as new technology was perceived as unfamiliar and alien. If and when benefits were perceived, the investment of the personal resources needed to use the new solutions was considered too high. Similar results have been reported from other investigations (e.g. Karlsson 1995; 1999). A key issue in elderly users' adoption process appears to be the balance between perceived usefulness of the new technical solution and the effort associated with accessing these benefits (cf. the concept of relative advantage proposed by Rogers 1995). However, even though usability and usability problems must be addressed, trying to understand the relation between elderly users and new technology emerges as an issue of meaning, motivation and of perspectives. A study by Selwyn (2004) concluded, for instance, that older adults often find that new technology has very limited relevance to their day-to-day lives, thus no meaning is attached to new technology or motivation to change one's everyday habits. Other studies have shown that older people are attracted to products that enhance their capability for independent living, and which provide greater sense of physical and emotional wellbeing, but reject technology that decreases their opportunity to socialise, which they find too impersonal and which is not safe (e.g. Gilly & Zeithaml 1985).

Furthermore, studies indicate that elderly people's interest in changing their habits, in adopting novelties including new technology, change according to changes in life perspectives (e.g. Östlund 1999). Referring to the Disengagement Theory, Specht et al. (1999) talked about

“a quantitative lessening of activity” and a certain *“slowing of the pace of life”* (ibid). The model of Selective Optimization with Compensation (Baltes & Baltes 1990) proposes that *“people increasingly tend to focus their limited energy on activities and domains that they perceive as being most essential and valuable in their lives.”* (ibid). Thus whereas ‘saving time’ may be a key element in the dissemination of technology for younger individuals, saving time or getting more “free time” may not be as important to an elderly person. This should not be taken to mean that the older a person gets, or the more care he or she needs, there is a progressive loss of interest in new technology. For instance, the earlier mentioned study on computer use by Namazi and McClintic (2003) illustrates wide differences between the long-term care residents who participated in the study. Many individuals lost interest but the five (out of 24) who continued to attend the computer classes arranged benefited by communicating with the outside world via the Internet and e-mail, they shopped online for daily necessities, played games online, searched historical records, and chatted with others experiencing the same medical difficulties.

Designing with the elderly user in focus

The implications are that promoting elderly users’ adoption of new technology is a matter of designing with the elderly user in focus. In fact, a design which considers older adults’ perceptual, motor and cognitive capabilities has been found to result in a reduction of differences in performance between younger and older individuals (e.g. Karlsson 1994). Familiarity and turning new technology into something familiar for the elderly users are other, important aspects to consider. For instance, Leonardi et al. (2008) argued that technology should be something that is *“perceived as belonging to our own world, that fits our daily practices”*, i.e. an argumentation in accordance with the principle of compatibility (Rogers 1995) and the importance of acknowledging users’ previous experience of technology (e.g. Caradec 1999). The example presented by Leonardi et al. (2008) concerns designing a computer interface where interaction by means of menus, keyboard and mouse was replaced by more familiar interaction modalities based on touch, pointing, clicking and similar natural gestures. As a design principle, compatibility, or similarity with existing and familiar solutions can be applied to different designs intended for elderly users. Moreover, elderly people’s habits and practices from their previous lives can become a resource in a new design. Another example is provided by Waller et al. (2008), who developed and implemented what was described as an ‘extended television’ in a nursing home. The underlying idea was to move *‘computer power from desktop computing to known everyday objects’* which have been present in the users’ environments for a long time, such as television. In addition to the regular broadcast programmes, the extended television offered the residents of a care home an internal care home channel and later a personal television photo album. The conclusions

drawn were that the internal channel was used and became a tool for the recollection of past experiences and events, as well as for interaction between the elderly, their relatives and the staff. The positive outcome was attributed the user-centred design process, which started by eliciting the older people's wishes and continued by listening to their opinions and (perhaps more importantly) through which the developers reached an understanding of "... *how older people in the nursing home act and think.*"

A central theme is thus user- or person-centredness (cf. Dickinson & Dewsbury 2006). Even though a user-centred development cannot ensure elderly users' acceptance and adoption of new technical products, the argument is that it will increase the likelihood of such acceptance and adoption. A key factor is the involvement of the users – as informants, as evaluators, or perhaps even as co-designers – and the acknowledgment of the elderly as knowledgeable and as a resource in development (cf. Essén & Östlund 2011). No doubt designing for elderly people, whether living at home or in care homes, requires a thorough knowledge of aging from different perspectives, biological, psychological and social, but elderly people's knowledge, experiences, ideas and wishes are important too in order to create solutions with meaning and relevance in their everyday lives, and hence for their acceptance and adoption.

