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Research Article

An Examination of How the 'Household Model' of Care Can Contribute to Positive Ageing for Residents in the 'Fourth Age'

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Abstract

Background: Promoting a good quality of life for the oldest members of society has become a top priority as evidenced in UK policy. The 'household' model is a departure from traditional approaches to care provision since it offers person-centred support - combing health and social care - to older people in specially-designed, small, homelike environments. Having gained increasing popularity in care homes across developed countries, the impact of this model of service delivery on residents' quality of life and its contribution to positive ageing is of increasing interest. Belong is a not-for-profit, UK care organisation currently operating several villages under the household model. The villages comprise independent living apartments (bought or rented) and residential/nursing care households offering 24 hours personalised, on-site care for residents. In each village there is a range of facilities open to the public (including a Bistro, hairdressers and gym facilities) and a domiciliary community service.

Methods: In this paper we present new data generated from qualitative interviews with a sample of household residents in the 'Fourth Age' and relatives across two villages in the North West of England, UK.

Results: We examine how the household model as operated at Belong facilitates the maintenance of autonomy and independence -which underpins positive ageing and quality of life in the fourth age - among residents.
Conclusion: We show how the household model contributes to positive ageing and quality of life as defined by residents.

Keywords
Positive ageing; Fourth Age; household model; care home; Belong; UK

1. Introduction

Over the last half century, the UK has undergone significant structural change in that the number of people living into very old age has risen quite remarkably [1]. This demographic shift is largely due to medical advances impacting on life expectancy and, as a result, the number of people in England aged 60 years and over is predicted to rise by almost 33% between 2014 and 2030 [2]. Within this cohort, the number of very elderly people aged 85 and above is projected to increase at the fastest rate, rising by 60% [2].

A division of later life has since been recognised which challenges the assumption that just one "old age" exists [3], and, instead of old age representing an entirely chronological phenomenon, it is often thought of in terms of two distinct phases; the third and fourth age [4].

The third age – or "young old age" - typically represents the post-retirement period when older people, who at this stage have lived out their career and family-rearing responsibilities, can exercise greater agency and choice and are faced with opportunities for self-fulfilment and purposeful engagement [5]. This age is generally characterised by good health and physical functioning, attributions of wisdom, social participation, and adaptive flexibility in daily living [6–9]. Contrastingly, it is the loss of agency and choice which differentiates the fourth age from the third age [7, 10]. Whilst there is no definitive chronological onset, the term "fourth age" - or "old old/deep old age" [3, 7] - denotes those people in the very later years of life, the "oldest-old", from approximately 85 onwards [7]. More defining of the fourth age is the associated physical, cognitive and psychosocial decline – what Baltes [11] referred to as the "negative biological trajectory of the life course" (p. 368). This is associated with the onset of bodily decline and a loss of independence and mobility [7] and an increased dependence on formal care services including long-term care in residential or nursing homes [12]. However, there has recently been a recalibration of how ageing is constructed and perceived by wider society in gerontological research and among policy circles and this has had significant impact on the models and ethos of care home provision. The contemporary focus is on 'ageing well' and positive ageing which represents a new paradigm in gerontological research and a departure from more negative aspects of ageing [13].

Over the past two decades in the UK there has been continued policy emphasis on personalised care and support for older people whereby service users exercise their right to choice and control. In this way, older people are no longer perceived as passive recipients of care, but rather as active agents. This has also meant that service providers are expected to encourage people to maintain

autonomy and independence in order to promote a good quality of life whilst simultaneously offloading pressure from public funding streams [14].

1.1 Aims of Paper

This paper is drawn from research undertaken as part of an ongoing wider Knowledge Exchange project between The University of Salford and Belong Ltd. which took place between February 2017 and January 2019. The wider project aims to identify how Belong – which operates a household model of care - impacts on residents' quality of life, staff, and the wider community to identify and develop ways of measuring and monitoring this over time. This paper aims to examine how living in a household in Belong contributes to positive ageing for residents in the fourth age. Here we take account of what positive ageing and a continuation of quality of life mean to residents themselves. The paper is structured in the following way: first, we introduce Belong; then ageing in conceptual, theoretical and policy contexts is discussed; third, the culture change movement in the care home sector is outlined to further contextualise the Belong model; fourth, the methodology and methods underpinning the paper are presented; fifth, the findings from the interviews with residents and relatives are analysed and discussed; finally, we offer a conclusion, stating our contribution to knowledge.

1.2 The Belong Model

Belong is a values-driven, not-for-profit care organisation, with the aim of creating community 'villages' which provide a range of accommodation and support services to people living in the village and in the wider community. The Belong brand was launched in 2007 and since then, seven villages have opened across the North West of England, with two more set to open in 2019 and 2020. The villages are comprised of apartments available for rent or sale, attached to a care home facility in which care is provided in 'households'; typically, six households are included in each village. The vision underpinning Belong's model of service delivery is one of 'providing a home for life, where older people have the right to enjoy the same community belonging and quality of life that they have always known' [15].

Guided by their vision, Belong has set the following commitments to its customers:

- **B**elonging to a vibrant community
- **E**njoying a home for life
- **L**iving an active lifestyle
- **O**ffering choices and independence
- **N**urturing relationships
- **G**iving peace of mind [16]

These commitments are translated into practice in several ways. First, within the main building of the villages, a community environment is created through the presence of a Bistro, hairdressing salon, therapy room, exercise studio -with personalised exercise programmes-, internet café and venue for hire. These facilities are all open to the public. Residents and members of the community can also access a programme of events and activities inside or outside of Belong, with opportunities for interaction with animals, children and the outdoors. Also, as a different approach to specialist day care, Belong organises so-called 'Experience Days', for people from outside of Belong who would like to be supported in their use of the facilities. During such a day, a

member of staff helps customers to co-ordinate their day to enjoy meaningful activities and be part of the village community. In addition, Belong offers a variety of services which enable users to experience holistic support as their needs change. These range from: independent living in Belong apartments, to domiciliary care for people in the wider community, through to residential or nursing care within the 'households' in the home, which includes end-of-life support.