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Applying Positive Psychology Principles to Care Home Design

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This chapter introduces ideas from the developing field of positive psychology, and suggests ways in which those ideas might be applied to improve quality of life in care homes. There is a variety of small ways in which the lived experience can be improved by paying attention to the detail of everyday life and what research in positive psychology has been found to make life more satisfying. This leads to design suggestions at the specific level of layout, access, information etc., but it is important to recognise that the care home should be considered as a whole system and it is important to pay attention to the wellbeing of all the people there: residents, care staff and other support staff. Improving the work experience of staff is likely to benefit residents. We also suggest that as well as the design of the physical environment, the design of ways of doing things is an important additional consideration.

Approaches in positive psychology

Although ideas about wellbeing in philosophy and religion are very old, and nineteenth century social science, as in Freud and Durkheim, had ideas about the causes and definitions of wellbeing, a systematic concern with what has come to be called 'positive psychology' is fairly recent, mainly starting from the ideas of Carl Rogers (1980/1995), Abraham Maslow (1971) and Ivan Illich (1973). Snyder and Lopez (2005) and Huppert et al. (2005) give a cross-section of current research in positive psychology. Williamson (2005) considers how these approaches might apply to an aging population.

In contrast to earlier work, research over the last twenty or thirty years has become much more empirical, using a variety of indicators of adjustment, health, contentment and effective functioning to evaluate theories of wellbeing. This literature suggests a distinction between three positive states: absence of deprivation and suffering, immediate pleasure and enjoyment, and deeper, longer-term engagement and satisfaction, which might arise either from social engagement or from involvement with tasks and activities. It is suggested that these work in different ways. Removing suffering will stop us from feeling bad, but does not in itself help us to feel good. Immediate pleasures are enjoyable, but we quickly habituate to pleasant things and need escalation and constant variety to maintain enjoyment (Brickman et al. 1978; Diener & Lucas 2006). Engagement and satisfaction, on the other hand, may result from activities which may not be immediately experienced as positive (and may well not be relaxing), but are valued in retrospect, and are seen as being capable of making a positive change in the individual, which in turn may lead to long-term benefits (Seligman 2003; Diener et al. 2005). This last process could be called 'deep satisfaction', and its potential for enabling personal development makes it an important component of the wellbeing literature.

Overall, this literature suggests that as well as improving things for people by removing unpleasantnesses and difficulties, designers might aim to enhance wellbeing in three general ways: enabling effective and involving action, with an awareness of prediction and control; encouraging satisfying social interaction; and promoting mindfulness, physical involvement and enjoyment. Removing discomfort and irritation has to be worthwhile, of course, and this area is well covered in writing on cognitive ergonomics and universal design. Where it might be combined with the other three goals will be mentioned below.

In what follows we discuss these general approaches, and suggest some specific ways in which those general goals might be applied to improve the quality of life in care homes for the elderly. Positive psychology can be criticised for being too optimistic and too focussed on personal growth. The long and medium term outlook for care home residents is not optimistic, and the personal and psychological changes they may experience are usually associated with decline rather than growth. However, a positive psychology focus on making the most

of whatever abilities and opportunities are available, while avoiding *unnecessary* limitation from disabilities, seems justifiable.

It is also important to consider these principles with regard to the wellbeing of workers in care homes as well as that of residents, since research has shown that the major determinants of residents' wellbeing are the attitudes, job satisfaction and low levels of staff turnover of home workers (Zimmerman et al. 2005a, b). Where there are conflicts between the needs of workers and residents, the needs of the residents should come first, but if increasing the wellbeing of staff can have important effects on increasing the wellbeing of residents, then making some compromises in favour of staff wellbeing might be appropriate. 'Workers' and 'staff' here can be taken fairly generally. It is the job of front-line workers in roles such as care assistant to work most closely and continuously with residents, but there are often other workers in a home (cleaners, cooks, secretarial staff, managers) who are part of the whole social life of the home and may contribute much to its overall atmosphere. Also, one theme of this book is that care homes should be regarded as overall systems, and the design, management and wellbeing of all aspects of the system are relevant to residents' wellbeing.