The households are small-scale, dementia-friendly domestic environments in which 24-hour health and social care is provided to residents. The small-scale domestic settings which characterise Belong reduce the amount of potentially overwhelming stimuli and risk of disorientation which could negatively impact on people with dementia. The ethos underpinning the design is the importance of promoting stability and familiarity with surroundings. Households contain a mix of residents, with people living with dementia, or nursing care needs, living together with those who do not. 71.8 per cent of all household residents in Belong have a diagnosis of dementia and staff are trained in dementia awareness and an Admiral Nurse[1] works across the village to specifically support residents with dementia and their relatives. The model recognises that needs often fluctuate and accordingly, care can be tailored to residents as required. Each household has a dedicated support team which always works with the same residents, enabling staff to get to know them well.

The households are designed to be an 'extended family sized community' for 10 to 12 residents, with ensuite bedrooms that lead directly to an open-plan, shared communal space. At the heart of each household is a kitchen, which is central to generating shared experiences between residents and staff. In the mornings, staff often bake a cake in the kitchen and throughout the day, a host helps to deliver 'marvellous mealtimes'. As part of 'marvellous mealtimes', residents are offered menu options, and can assist with meal preparation or table setting as they wish. Meals are prepared and cooked in the household kitchen to simulate the sight, smell and sounds of cooking which are commonly associated with home. While mealtimes as such are flexible around a resident's preferred schedule - and residents are free to decide when and where they would like to eat - Belong aims to promote a family mealtime atmosphere to encourage and facilitate interaction between residents and staff. Residents, relatives and friends are free to help themselves and others to refreshments throughout the day.

Many care homes operate a 'medical model' of care, which encourages a 'sick' definition of self in residents. Such residential facilities optimise structures of rigid routine, excessive 'risk' management and use of chemical restraints to reinforce passive or dependent behaviour in residents which is then more easily controlled by staff [17]. However, in Belong, this kind of institutionalised ethos is specifically avoided. Indeed, in Belong, residents need not adhere to a specific waking routine and there are no tea trolleys, bathing or medication rounds, as residents – or 'customers', as they are known - are supported holistically in a place and at a time they choose. The use of anti-psychotic medication and sedatives is kept to an absolute minimum for people with complex needs related to dementia; instead, staff take time to observe and address causes of distress. In addition, Belong's vocabulary avoids the use of such terms as units, patients, and 'sufferers', instead encouraging the use of positive language around households (rather than

[1] Admiral Nurses are specialist dementia nurses who give expert practical, clinical and emotional support to families living with dementia

residential care units), Experience Days (for day care) and independent apartment living (not extra care).

Exercise is high on the agenda at Belong. A dedicated gym instructor, with both care and fitness experience, aims to create a personalised exercise plan for each household resident to improve mobility and wellbeing. The instructor will either support residents in the exercise studio, or in the household. In addition, chair-based exercise classes are offered. Belong also has a large garden area and residents are encouraged and supported to use this.

The staff to resident ratio in Belong is higher than average, with three staff per household and a floating nurse on shift, which allows staff to spend more time with residents. In the UK, minimum hours of care or ratios of care are not specified in national regulations. However, the UK Royal College of Nursing published guidelines for nursing homes with a patient to staff to resident ratio of 1:5 for early shifts, 1:6 for late shifts, and 1:10 for nights (with an average of 35% registered nurses and 65% care assistants). Belong aim for a ratio of 1:4 staff to residents in the households between 8am and 10pm plus at least one nurse on duty 24/7. There is at least one nurse on duty 24/7 who is responsible for directing the care of residents who have nursing needs. One of the senior team is on call out of hours. During the night, there is a dedicated waking support worker per household, in addition to a floating support worker and the floating nurse.

Staff work closely together with primary care teams and hospitals, in order to keep hospital admissions and stays to a minimum. Wherever possible, people are cared for at home in Belong, right up until the end of their lives. Staff are provided with learning and development opportunities as Belong aims for all staff to hold an accredited qualification. In addition, a Practice Development Facilitator works across each village to ensure that staff have the skills, confidence and support to work effectively, have undertaken core training and to identify any additional training needs. In April 2017, Belong chose to substantially increase the pay for all hourly paid staff on the National Living Wage (NLW) with 17.4%. Those members of staff are now remunerated in line with the Living Wage, which is an hourly rate that is calculated according to the basic cost of living in the UK. This increase has meant that a care worker in Belong is now paid more than the average care worker in the UK, according to data from the National Minimum Dataset for Social Care as presented by Skills for Care.

Belong's approach to care and management of its staff has been recognised as a good practice by several organisations providing relevant performance and quality standards and all Belong villages have received a Care Quality Commission (CQC) rating of 'good' or 'outstanding'. The CQC, as a regulator, investigates whether the services provided are safe, effective, caring, responsive to people's needs, and well-led. In addition, Belong is part of the National Gold Standards Framework (GSF) in Care Homes Programme for palliative care. This programme aims to improve the quality of care, inter-agency collaboration, and support for individuals who wish to die at home, for example by promoting choice and control at end-of-life through advance care planning. Most of the existing villages have received GSF accreditation, while the newer villages are working towards achieving it. Belong was awarded the international award of 'Excellence in the Third Sector' of Investors in People in 2018 for its investment in 'class-leading recruitment, training and development opportunities'. Finally, Belong received the Investors in People Gold Standard accreditation in 2016 [18].

1.3 Ageing in Conceptual, Theoretical and Policy Contexts

'Ageing well' is the lay term for a positive trajectory of ageing, encompassing labels such as healthy, successful, competent, optimal, vital, active, productive (and positive) ageing. These terms can be understood as constituting a 'semantic network' representing a shift to a positive paradigm in gerontology research [19]. Healthy and successful ageing are used most commonly in biomedical research, with healthy ageing denoting an absence of illness and functional independence, while successful ageing integrates additional biomedical and psychosocial conditions including a low probability of illness and disability, cognitive fitness, positive effect and control and social participation [19]. However, a purely biomedical approach to successful ageing neglects the psychological and social complexities associated with growing older [20], since it does not take account of older people's perceptions of what constitutes successful ageing for themselves [21]. For example, previous research has shown that many people subjectively rate themselves as "successful agers" despite not conforming to the objective "disability/illness-free" definition [22]. Often, older adults perceive successful ageing more in terms of psychological and emotional wellbeing, activity participation, enjoyment of leisure and experience shared with others, than in terms of their physical health [23]. By this definition, successful ageing is more commonly associated with the third age which then implies that those in the fourth age are "unsuccessful". Historically, adopting this approach has led to models of care predominantly focused on the treatment and management of physiological ailments [24]. Such a stance led to a social construction of ageing as a "medical problem" encouraging the view that ageing is abnormal [24]. Applying this 'problem' of ageing to long-term care provision historically raised the misconception that older people are passive recipients of care practices "based on hygiene, pressure area care, medications and food" (p. 955) [25].

There are issues in operationalising concepts of ageing, there are different meanings associated with different terms [19] and we do not treat these as being synonymous. Although the focus of this paper (and the special issue) is on positive ageing, active ageing principles underpin the policy framework which shapes care home provision (and therefore the Belong model, also influenced by the culture change in the care home movement). Therefore, there are some relevant overlaps and we identify these below, particularly in relation to how both terms are concerned with quality of life. Autonomy and independence are recognised as factors that are associated with active ageing, an approach which challenges the passive and dependent stereotypes commonly synonymous with older age [21]. Defined as "the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age [26], active ageing is regarded as a mechanism through which to address the challenges of population ageing [21]. The responsibility of active ageing lies both at a societal (structural) level in that policy action should afford empowerment and opportunity for activity amongst older people, and at an individual level (agency) with older people exercising their personal freedom to engage with these opportunities [21]. Potential outcomes for the individual include social inclusion, enhanced wellbeing and quality of life, and at a societal level, reduced pressures on public spending on pensions, health and social care [21, 27]. According to the World Health Organisation, which introduced the term [26]:

"Active ageing policies and programmes are needed to enable people to continue to work according to their capacities and preferences as they grow older, and to prevent or delay disabilities and chronic diseases that are costly to individuals, families and the health care

system… People who remain healthy as they age face fewer impediments to continued work… This would help to offset the rising costs in pensions and income security schemes as well as those related to medical and social care costs." (p. 9).

In practice, however, active ageing policy across Europe has been criticised for focusing too narrowly on labour productivity, which excludes and potentially stigmatises those who are unable to work, in particular the oldest-old in the fourth age [28]. Active ageing then, should not be entirely focused on physical activity and participation in the labour market but should be also be inclusive of social, cultural, spiritual and civic affairs [26]. Such "activity" should be meaningful and contribute positively to the wellbeing of older people and that it should be inclusive of *all* older people, including frail and dependent older people in the fourth age [29]. The goal of active ageing in the fourth age therefore, should be on maximising participation and autonomy. In this sense, a broader approach to active ageing supports the notion that it maintains relevance throughout the ageing process as a whole, as opposed to being applicable only to those in the third age [30]. A commonality between positive, active and successful ageing is that they emerged as opposing responses to disengagement perspectives of ageing [29]. The largely discredited body of disengagement theories of ageing propose that as people experience the transition from the third to fourth age, they experience a lessening of social interactions and an inevitable withdrawal from society occurs [31, 32]. However, these assumptions are incompatible with empirical evidence which shows many older people continue to engage with employment, political and social domains of life in particular [33].

It is also important to take account of older people's interpretations and expectations of 'ageing well' in their own lives [28]. A previous study of active ageing in a care home context [30] found that key determinants were reported as: a welcoming, homelike environment and culture; having choice and control over decisions and care; the opportunity to participate in meaningful activity; a sense of usefulness; and the promotion of independence, neighbourhood integration and social participation. Thus, despite a physical and mental decline in this age, it seems clear that active ageing can both useful and applicable to people in the fourth age who are living in a care home context [30] and that there is a role for care provision in facilitating this. Those elements related to the maintenance of quality of life encompassing positive emotional states and social integration (included in definitions of positive ageing) are key to our analysis.

Multidimensional concepts of positive ageing encompassing 'objective indicators' (including fitness/ health and optimal cognitive functioning) and 'subjective indicators' (including positive emotional states and social investment) have been proposed and these have methodological implications [13]. In this paper, our analysis is undergirded by an interpretive epistemology, based on residents' subjective accounts of their own experiences of positive ageing, as the importance of understanding such experiences from a residents' perspective are key (42). In this way, we focus on residents' recounting of such 'subjective indicators' within the context of health and cognitive function in the fourth age, rather than focusing on biomedical factors per se, in part since in this stage of life the applicability of the objective indicators reduces [13]. The fourth age is not a continuation of the third age since it is largely characterised by pathology – health status and functionality – so healthy and successful ageing has limits from a biomedical perspective when understanding people's experiences of positive ageing in the fourth age (Baltes and Smith, 2003 cited in Fernandez- Ballesteros et al, 2013 [19]).

Thus, we apply positive ageing as a conceptual framework, yet we conceptually engage with active ageing as the policy framework though which positive ageing is delivered. In this way active ageing can be understood as the policy mechanism through which to address the challenges of ageing. Our focus is on subjective indicators (positive emotional states and social investment) of positive ageing. In other words, this is not a focus on the number of illnesses or measures of cognitive and physical function instead we address residents' subjective interpretations of well-being (positive emotional state) and the maintenance of social investment (or social interaction). We focus on positive ageing and therefore how this can be facilitated into the fourth age in terms of such subjective indicators and how this is inextricably linked with quality of life and can continue in spite of physical and cognitive decline [13]. We posit that the household model as operated by Belong facilitates this since it focuses on people as active agents, rather than passive recipients of care, and the promotion of positive emotional states and social investment: representing continued quality of life [13].

Clearly then, quality of life is a broad and multifaceted concept encompassing physical, social and psychological aspects of life [34]. However, despite its complexity, the core element to quality of life is that it signifies what makes life meaningful, enjoyable and worth living *as defined by the individual* [35]. Any such commitment to promoting quality of life in care homes needs to be driven by what matters most to the individual and how they wish to be supported, as opposed to staff assumptions about what older people want [35].When moving to long-term care facilities, it is important for quality of life to be preserved in terms of 'feeling at home' for older people. Cooney [36] identifies four core features of finding a home, including: 'continuity', 'preserving personal identity', 'belonging' and 'being active and working'. Continuity in this respect relates to older people's continued engagement in their normal, everyday activities and maintenance of their usual routines, for example, waking and going to bed when they choose and dressing how they like. Preserving identity relates to older people having privacy, having their own personal space with their belongings around them, and feeling known and valued as an individual. Belonging is associated with feeling part of a group and experienced as a sense of solidarity, companionship, relaxation and fun. Finally, 'being active and working' relates to the opportunity to engage in both meaningful activities, as well as those that constitute daily activities such as socialising, watching television and domestic activities of daily living [36]. These findings are also consistent with the work of Nolan et al [37], who developed a "senses" framework intended to inform best practice in care home environments. The framework highlights that where a service affords good quality of care, users will experience a sense of security, belonging, continuity, purpose, achievement and significance.