Findings from user workshops in Finland

There are some useful reviews of environmental design for wellbeing in dementia homes and care homes, mainly based on empirical research. Barnes et al. (2002), Brawley (2006), van Hoof et al. (2010) and some chapters in this book (e.g. Hujala & Rissanen; Kälviäinen) discuss how environments can match the sensory capacities of older people. An aim of this chapter is to complement those reviews with a theory-driven set of suggestions.

We have also been guided by two user information workshops with older people in North Karelia in October 2010 as part of the CoWell project. We talked to 67 respondents (57 women, 10 men): people with heart problems and their relatives, people with relatives in a care home, and people caring for relatives at home. They were asked about what it would be important for them still to be able to do, things they would like to take with them if going into a care home, how they could retain their identity, what would remind them in a pleasurable way of their past life, and what activities should be public and private.

What people wanted to keep was a variety of things – memories, customary surroundings, continuing activities and hobbies, ways of keeping in touch with the world. What people wanted to be able to do was a continuation of what they had done before – to live a 'normal life', not an 'institution-controlled' life. They were clear that they wanted to be able to continue to live *their* life: the word 'own' was used repeatedly: own plants, own activities, own music, own books, own decorations, own clothes (and underwear).

Our respondents had clear ideas about the distinction between private, personal and communal. Some of the important private

activities were mundane (breakfast coffee, newspapers) as well as more traditionally personal activities (toilet, dressing). Communal desires included being involved in activity for the common good – laying tables, deciding on menus – as well as general social activity.

The suggestions here might be used as guidelines for designers: the beginnings of a pattern language (Alexander et al. 1977) for designing for wellbeing. The references cited in the lists of guidelines at the end of each section give some support for the principles, sometimes empirically based, sometimes not. There are some principles which the authors have derived from their own experience (as psychologist and designer, and as educators): we hope these will seem reasonable and self-evident to the reader. It is necessary to validate these principles against actual design examples, of course. We give some examples here, but finding more examples, and testing out these principles in action research, is an ongoing project.

Action, prediction and control

It is important for people to live in a world where they can predict what is likely to happen to them, and feel that they have some control over that world: that is, they feel that they can take actions which will have some effect on what happens. Seligman's early work (1975) on learned helplessness emphasises the debilitating effect of both rewards and punishments which arrive in no predictable pattern, and which do not seem to be influenced by the individual's actions or responses.

The importance of allowing people a sense of control and responsibility in their lives in care homes has long been recognised, at least since Rodin and Langer's study (1977) "Long-term effects of a control-relevant intervention with the institutionalized aged", which showed the positive health effects of giving residents some choice and responsibility for aspects of their daily lives. This has been backed up by much subsequent research (Schulz 1976; Secker et al. 2003). Increased control and responsibility might be associated with increased risk, and obviously maintaining safety is a main objective in care home management. However, it does seem in much research that an increased concern with safety is associated with reduced quality of life (Parker et al. 2004; Bland 2005). The design issue here is in providing opportunities for autonomous action within an inherently safe environment. A common example is giving free, but basically safe, access to secure outdoor spaces (Chalfont & Rodiek 2005).

Control and responsibility are issues for workers as well as residents. One of the features of the Green House movement is the role of Shabaz, a worker who has prime responsibility for most of what happens in their unit, being involved in nursing, social and practical aspects of the house management. Such a role might be much more fulfilling and absorbing than that of a basic care assistant. Rabig et al. (2006, 538) in their report from an early implementation of the Green House concept in Tupelo, Mississippi, note that "Most Shabazim embrace the empowerment of

their roles and visibly demonstrate increased skills, self-esteem, problem solving, and self-possession”.

People generally find involvement in a task satisfying if that task places reasonable demands on their skills, but is not so difficult as to be beyond their capabilities. Seligman’s (1975) work on learned helplessness points out that both failure and success which arrive arbitrarily are damaging to people’s sense of competence in dealing with future challenges. Elderly people in care homes are likely to have many of their abilities restricted, but they still do have abilities, and it is possible to match the demands imposed on them with those abilities, with some sensitivity. Zeisel (2011) points out how awareness of the specific cognitive weaknesses and strengths of a person with dementia can be used to avoid ways of interacting with them which leave them helpless, and choose ways which will allow them to respond effectively. Secker et al. (2003), in a valuable article, suggest that we could see dependence and independence as separate dimensions. Residents in a care home are necessarily heavily dependent physically and perhaps cognitively, but can still have the capacity to make immediate choices of what to do, and maintain a sense of having a meaningful social role, and therefore maintain some sense of independence.