Many of the discussed practices, behaviours and attitudes associated with a good quality of life – continuity, maintenance of personal identity, meaningful relationships, personalised care, autonomy, choice, control and involvement in decision-making, a positive living environment, safety, and meaningful daily and community life – feature as themes in Blood's [38] review relating to what makes for a 'better life' for older adults. The evidence suggests then, that models of care for older people should adopt a holistic approach considering health, well-being, physical, cognitive and social functioning, as well as continued engagement with social life and activities if they are to promote positive outcomes/experiences for older people: in other words, facilitate the maintenance of quality of life into the fourth age.

1.4 The Emergence of The Culture Change Movement: Towards The Household Model of Care Provision

The recurring themes throughout the above literature and policy review: choice, empowerment, autonomy, independence, activity, identity, personalisation, relationships, and community, reflect how developments in research and policy have transformed the image of old age from one that is negative and fixated with illness and disease, to one that reflects positivity, wellbeing and quality of life. In doing so, research and policy initiatives have facilitated a culture change within care home settings, evolving innovative new models which diverge from traditional care home practice through the reconceptualisation of the structure, roles, and processes of care [39].Having provided the policy context within which models of care are currently operating, we now contextualise the culture change movement and review a number of models to contextualise Belong.

As meeting the psychosocial needs of older people has become a priority in the context of long term care, it has become increasingly recognised among consumers, policy makers, and providers that the traditional, institutional model of care limits autonomy and is unconducive to this aim [40]. As such, throughout the past three decades innovative philosophical developments have emerged which have sought to transform institutionalisation towards care which puts older people at the forefront of all decisions and practices; a change which makes "long-term care less about care tasks and more about caring for people and the relationships between people"(p.xiii) [41].

As highlighted above, policy and legislative initiatives across developed countries that have mandated an individualised, person-centred approach to care and this has helped to inspire the grassroots culture change movement in care homes [42]. The birth of this movement is generally attributed to developments in the USA during the late 1990s when a group of care service providers, researchers and consumer advocates collaborated to determine the common principles that featured in their vision for culture change in care homes [43]. This collective group, known as the Pioneer Network, articulated thirteen values that characterise the underlying ethos of culture change which include: Know each person; Each person can and does make a difference; Relationship is the fundamental building block of a transformed culture; Respond to spirit, as well as mind and body; Risk taking is a normal part of life; Put person before task; All elders are entitled to self-determination wherever they live; Community is the antidote to institutionalization; Do unto others as you would have them do unto you; Promote the growth and development of all; Shape and use the potential of the environment in all its aspects: physical, organizational, psycho/social/spiritual; Practice self-examination, searching for new creativity and opportunities for doing better; Recognize that culture change and transformation are not destinations but a journey, always a work in progress [43]. The overarching goal of culture change is to offer homelike environments to older people in which maximum quality of life can be achieved for both residents and staff [44, 45].

To better illustrate the philosophies that underpin resident-directed practices inherent to culture change in care homes, it is now useful to review some of the contemporary models in operation. The Eden Alternative (EA), founded by Dr William Thomas, was one of the first culture change models in the early 1990s. Thomas rejected the medical models "fixation on diagnosis and treatment" believing this fosters care of low quality [46]. The EA model premised that residents

should be treated with dignity and respect, valued as individuals and be the active decision-makers when determining their daily lives. The EA model stipulates that care settings should be homelike, social and vibrant environments including the presence of plants, animals and children. Early evaluation studies of the EA approach returned conflicting results about improvements in physical health [47, 48]. However, evidence suggests that resident and family satisfaction and residents' independence improved [49, 50].

The culture change movement in care homes is viewed as a method of continuous quality improvement [51]. Thus, with early research yielding conflicting findings relating to the benefits of an EA, it became clear that more systemic and structural changes within the structure of care homes were necessary [52, 53]. Indeed, pioneers of the culture change movement recognise that in order to facilitate positive outcomes for older care home residents, radical physical reconfiguration of traditional care home environments is necessary to implement the principles underlying culture change [42]. A fundamental aspect within the vision of the culture change movement was that it should be more representative of a genuine "home" [54]. The fact that traditional facilities are large and unrepresentative of the average family home provided the impetus to de-scale to smaller "households" – hence, the "household model" was conceptualised.

The predominant characteristic of a care home operating a household model is that it comprised of smaller, homely units intended to house between 6-12 residents. The model has been described as "a living arrangement where all activities of daily living occur within a small - scale environment, reminiscent of a large family home… an environment that is immediately understandable to residents and visitors as a setting that has been a natural part of everyday life" (p.9) [55]. The underlying philosophy of the household model is akin to that of the Eden Alternative, that service provision is customer focused and process oriented delivered by a consistent team of care workers, as opposed to a service-led, task-orientated approach operating in traditional cultures where older people are perceived as passive recipients of care [54, 56].

The first incarnation of the household model was in the USA in 1997 at Creekview in Evergreen Retirement Community, Wisconsin. A 'neighbourhood' of 36 residents was designed, made up of four small-scale households housing nine residents [54]. Each resident had their own private bedroom with en-suite facilities centred around an open plan, shared living, dining and kitchen area. Residents also had access to a secure garden, allowing continued exposure to the natural environment [55]. A household model of a similar structure operating in Australia, known as the ADARDS model, involves four small households of nine residents connected around a centralised room. The individual households operate independently during the day and cooperatively as one unit over the night allowing for lower staff-to-resident ratios during this quieter period [57]. Flexibility is central to the philosophy of the model, for both staff and residents [57], and staff can organise their own working rotas to accommodate family life [58]. Flexibility in residents' daily scheduling fosters an atmosphere conducive to individualised care and is intended to remove the regimented routines found in traditional institutions. Meal times are innovatively structured to create a shared and meaningful experience whereby staff members are encouraged to eat with residents and relatives, avoiding the social divide associated with the traditional care home model.

Additionally, the physical environment plays a significant role in shaping the actions of individuals and groups, by providing opportunities for the preservation of identity to be supported, as well as facilitating opportunities for social interaction through which positive relationships can be established [55]. Within traditional institutional settings preservation of identity is largely

prohibited with shared bedrooms and bathrooms, offering limited space for residents' personal belongings. Care home environments that facilitate a sense of familiarity have the potential to offer plenty opportunity to engage with a range of activities and provide a comfortable balance of private and community spaces and are associated with a higher quality of life [59].

However to date, there is limited evidence of the impacts of the household model on residents [60, 61]. In their systematic review, Ausserhofer et al. [60], explored the impact of homelike residential care models for residents with and without dementia on resident, family and staff-related outcomes. They found only 14 studies, conducted between 1994 and 2014, with most studies examining behavioural or quality of life outcomes. The six studies on quality of life that were identified shared mixed findings, with some presenting improvements in some, but not all domains of quality of life; better outcomes compared to one nursing home but not the other; and/or better outcomes in some domains, but worse in others compared with traditional settings [60]. Of the studies reporting positive changes, the physical and psychosocial benefits of a household model approach to care are emphasised [62]. For example, Morgan-Brown, Newton and Ormerod [63] measured resident social and activity engagement in two Irish care homes pre- and post-implementation of a household design. The changes included adopting an open plan design with a unit kitchen, employing staff in a homemaker role and transforming task-based provision to person-centred care. Within both facilities, engagement with interactive occupation (defined as activity such as participating in a game or craft activity) and social interaction significantly increased following implementation of a household design [63]. Other reported positive benefits associated with small-scale living arrangements in include higher motor functioning and mobility; less anxiety, and depression [62].

2. Materials and Methods

2.1 Methodology

The methodology underpinning this paper is qualitative with commensurate methods: in-depth semi-structured, face-to-face interviews, and is congruent with our focus on exploring the subjective elements of positive ageing as explained above. A purposive sample of residents was taken to reflect a mix of gender, age, time lived in Belong and village location. Although we acknowledge that the sample is not necessarily representative of all residents in Belong, nor of older people in care home environments, we make an empirical and theoretical contribution to knowledge as outlined in the conclusion. A total of 18 interviews took place with 14 household residents[2] and three family members across two villages. A list of residents' names was obtained from management staff who were able to advise whether the resident would be able to undertake an interview. Contact details of spouses or family members were then obtained for those people who were unable to participate. Four of the residents' relatives were subsequently interviewed, three because the resident was living with dementia which impacted on their capacity to undertake the interview. The interviews took place in two Belong villages between September 2017 and October 2018.

[2] 'Nigel' was interviewed twice – once with his daughter in September 2017 and again on his own (both times at his request) in October 2018

Participants were sent an invitation letter and information sheet via post and were asked to register their interest in being interviewed. Those who confirmed interest where then invited for an interview asked to provide consent on the day the interview took place. The interviews lasted for an hour on average and focused on: experiences of living in a Belong village; transitions to a care home environment; views on care, activities and facilities; being able to exercise control and autonomy; and interpretations and experiences of continued quality of life.

The characteristics of the residents can be found in Table 1. The average age of all participants was 85.5 years, ranging from 69 to 97 years. Most of the participants (15 out of 17) were currently living with one or more chronic long-term conditions, including, but not limited to, Dementia, Parkinson's Disease, Multiple Sclerosis, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, Cardio-Vascular Disease, and various forms of cancer. In order to protect the identity of all individuals, pseudonyms are used and the location of the village where they live is omitted. The research was carried out to the standards set in the ESRC Research Ethics Framework and the British Sociological Society's Statement on Ethical Practice. In accordance with these guidelines, the research was conducted with the welfare of participants in mind and the overarching project received ethical approval through the University of Salford's Research Ethics Panel.

Table 1 Resident Profiles

Resident	**Gender**	**Resident's age at time of interview**	**Time in Belong (at time of interview)**
Arnold (interview with Christine, Arnold's spouse)	Male	74	41 months
Elsie (interview with Ralph, Elsie's son)	Female	85	10 months
Margot (interview with Don, Margot's spouse)	Female	79	53 months
Nigel, interviewed with his daughter Sally	Male	86	30 months
Sandra	Female	69 (deceased since interview)	18 months
Rose	Female	76 (deceased since interview)	5 months
Norma	Female	97	10 months
Alice	Female	80	8 months
Helen	Female	89	6 months
Joe	Male	88	3 months
Bernice	Female	93	13 months
Brenda	Female	92	21 months
Patrick	Male	77	8 months
Belinda	Female	93	2 months
Madge	Female	92	41 months
Annie	Female	92	5 months
Louisa	Female	91	14 months

2.2 Analytical Framework

The interviews were transcribed, and a thematic analysis was undertaken using an iterative approach between the data and the literature. Thematic analysis is a method for identifying,

analysing and reporting patterns within data, and a theme captures something important about the data in relation to the research question [64, 65]. As such, theoretical thematic analysis is driven by the researcher's theoretical interests [66] – in this case positive ageing and people in the fourth age living in care home environments. We synthesise and apply the subjective indicators imbued in theories of positive ageing which highlight the factors which promote and sustain quality of later life. The premise is that a person is able to maintain a sense of self, belonging and autonomy as they age. Our thematic categories are presented under the following headings: The decision to move to a care home: exercising choice and autonomy during the transition; Living in a homelike environment: facilitating a positive emotional state; Choice and control over daily life: facilitating a positive emotional state; Interaction with others: facilitating opportunities for social investment; Activities/meaningful engagement: facilitating a positive emotional state and opportunities for social investment; Optimising health and well-being through activities: facilitating a positive emotional state; and Quality of life: residents' perspectives.