Csikszentmihalyi’s (1990) concept of ‘flow’ is worth thinking about here. Flow is a state in which people become deeply, effortlessly, involved in what they are doing, lose both self-consciousness and track of time, and experience a sense of control and satisfaction. This is usually associated with activities where there are clear goals with immediate feedback, where the task is challenging and requires skill, and the level of skill required matches the level of skill available. ‘Deep, effortless involvement’ is perhaps an optimistic goal in care homes, and some of Csikszentmihalyi’s examples are intense activities like rock climbing and virtuoso music performance, but he also reports people finding flow in housework, doing schoolwork or bringing the cows home, and at that level, absorbing, satisfying activity is a reasonable goal. The point made by Zeisel (2011) about sensitively supporting cognitive abilities applies to other areas of skill, and knowledge of each individual’s abilities and how they might be reflected in the demands of the environment and activities, from washing vegetables to playing the piano, can help in supporting meaningful activity for each person. People will also want to continue with their own interests and skills, even if at a more modest level. Those who have been keen knitters in earlier life will still like to knit; one of our respondents, who had enjoyed working on his car when he was younger, still enjoyed looking through illustrated books on car maintenance.

In this context designing for satisfying involvement is mainly a matter of task design, both for workers and residents. Management might take responsibility for specifying workers’ roles in such a way that they have challenging but clear goals for the ways in which they support residents (whose responses will provide feedback), but also ensure that workers have sufficient training, skills and support to be able to perform those

roles effectively. One of the important, challenging roles for workers could be to support residents in involvement in activities which for them are also challenging at an appropriate level of skill, however mundane those activities might seem, as suggested above. Verbeek, van Rossum, Zwakhalen, Kempen and Hamers (2008, 259) in a literature review of small, homelike care environments for people with dementia, point out that a common feature is involving residents in household activities, but comment that “Daily life is organised around meaningful activities, such as cooking, with a lot of personal contact. This requires the staff to have specific skills, such as high levels of social and communicative skills.”

Since the most beneficial form of skilled behaviour here is in the human, interactive aspects of activities, systems design which allows workers to focus on these, rather than mechanical problems, will be an advantage. People should be free to use their skills in gathering information from residents rather than being challenged by record keeping systems; to concentrate on keeping someone calm and comfortable, rather than concentrating on the difficult-to-use hoist system. Training guides, such as Grealy, McMullen, and Grealy (2005), can give guidance on ways of approaching and interacting with people with dementia to reduce conflict and make interactions more social and less threatening.

The same principle goes for residents. Crews and Zavotka (2006) have pointed out that the standard ergonomic measures used for designing furniture derive from young fit men and women, whereas the majority of care home occupants are elderly women, and standard chair and table heights are inappropriate for this population. Coping with ill-fitting furniture would reduce people’s ability to focus on whatever constructive activity they might be involved in. There may be a conflict here with the aim of providing a homelike setting: specially designed furniture may appear more institutional than domestic. This is an area where design sensitivity could usefully improve the feel and aesthetics of ergonomically driven design.

Summing up the research on this area in an earlier paper on design for wellbeing (Miller & Kälviäinen 2006) we identified a number of guidelines for supporting wellbeing by enabling action, prediction and control:

- Provide challenges which match people’s level of skill - and flexibly match changing levels of skill (Csikszentmihalyi 1990)
- Provide a match between effort and chances of success (Seligman 1975)
- Allow a sense of prediction and control of what is going on (Seligman 1975; Langer 1983)
- Allow people to express their meaning in action - without that stopping other people from doing the same (Illich 1973)
- Allow them to relate desires and goals (Csikszentmihalyi & Rochberg-Halton 1981; Csikszentmihalyi 1991)

Satisfying social interaction

Design for social interaction is partly a matter of designing convivial social environments. Hall (1966) proposed the concepts of sociopetal and sociofugal spaces; *sociofugal* spaces drive people apart, while *sociopetal* spaces bring them together. The analogy is with centrifugal and centripetal forces in physics. Examples of sociofugal settings are airport lounges or dentists' waiting rooms, while sociopetal settings are restaurant booths or even a conference table. The example of restaurant booths also suggests that spaces can serve both functions at the same time: holding a small group of people together, while separating them from those around them. One stereotype of an unsatisfactory public space in a care home is a room arranged like a doctor's waiting room, with chairs around the walls and a television, which might be a sociopetal focus in other circumstances, playing unattended in a corner. This is sociofugal space – one which makes people socially separate. It is desirable to design spaces which encourage interaction between people, at whatever level is manageable for them, or spaces that allow flexible shifting between privacy and intimacy and broader social contact. However, whatever the physical structure of a building, considerable changes can be made to its sociability by rearranging chairs and tables. In our interviews, respondents were able to identify homelike furniture arrangements which they thought would make more pleasurable semi-public spaces in comparison with the 'waiting room' layout.

Management of spaces to support appropriate social interaction is one aspect of Alexander's pattern language (Alexander et al. 1977) for architectural design, or Jane Jacobs' (1992) ideas about neighbourhood structure. In care home design, this suggests that spaces might be organised to *encourage* social interaction, but it is also important to *manage* social interaction. Part of the Green House idea is to put groups of people, both residents and staff, together in appropriate numbers and in appropriate spaces to support the range of social interactions of everyday life.

The kind of social interaction which is appropriate varies from setting to setting and situation to situation. Throughout life, we learn to respond very effectively to cues for appropriate socialisation. Zeisel (2011) points out that these social skills are part of the implicit learning people may retain for a long time in dementia, and so providing strong signals as to what is happening here, both in the design of the room and the fittings, and in the demeanour of the workers, may be useful in channelling appropriate behaviour.

Settings should allow for a variety of social interactions, and people should be allowed some sense of control over settings and interactions. Provision of a variety of private, semi-private, and quietly social as well as stimulating public spaces, and allowing residents flexible access to these different settings, should support both the sense of control over social interactions and the amount and quality of those interactions (Barnes et al. 2002). The preferences of workers, residents and visitors

may differ here. Duffy et al. (1986, 246) found that although both “administrators and designers favored designs that promote social interaction, nursing home residents consistently selected designs that enhance privacy”. Chapman and Carder (2003) found that the most popular places for relatives’ visits were public and semi-public spaces, although families were also concerned to personalise their relatives’ living spaces and to keep track of personal possessions. Lum and Kane (2008) point out that meeting the needs of visitors and family is important in maintaining the psychosocial wellbeing of residents. Perhaps given that there will be a variety of preferences, and a variety of kinds of social interaction, in a care home, designing for variety and flexibility of social settings should be the aim. Yang and Start (2010) support this idea, on the basis of a qualitative study, and point out that making public spaces reservable can transform them into private spaces without the need for physical rearrangement.

However, designing for social interaction is not merely a matter of physical design. Designing the roles of workers so that part of their job is to talk to people, and giving them the time and lack of other pressures to do this would have a bigger effect on the level of satisfying social interaction than would be achieved by rearranging the chairs. Not surprisingly, the participants in our workshops expressed a wish for a setting in which the staff would be ready to talk to them. Similarly, the daily regime can be designed to encourage social activity. Charras and Eynard (2011), introducing the French Eval’zheimer system, stress the importance of communal dining, with staff and residents seated together and serving each other. Charras and Frémontier (2010) report weight gains in residents eating like this compared with others who did not have communal meals, along with increased autonomy in residents and improved staff perception of work conditions.

The importance of the past, personal, family, or social, either as a way of providing reassurance and rootedness, or as a way of judging progress and development, is a recurrent theme in accounts of what people at all ages value and find uplifting. In the second author’s research on how people valued craft objects (interviews carried out March–October 2002 with 30 Finnish respondents, 20 female and 10 male), there were strong themes of connection to family, history and loved ones, and objects were also valued as the production of people whom the owners respected and admired (Kälviäinen 2006). A striking feature of this research was how ready people were to ascribe personal identity and social links to some of the objects they owned. This happened both through linkage to the designer or maker but also through the memories and meanings connected to the product. Clothes, chairs, rugs and ornaments can serve this function: such things were often mentioned by the elderly people that we talked to.

We have said elsewhere that this “suggests that systems should allow people to preserve durable traces of what has gone before, and make them easily available in the sometimes distant future” (Miller & Kälviäinen

2006). The care home context is that ‘distant future’ and encouraging residents to keep and use mementoes of their own past and a wider social past is usual. In coming years, the range of ‘durable traces of what has gone before’ will change. It is more difficult to preserve digital texts and emails than letters, but it might be easier in the future to make photos and videos available and accessible (through digital photo frames, for instance).