3. Findings and Discussion

3.1 The Decision to Move to A Care Home: Exercising Choice and Autonomy During the Transition

As people transition into the fourth age - when moving into long-term care in particular - they often experience drastic life changes. Leaving behind their home and neighbourhood and experiencing personal losses [67] often occurs in conjunction with a loss of independence and a decline in physical and mental health [68]. When residents talked about their lives before moving to Belong, they often focused on the agency and independence they were able to exercise and the activities they engaged with prior to needing care and support. For Bernice, this involved flying down to see her sister's children; for Joe, being active and happily retired; and for Norma being actively involved in the church. However, often an abrupt physical change impacts and means that such activities and autonomy are no longer possible. Bernice accepted and adjusted to this and now 'the telephone must do' to maintain contact with her family now she can no longer travel to see them in person. Norma remains as involved as she can be with the limitations imposed by her physical condition, and Joe 'adjusted', realising what he 'can and can't do':

> *I used to … fly down to see [my sister's] children in Devon and Cornwall because we've always kept in touch. But I can't do that as much as I used to now, so the telephone must do.* (Bernice, 93)
>
> *I was happily retired, I was very active, up until about four years ago I used to dance a lot. And then all of a sudden I just started to deteriorate quite quickly, and so I adjusted things you know slowing down and stuff and I think you start to realise what you can and can't do but I was alright up until about five or six weeks ago until I had a couple of falls and they really set me back.* (Joe, 88)
>
> *Oh well I was very involved in the church, I used to get involved in everything there… different services and coffee mornings… I got out and about yes. You see after I'd had my fall I couldn't walk so I couldn't do that stuff, I can't go without my frame now…I get involved in as much as I can…and of course I can only do certain things because I can't see.* (Norma, 97)

For many people, the actual admission to a care home is usually at the time of crisis, often following hospitalisation or a fall [69]. Such an experience then, has the potential to be traumatic and disruptive and therefore potentially unconducive with positive ageing. In all cases for the participants in this study, some health issue or crisis precipitated the move to Belong. Among those for whom the decision to move was taken by the resident themselves, or jointly with family members, it appeared to be a more positive experience as they had some control and autonomy over the process. However, that is not to say that the move was without difficulty and there was a recognition that help to maintain quality of life was needed and the ability to adapt appears to be key.

Annie made the decision to move into Belong (in conjunction with her family) after feeling that the care arrangements in her original home were no longer satisfactory. Annie adapted to her new circumstances and ultimately took control of the whole process, although her family 'all agreed' with the decision for her to move to a care facility. It was she however, who 'decided', 'rang for a brochure', 'thought it looked nice' and 'made an appointment'. In this way, Annie exercised agency and autonomy about the decision and the move to Belong, leading her to have 'no regrets at all':

> *'We all agreed it was good, so I've no regrets at all. I feel more settled and more organised now I'm here, you know when I was at home there were so many different people coming in and out to look after me and it just wasn't suitable... I decided that I'd better get myself into a home, and I rang here for a brochure and thought it looked nice, so I made an appointment to look around and I came, and I liked it'.* (Annie, 92*)*

For Helen, following her diagnosis and treatment for cancer, it became apparent that she would have to alter her original plan to move into sheltered accommodation as she needed more care and support than would have been available there. It was 'obvious' to Helen that she needed additional care and she exercised agency in making the decision to move to Belong where she would receive appropriate levels of care:

> *'I was thinking about going to into care but more like sheltered housing type of thing but then I got cancer, so I moved into a care home that was nearer [the] hospital. So, I was booked in for six weeks, four weeks treatment and two weeks recovery but I didn't recover, it took me a long time to get back on my feet. So, it was just obvious that I couldn't just go to sheltered, I needed more'*. (Helen, 89)

Similarly, Alice who broke her hip following a fall recognised she could no longer manage to live independently. However, the transition for her was not easy, being unable to return to her flat was 'very disappointing'. Alice appears to be less positive about her change in circumstances and instead was reluctantly resigned to the change in circumstances - moving to a care home:

> *'I fell in my flat last year and broke my hip so that's why I am here, and I can't go back to my flat which is very disappointing'.* (Alice, 80)

Belinda also recognised that she needed additional care and support and could no longer live independently, and like Alice she appeared to be disappointed by this. Belinda's use of - 'I know/I'm very aware/I'm not stupid - when she talks about her change in circumstances shows clear evidence of her agency, autonomy and independence of spirit. Additionally, Belinda's use of 'I can pay for it' reinforces her recognition that although she cannot continue to live independently, she remains independently minded, financially independent and therefore able to exercise a degree of control through being able to 'ask for help':

'I know I need a lot of help. I couldn't be on my own now, I had a house, but I've sold it now, there's no point you see…I'm very aware that I will need more help soon, I'm not stupid. I can always ask for help, and I will, and I can pay for it'. (Belinda, 92)

Rose felt that move to Belong was best for her son and daughter as they thought it was the safest place for her. However, Rose did not appear to be happy with the decision to move or to feel that she had exercised control over the decision, or that it was necessarily in her best interests:

'I think my son and daughter felt this was the safest place for me, it was best for them'. (Rose, 80)

It appears that the circumstances of people moving into a care home environment are significant. Such transitions often involve moving after a crisis of some kind (illness/a fall/ loss of capacity) and in these circumstances agency and autonomy could be compromised. The most positive outcome appears to be where the transition to a care home can be managed as much as possible to help older people work adapt to their changed circumstances. In this way, care providers can play a role in countering the ramifications associated with moving into a care home. Evidence suggests that where an admission is planned and where residents are involved in the decision-making process, the adjustment to care is much easier [70]. The use of a life/care plan during the transition to a care home environment has the potential to facilitate autonomy and choice and to promote continuity regarding how life was lived before. When a resident moves into Belong, an electronic care plan is created in the Person Centred Software (PCS). This plan is created through the completion of several risk- and care assessment tools, in addition to an initial assessment during which questions are asked about a resident's emotional state and social preferences. Information is gathered about things which capture what a resident's life looked like before moving into Belong, such as important life events, social interests and hobbies, daily routines, skills, likes and dislikes. In this way, staff can easily become aware of things that residents might like to do or talk about. Members of staff can add information to the plan at any time as a situation changes and all aspects of the care plan have review cycles to ensure that the plan is kept up-to-date.

3.2 Living in a Homelike Environment: Facilitating a Positive Emotional State

A welcoming, homelike environment and culture in a care home context are integral to promoting positive ageing among older people [30]. Belong embodies the philosophies of the culture change movement that underpin resident-focused practice which emphasises a home for life and continuity of engagement and quality of life. Christine talked extremely positively about Belong's ethos:

'I love the philosophy of the place. I love the idea that you're still living in a community, you're not just one person sat on a chair in this great big room. People treat you like people, this is your home, you know… this philosophy and this kind of care needs to become the norm'. (Christine, Alfred's (74) wife)

Residents and their relatives reported that the smaller scale household design in Belong was more homelike than traditional care home configurations:

'I like the layout of the households with the lounge area, the television area and the dining area'. (Ralph, Elsie's (85) son)

'I like that its smaller than others, I'm not one for crowds'. (Nigel, 86)

Care home environments that provide a comfortable balance of private and community spaces and are associated with a higher quality of life [59]. In addition to the positive culture and ethos in Belong, residents and their family members all talked very positively about how Belong felt more 'like home' rather than like an institution:

'I came here presuming it would be you know like home really and that's how I feel, like home. It's lovely'. (Sandra, 69)

'I settled in ok… I feel safe here, it's a home it's not an institution. There's no rules… it's like being part of the family'. (Belinda, 92)

Resident's family members talked about their relatives being 'settled' in Belong suggesting feeling or seeming at home. This also suggests that the transition from previous living arrangements to the care home environment was a positive one:

'Dad has settled in lovely here…it's great. (Sally, Nigel's (86) daughter)

'[My mother is] far more settled here'. (Ralph, Elsie's (85) son)

Within traditional care home settings with shared bedrooms and bathrooms, there is limited space for residents' personal belongings which negatively impacts on preservation of residents' identity [59]. Residents and family members highlighted the positive effects of having personal belongings around in terms of it being 'homely' or 'homelike':

'Yes, I do [like my room]. I'm going to get a few more things in to make it homely… it feels like my home now'. (Annie, 92)

'It's as homelike as it can be… their own rooms are their own rooms and if they want to bring their own stuff in they can… They can bring their own pictures, their own TV, music or whatever and the rooms are made as homely as possible'. (Don, Margot's (79) husband)

Feedback from household residents suggests therefore that living in a small-scale, homelike environment as operated by Belong has benefits in terms of facilitating positive impacts on emotional states, represented by reports of feeling 'at home' and 'being settled'. The design and ethos of Belong – a departure from traditional institutional arrangements – also has beneficial outcomes on experiences of positive ageing from the perspective of residents.

3.3 Choice and Control over Daily Life: Facilitating a Positive Emotional State

Being able to have control and autonomy also relates to older people's continued engagement in their normal, everyday activities and maintenance of their usual routines, for example, waking and going to bed when they choose and dressing how they like [36]. Residents talked very positively about being able to exercise choice over their daily lives, in terms of going to bed/waking up; mealtimes; and having their personal belongings around them. For Nigel, being able to play board games whenever he wanted was positive:

'You can get up in the middle of the night and have a game [of draughts] you know …you can do anything you like if you want' (Nigel, 86)

Having choice over bedtime and waking was also raised as being important in maintaining continuity [38], although Nigel acknowledged that his choices were facilitated - for example he is 'put to bed':

You can go to bed at night about 7 or 8 o'clock or 9 o'clock…they put you to bed at a certain time and get you up at a certain time… you don't get up early if you don't want…you might

be an hour later than everyone else, it doesn't matter…there's no rushing any of us…you have choice about everything' (Nigel, 86)

'She gets up when she wants to get up from what I can gather between half nine and half eleven, and then someone comes to see her after lunch'. (Ralph, Margot's son)

Flexibility and resident-led practices include the timings of meals, where residents are able to eat (in the privacy of their room or in the communal area) and the type of food available. Residents talked positively about being able to exercise choice over mealtimes, in terms of where meals are eaten, what is eaten and when meals are taken. Nigel recognised the benefits of eating in the communal area but acknowledged that he could eat in his own room if he chose, which Bernice preferred:

'You can have your [meals] in here (own room) if you're not well, but if you are well you should be out joining in…you have a good choice of food here as well'. (Nigel, 86).

'I've got shaky hands, and it's embarrassing for me, so I eat in here (her room not the communal household dining area). They don't mind, I asked …if I could dine alone and …that's fine'. (Bernice, 93)

Ralph, Margot's son spoke positively about how flexible the staff were regarding mealtimes, highlighting that his mother was never pressurised to eat:

'They don't force food down her, they try to encourage her to eat …if my mum isn't hungry they don't kick up a fuss and make her eat it there and then, they just give it to her an hour later so there's no pressure'. (Ralph, Margot's son)

Similarly, Christine talked very positively about the efforts made to maintain her husband's dignity and regarding the way his food was presented and served:

'They go out of the way he's got his own menu …he has pureed food now but it's laid out like a proper meal even though he can't see it really'. (Christine, Alfred's (76) wife)

Preserving identity also relates to older people having privacy, having their own personal space with their belongings around them, and feeling known and valued as an individual. Residents and family members acknowledged the importance of this:

'You can have your own things around you and you can pick your clothes'. (Sandra, 69)

3.4 Interaction with Others: Facilitating Opportunities for Social Investment

The physical space and environment of Belong appears to have a positive impact on facilitating opportunities for social interaction through which positive relationships can be developed and sustained [55] and positive ageing in a care home context also encompasses the opportunity to participate in social participation (23). Residents talked about the opportunities for social inclusion, being able to avoid loneliness and having opportunities to make friends and interact with others:

'I was lonely [before I came here] with my husband going and my mum and dad going…I enjoy the company'. (Sandra, 69)

'I eat my meals in the communal part of the household, I've got two friends I sit with. (Belinda, 92)

'I've made many many friends here. I've made many enemies as well' [laughs]… When I go downstairs they say "oh hello Nigel". Everybody knows who I am'. (Nigel, 86)

In Belong there appear to be opportunities for continued interaction and engagement; there are more people around and again the layout of the household and village is significant in reducing isolation, encouraging companionship and interaction:

'Well I particularly like the bistro downstairs because it means when we come and see my mum, walk her down to the bistro she sees people, well people see her and they say 'Hello Elsie and how are you?' and she enjoys that. (Ralph Elsie's (85) son)

The physical space and environment of Belong also appears to have a positive impact on neighbourhood integration (23), and residents welcomed the opportunity to engage with the public:

'Yes, I think that's a good idea that the bistro and the gym are open to the public…in fact it's been nice because if my friends were around and they'd pop in downstairs they would just send a message to say they were here and I could just pop down if I wanted to'. (Brenda, 92)

Being able to exercise choice and autonomy over daily life – in other words not being regimented or restricted – was also reported as being important by residents in terms of promoting a positive emotional state and maintaining quality of life which encompasses positive ageing.