The guidelines for supporting satisfying social interaction are:

- Encourage/enable high levels of social interaction – a useful approach is in removing barriers to social interaction for those who have difficulty in achieving it.
- Allow presentation of oneself as the kind of person one would like to be taken for – and allow other people to go along with that pretence gracefully (Goffman 1959)
- Allow people to manage stigma, handicap or shortcomings (Goffman 1963)
- We say ‘manage’ rather than ‘conceal’ here, because some wellbeing suggestions are about authenticity, and living successfully with stigma could support wellbeing better than effectively concealing it.
- Provide a stable sense of how people should behave with each other (Durkheim 1893/1984)
- Support people in expressing love, being loved and connected to other people
- Allow them to relate past and present (Csikszentmihalyi & Rochberg-Halton 1981; Csikszentmihalyi 1991)

Mindfulness and enjoyment

Ellen Langer’s research (1990), suggests that there are psychological benefits from increasing awareness and focussing on the immediate moment, or ‘mindfulness’, an idea familiar from many religions and philosophies. Novelty and unpredictability are likely to jog us back into mindfulness, but subtle variations and unexpectednesses may help to remind us to pay attention and be present, even with familiar objects. This may be one reason for the often noted benefits of contact with natural environments, which are full of unexpectedness and subtle variations.

Robert Emmons and Michael McCullough (2003) found that people who reminded themselves daily of their ‘blessings’, things in their lives that they felt gratitude for, reported higher levels of happiness than others who reflected on hassles or on neutral topics. This focussed mindfulness can be encouraged by objects in someone’s life, as with things which reinforce a sense of rootedness or links with valued others, as discussed above.

These principles may seem paradoxical in dementia, where focussing on the present moment (or at least being aware of it) may be all that people can do, and where there is no memory of recent positive or

negative events, but allowing or encouraging people to concentrate on those 'blessings' they can recall would be worthwhile. This is an area where it is useful for staff to have good information about residents' history and values. Similarly, providing opportunities for people to focus on immediately involving positive experiences is beneficial. This may be one reason for the frequently-reported positive effects of having pet animals in care homes and the value of gardens (Gammonley & Yates 1991; Hoover 1995; Cooper Marcus & Barnes 1999). The value of mindfulness is also some justification for involving residents in activities which might seem 'pointless' and even demeaning to onlookers: allowing people to focus on a momentarily pleasant experience, however trivial, can be worthwhile in itself.

The guidelines for supporting mindfulness and enjoyment are:

- Give people (perhaps unexpected) positive experiences, which indirectly promotes wellbeing by increasing their openness and flexibility (Fredrickson 2003)
- Encourage/enable people to be more aware of the immediate moment (Langer 1990)
- Encourage people to be aware of and reflect on positive aspects of their lives (Emmons & McCullough 2003; Seligman 2003)

Physical activity

High levels of physical activity are often recommended for younger people in the wellbeing literature (for example Biddle & Ekkekakis 2005). Maintaining physical activity (though probably not at high levels) also has benefits for physical health, of course, and care homes will commonly use physiotherapists and exercise rooms to encourage this, but it is also worth bearing the wellbeing benefits in mind. Basic safety and support systems like clearly visible handrails and step-free thresholds allow free movement around the building, but effective design can encourage mobility.

One way of increasing physical activity is to consciously set out to take exercise, as in visiting a gym, and taking out expensive gym membership, or agreeing to exercise with a friend, are both strategies that people use to encourage themselves to actually *take* the exercise they might benefit from. Using exercise machines will not be a realistic option for many people in care homes (though providing such facilities for those who would want to use them is a good thing), but it is possible to arrange things so that there are social and material drivers to encourage physical activity in the same way as they can be used to encourage gym use. It is possible to provide things to visually encourage people to approach them (attractors) like a door leading to a visible garden, or windows with attractive or interesting views, which may help to encourage walking. Further activity can be encouraged if it is arranged so that different attractors are visible from each other, and there are places to rest near attractors, like places to sit just inside and just outside access to a safe outside area (Brawley 2001). People can be encouraged to collect snacks

and drinks when they are capable of doing so, rather than having the convenience of having everything brought to them. Attending to other aspects of wellbeing mentioned here can also encourage mobility. If people are maintaining a social life, they have motivation to travel to visit, even if that travel is only across the corridor; if they can pay attention to pleasurable and mindfulness-encouraging experiences, there is a point in getting up and walking to where those experiences are available.