3.5 Activities/Meaningful Engagement: Facilitating a Positive Emotional State and Opportunities for Social Investment

Positive ageing in a care home context is also associated the opportunity to participate in meaningful activity [30] and residents talked about being able to enjoy activities, such as gardening, music, educational activities and outings if they chose to:

'I do a bit of gardening…I go to the music'. (Sandra, 69)

'The activities are very good… I go to the ones I fancy…more educational things, a variety of things really …I went in a coach one time to a … big lake in Yorkshire, it was a lovely day. I was with another lady in a wheelchair around the lake it was lovely'. (Bernice, 93)

'Then there are some activities, I go to some of them, and then lunch. (Helen, 89)

Again, Nigel acknowledged that being able to participate in activities is facilitated by Belong staff (they wheel us in) and he is able to continue to enjoy watching Manchester United football matches on satellite TV with his friend in the household.

'[I enjoy] watching united play on the tv. They wheel us into the bedroom you know. If they're playing a big match we can sit in that corner in that chair and then prop another chair round here, because some of the television doesn't include united does it?' (Nigel, 86)

Positive ageing in a care home context is also associated the opportunity to find a sense of usefulness [30], and some residents and their family members felt this was achieved through being involved in chosen activities:

'I've found things to do, one of the things they do is that I operate the sweet trolley. I take the trolley around twice a week, sweets, chocolates, toothpaste, lots of things. I go to the gym every day. The other thing I do is I look after the plants on the balcony here'. (Patrick, 77)

'They also let her have a go with the hoover and the duster, tidy the tables up and wash the dishes…it makes a big difference to her, she thinks she's helping out and being part of it here'. (Ralph, Elsie's (85) son)

Being able to participate in activities and meaningful engagement appears to fulfil two purposes: the maintenance of a positive emotional state and providing opportunities for social interaction – both associated with positive ageing. Even if participation in activities and engagement was facilitated by Belong – as part of their customer commitments and person-centred ethos, the benefits were reported by residents.

3.6 Optimising Health and Well-Being through Activities: Facilitating a Positive Emotional State

Optimising health and well-being are important features of positive ageing and Helen and Annie talked positively about how living in Belong helped them to remain active. For both women this appeared to centre on exercise and physical activity which they acknowledged was beneficial to their health and emotional well-being. For Helen, this involved rehabilitation after a fall and for Annie taking exercise for the first time:

'They encourage you not to give up on, to keep going which is good...Like keeping active but also resting if you want to rest'. (Helen, 89)

'I go on the bike, it's a good challenge for me… yes because I wasn't doing any exercise beforehand so that's good'. (Annie, 92)

3.7 Quality of Life: Residents' Perspectives

As discussed above, the overarching goal of culture change is to offer homelike environments to older people in which maximum quality of life can be achieved for residents [44, 45]. Quality of life is linked to positive ageing as we are using it – being able to maintain a positive emotional state and opportunities for social interaction. This is best understood when taking account of older people's interpretations, expectations and experiences of positive ageing in their own lives [28]. Most residents talked positively about the impacts on their quality of life since moving to Belong and indicated that it had improved since moving from their previous living arrangements. Feeling safe, being looked after and having their needs met, being well-fed and having company were all cited as enhancing quality of life by residents, including Joe:

'Well I'd say I've got a very good quality of life, I'm looked after, I'm safe and I'm well fed in good staff company.' (Joe, 88)

For Alice, since moving to Belong she is able to do more than she could while living alone as she felt 'safe', was no longer 'scared of falling' as help is on hand if she needed it. Through feeling safe, Alice felt that her dignity is preserved which positively impacts on her quality of life:

'It's about maintaining my dignity, you see I can't walk without my frame and I'm always scared of falling…Also, what's important is feeling safe because if I do fall I know someone will help me'. (Alice, 80)

Similarly, for Helen, being in Belong enables her 'to cope' – in other words exercise some control and autonomy over her life- which she equates with a good quality of life:

'I think quality of life for me is that I'm able to cope sort of thing, and that I feel safe and I think I do here really'. (Helen, 89)

Annie was very clear that her quality of life had improved because she had moved to Belong. She recognised that she was 'struggling' in her previous home and now this is facilitated, illustrated by Annie's comment 'all that stuff I can do because I'm here'.

'I do feel as though I have a quality of life now that I'm here...so yes, all that stuff I can do because I'm here … than if I was at home struggling'. (Annie, 92)

4. Conclusions

In this paper we presented new data generated from qualitative interviews with a sample of household residents in the fourth age living in Belong. From the evidence presented above - drawn from the subjective accounts of residents' experiences - it is evident that the household model as operated at Belong does facilitate the maintenance of a sense of self and personal identity, promoting positive emotional states and facilitating social investment, which are subjective indicators of positive ageing. Residents and their family members talked about being known as an individual and feeling that choice and autonomy are to a very large extent - and within the context of physical and sometimes cognitive impairment – facilitated and maintained, again contributing to positive ageing.

We have shown that the household model as operated at Belong facilitates the maintenance of autonomy and independence among residents and that this contributes to positive ageing and quality of life as they define it. However, it should be acknowledged that for people in the Fourth Age, often, autonomy and independence must be enabled or facilitated alongside physical and bodily decline and needs to be understood within the context of such changing circumstances. There are key junctures where these adaptations can be made, with the decision to move to a care facility being particularly significant. It seems that those people who exercised a degree of control over this process were the happiest with the decision taken, and the most likely to report experiences of positive ageing. For service providers, understanding the life of the person before the need for care is crucial in facilitating quality of life and positive ageing. Additionally, assisting with the transition to a household – maintaining as much independence and autonomy as possible - while also facilitating an understanding of how changed circumstances impact on the ability to maintain continuity are key interventions for service providers who subscribe to the culture change ethos.

Living in small scale households with a resident-led ethos as operated under the Belong model appears to have significant positive impacts on older people's quality of life and wellbeing. Not feeling 'institutionalised' and living in a homelike environment can also make the transition to a care home context easier to navigate. Higher staff ratios where residents feel known by staff also seems to contribute to this, as does the design of the households which facilitates a homelike atmosphere and provides opportunities for interaction with others. Encouraging choice and control over meals, daily activities and opportunities for household, village and neighbourhood interaction all appear to have positive impacts on residents' quality of life and ability to age positively. Thus, despite a physical and mental decline in this age, it seems clear that positive/active ageing can both be useful and applicable to people in the fourth age who are living in a care home context and there is a significant role for the household model of care provision in facilitating this.

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Ahmed is the lead author and was responsible for leading the writing of the paper and data analysis. Ormandy contributed to writing the paper and analysis of the data. Seekles contributed to writing the paper and the literature review.

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