The guidelines for supporting physical activity are:

- Use design features to support people in being active safely
- Use design features to encourage, and perhaps require, mobility, as far as that can be done without excluding those less mobile
- Exploit the positive motivations for sociability and mindfulness to encourage mobility

Designing wellbeing systems

A conclusion we reached in an earlier paper presented at a conference on Design and Wellbeing (Miller & Kälviäinen 2006) was that the notion of a designer making something complete in itself and ‘producing wellbeing’ is erroneous. It is more useful to think of concepts that combine designed objects, services and ways of working, which together might be more effective in supporting the possibility of wellbeing. As Klaus Krippendorf (2006) says: “Design has to shift gears from shaping the appearance of mechanical products [...] to conceptualising artefacts, material or social, that have a chance of meaning something to their users, that aid larger communities, and that support a society that is in the process of reconstructing itself.” As we suggested in the last part of the discussion on physical activity above, elements of wellbeing may also be mutually supportive, and there can be a synergy in which promoting some aspects of wellbeing will effectively support other aspects.

Designers, psychologists and other professionals might therefore work with healthcare or social services to develop objects and systems that allow people the chance of being active, developing themselves, experiencing flow – and getting long-term satisfaction. Care home environments and staff members should provide tools and opportunities for residents to do things by choice, their own imagination and control, as far as possible. Although design tradition in many cases encourages designers to produce some single complete ‘thing’, the heuristics of wellbeing point out that the feeling of wellbeing is born of individual opportunities, activities, social connections and feelings of growth, and the designer can only make scaffolds for these purposes, not some complete product or architectural design producing wellbeing. The care home needs to be considered as a complete system. In that way good design intentions can be carried through effectively rather than being “spoilt” by misunderstanding or inattention by the care staff. Since much of the opportunity for residents in care homes to ‘do wellbeing’ depends on the support and involvement of others working in the home, concern

with workers' wellbeing, and understanding of what can be done to support wellbeing is central to promoting the wellbeing of all.

The concern of management should be to maximise the wellbeing of all those in the home, recognising that it is a society in which a satisfying life depends on the inter-relationship of all its members.

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Afterword: Managing Wellbeing

Sari Rissanen & Anneli Hujala

Good intentions regarding the design of wellbeing in elderly care homes are not always enough. Fulfilling the wellbeing needs of different actors and balancing diverse, often conflicting expectations is a challenging task. This afterword highlights some crucial issues of designing wellbeing from the perspective of management.

Managing wellbeing at different levels

The main aim of elderly care management is to enhance wellbeing, and care managers' work may even be described as the management of wellbeing. Elderly care management takes place at diverse levels of management including political management, strategic management, middle management and front-line management. Designing wellbeing in care homes entails a balancing act among these. In general, the role of macro-level management in the production of elderly care services varies depending on the provider structure and the financial systems of the services (e.g. public vs. private services, tax-based systems vs. insurance-based systems), but some kind of information, fiscal or normative steering from the macro level (e.g. central government) to micro level (e.g. elderly care organizations) is always under way.

Implementing macro-level goals in the practice of elderly care is in many respects a challenge for management. One example of this is the concept of active ageing, which is emphasized in diverse steering documents (e.g. European Year for Active Ageing and Solidarity Between Generations 2012). However, active ageing is a very complex issue when applied to frail, vulnerable and dependent old people. The understanding of good (active) ageing should be based on the holistic, multi-dimensional wellbeing needs of elderly people without excessive focus on the physical aspects as currently seems to be the case. From the management perspective it is important to recognize such reality gaps between macro and micro level goals.

Another example of steering at the political level are national recommendations and legislation governing elderly care. These can be interpreted not only as a steering mechanism but also to a degree as the insights and beliefs of the whole society regarding the wellbeing of elderly people. As an example, the design guidelines for care environments often focus on issues which are easy to operationalize and measure, such as size of the rooms or the existence of safety devices, which may lead to a fragmentary concept of wellbeing. To avoid such problems the implementation processes of the political goals and bottom-up strategy formulation processes need to be supported in elderly care.

Managing different wellbeing needs

The wellbeing of elderly residents is self-evidently the most important goal of the management of wellbeing in care homes. The needs of elderly people, however, are not by any means an unambiguous issue. For instance, the future cohorts of older people will probably expect more personalized care and cure covering wider aspects of their subjective wellbeing than does the current cohort. Similarly, the concept of a good care environment changes due to the changing interests based on the life histories, cultures and health status of care home residents. Coming generations of elderly people will be familiar with the use of many

kinds of ICT and self-care technologies and such a development has to be taken into account in the design of care environments. Likewise the popular concept of “homelikeness” may acquire new meanings. Instead of conventional homelikeness, old people in the future may want to have more a wellbeing-centre oriented environment or even a hotel-like atmosphere for their declining years.

The discussion about the needs of elderly residents is also connected to the structures of service provision. The recent development in elderly care seems to lead to larger organizations than before, at least in some Nordic countries. Small care units are being replaced by more standardized and cost-effective-oriented organizations, in which the implementation of personalized care, homelikeness and client choice may be more difficult to accomplish.

Meeting the needs of elderly residents is, however, only one part of the whole picture of managing wellbeing. Care homes are also working environments for the staff and managers. From the staff perspective daily care and management routines require functional environments and devices. Non-functional work environments may cause low levels of job satisfaction and high rates of staff turnover. Appropriate environments save time in routines and make it possible to focus on other aspects of wellbeing. At their worst the negative characteristics of care environments may have a stigmatizing effect both on elderly people and care staff, with a deleterious effect on the reputation of the whole field of care.

The help and participation of relatives and other informal carers is an important part of elderly people’s wellbeing, also in care homes. It seems still that the needs of these actors have been somewhat neglected in the design of care environments. For instance, the opportunity for residents to do something meaningful with their relatives is rarely encouraged through spatial solutions in care homes. In addition to relatives, the other external actors, such as voluntary organizations (e.g. associations of pensioners, pet visitors) and service providers (hairdressers, physiotherapists) visiting care homes should be taken into account in spatial solutions.

Managing different actors

Elderly care management is not confined within the walls of the care homes. It includes co-operation with both internal and external actors. The design of physical environments is an eminently interesting part of management in this sense. Successful design of care environments demands that many different kinds of expert knowledge are merged with each other. Conventionally, however, the division of labour concerning the design of care – in the broadest meaning of design – starting from planning and organizing care services and ending with arranging and designing physical facilities – has been very fragmentary. Diverse actors operate in different arenas. The responsibility for the architectural planning of care facilities, for example, has mainly rested with architects

and other experts in building construction, who liaise with upper-level care managers and authorities, while the practical-level managers, other professional staff of care homes or elderly people themselves as end-users have not been involved in the design process. The fact is that different actors in care and in design do not interact sufficiently with each other during the planning, design and construction processes.

Thus it is worth asking who has the final say in the planning processes. Firstly, probably most often 'the say' is that of money, because scarce financial resources often necessitate standard solutions or otherwise suboptimal end results. Secondly, designers and end users do not always have a common language. For example, the risk exists that the design of care environments is based on the capacity of average people and on their lifestyles, and a generation gap impair the outcome. Thirdly, care providers, residents and other end users may not be culturally ready to accept environments based on the new ideas of future design, though at their best new and innovative architectural arrangements may be even a way to renew care processes.

To conclude, in the holistic design of wellbeing in elderly care homes it is essential that the voices of all actors are heard. Balancing different needs, expectations, cultures and discourses, as described in this book, requires that co-operation between diverse actors receives special attention. All actors – public and private providers of care, funders, policymakers, architects and other designers, constructors, managers, care professionals, informal carers, researchers and elderly people themselves – are together responsible for enhancing the wellbeing of elderly people.

What is it like to live or work in an elderly care home? What does a look at its design reveal about wellbeing? *Designing Wellbeing in Elderly Care Homes* questions conventional understandings of wellbeing issues. The book is based on the work of researchers from Denmark, Finland, Norway, Sweden and the UK, aiming to bring to the fore crucial themes concerning the construction of wellbeing in elderly care.

'Design' refers in particular to the planning of concrete physical environments for care, but widens its scope to include its necessary interplay with the design of organizations. Moreover, the book addresses relevant topics in managing wellbeing, discussing issues such as active aging, homelikeness, organizational aesthetics, multiculturalism and positive psychology. By presenting examples from empirical studies in the Nordic countries together with theoretical reflections, the book makes a versatile contribution to wellbeing discourses on the extremely important topic of elderly care.



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